REPORT ON THE
LOOK-BACK REVIEW INTO
CHILD & ADOLESCENT MENTAL HEALTH SERVICES
COUNTY MHS AREA A

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1 TABLE OF CONTENTS

1 EXECUTIVE SUMMARY

Concerns were raised about the clinical practice of a Non-Consultant Hospital Doctor in prescribing, care planning and diagnostics in CAMHS Area A by a Non-Consultant Hospital Doctor (NCHD2) and again by a Locum Consultant, Child and Adolescent Psychiatrist (CP1) in September 2020. The concerns pertained to the practice of NCHD1, who was employed by County MHS Area A from July 2016 to June 2020 as a Senior House Officer (SHO) in CAMHS. These concerns were reported as a potentially dangerous occurrence and managed in line with the HSE Incident Management Framework 2020.

An assessment of the concerns raised was undertaken by a Consultant Child and Adolescent Psychiatrist (CP5) in the form of an audit of 50 clinical case files in order to establish what, if any level of departure from best practice could be identified in the prescribing and care planning of NCHD1.

The 50 files represented 10% of the clinical caseload of the team and 20% of NCHD1's caseload. The outcome of this audit informed the decision to progress to a Look-back Review (LBR). The LBR was formally commissioned by the Chief Officer in the CHO in April 2021.

The purpose of the LBR was to consider the potential clinical issue relating to the clinical practice of NCHD1 in prescribing, care planning, diagnostics and clinical supervision in CAMHS Area A between 1 July 2016 and 19 April 2021, and to complete a Recall Stage, in line with the HSE Look-back Review Policy 2015. The Look-back Review process commenced on 19th April 2021 and the clinical review of patient records concluded on 9th September 2021.

Please note that this report has been anonymised and reference to they/their has been used in this document to support anonymity in a small community.

1.1 STATEMENT OF FINDINGS

1. No extreme or catastrophic harm had occurred in the 1,332 cases considered between July 2016 and April 2021.

2. There were 227 children managed by NCHD1 where the diagnosis and/or treatment exposed them to the risk of significant harm by way of one or more of the following: sedation, emotional and cognitive blunting, growth disturbance and serious weight changes, metabolic and endocrine disturbance, and psychological distress. The medicalisation of ordinary emotional responses in children and their suppression by medication, risks delaying or damaging the development of skills in the self-regulation of emotions which normally happens as children mature.

3. 13 other children were found to have been unnecessarily exposed to a risk of harm under the care of other doctors in the service.

4. There was clear evidence of significant harm caused to 46 children in the files that were reviewed. This included galactorrhoea (the production of breast milk), considerable weight gain, sedation during the day, and elevated blood pressure. This figure of 46 will change as new information becomes available from meetings with the children, young adults and parents affected.

1.2 KEY CAUSAL FACTORS

1. The diagnoses of ADHD, particularly for secondary-school children, was frequently made without adequate evaluation and/or without the required level of information in relation to their presentation in school from their teachers.

2. Feedback from teachers was not requested as part of the management of treatment response for ADHD. There was evidence that this was the practice of the doctors who were prescribing for ADHD in general rather than being confined to NCHD1.

3. There was evidence of inconsistent and inadequate monitoring of adverse effects of medications, this included:

a. Children started on stimulants did not routinely have a baseline pulse, blood pressure, height or weight measured and charted, to establish pre-treatment values.
b. Children started on antipsychotics did not routinely have a baseline blood test to establish pre-treatment values.
c. There was no expectation of checking pulse and blood pressure seven days after starting stimulant or increasing the dose.
d. Repeated height, weight, pulse and blood pressure measurements were erratic and not plotted on developmental charts.
e. The patient's GP was asked to do the blood tests in some but not all instances when children were started on antipsychotics. There were no results of this on file in the majority of cases. The tests were not routinely repeated at regular intervals.

4. It is a reasonable assumption, but cannot be confirmed because NCHD1 was not available to be interviewed by the LBR Team, that they were intending to help, not harm, the patients they treated and that the exposure to risk and harms occurring were as a result of a lack of knowledge about good practice. While the NCHD contract specifies involvement in education and training, these requirements are generic and could be met by any faculty registration for NCHD's on the General Division of the Irish Medical Council Register. There was no contractual requirement, or support and monitoring through supervision, to develop skills in the sub-specialty of child and adolescent psychiatry.

1.3 KEY CONTRIBUTORY FACTORS

1. There was an absence of a Consultant Clinical Lead for Team A which contributed to this failing to deliver and sustain a high-quality service. CP2 agreed to cover the gap in service in 2016, in the reasonable expectation that it would be a short-term solution, while a replacement was sourced, either by recruiting to the substantive post or by employing a locum. When this did not happen, there was no clearly documented reconsideration of the risk or change in the mitigating controls or measures in place.

2. The absence of a consultant in Team A meant that there was not regular, effective oversight of NCHD1's work through formal supervision and frequent joint working with a senior doctor.
   a. Supervision of NCHD1 did not identify the extent of their experience, skills, ability or limitations or the problems as they developed in 2017 and 2018.
   b. When concerns about NCHD1's practice were first described by CP4 in 2018, no effective action was evident to address them.
   c. Concerns regarding prescribing by NCHD1 were clearly identified in 2019. The supervising consultant and the ECD2 in the main, "advised", rather than directed changes in practice to prevent further problems.
   d. NCHD1 was known to have been working excessive hours and to be tired, if not exhausted, at work.
   e. Internal processes and procedures to address these types of problems through Occupational Health and Human Resources were not activated.
   f. There was no systematic supervisory check of the prescribing practice, or more broadly the quality of service provided by NCHD1, by their consultant and the ECD2.
   g. In 2020 NCHD1 was recognised as hardworking and still considered an important asset to the service. Despite the concerns that ECD2 had attempted to address recently, because of the perceived threat to service continuity, they agreed that NCHD1 could come off the adult mental health on-call rota by moving to an agency locum post.
   h. The serious concerns about NCHD1's practice were not handed over to ECD3 in the summer of 2020.

3. The service has not implemented many of the recommendations of the CAMHS Standard Operating Procedure 2015 or the subsequent CAMHS Operational Guideline 2019.
   a. Having clear treatment plans that are updated regularly and shared with the patient, their family and the referrer

b. Appointing a Key Workers to all cases, which would improve communication and case management, share the caseload with the doctors and reduce the risk of cases being lost on the treatment pathway
c. Appointing a Team Coordinator which would share the governance role with the Consultant covering the clinic and reduce the risk of gradual degradation of service quality, focussing on clinical practice
d. Appointing a Practice Manager which would share the governance role with the Consultant covering the clinic and reduce the risk of gradual degradation of service quality, focussing on administration and organisation.

4. The proportion of referrals accepted by Team A was noticeably higher than the National and CHO average and has not reduced in line with the other services.

5. 10% of the referrals which were not accepted were not dealt with promptly and were left awaiting a decision on acceptance

6. Despite several efforts documented over the past five years by the line managers, the Team A team does not keep a shared diary. Reception staff do not know who is coming in for appointments, those in coordinator roles cannot quickly identify who is working on a case, and cases are lost from the clinical pathway.

7. Line managers have not been able to enforce the policy on case-record management. The administrative office/record store is open to all clinicians who can and do remove files without signing them out. Neither staff nor managers knew how to authorise the file room door being locked as a possible solution; clinicians saw record management as an admin problem and administrators did not think clinicians would agree to such changes and there was no sense that safe practice adhering to the HSE policy would occur.

8. Records management processes were not robust within the service. Clinical information was not always recorded in the appropriate patient record, and there is evidence of 2 missing referrals and 10 full case records. Missing records have been reported in line with the HSE Data Protection Policy 2019[1.] 136 files had gaps in the clinical record and for 92 of these, the absent information contributed to the need for recall as it was not possible to be sure the child had not been exposed to harm.

9. Doctors were present in 56% of initial assessments, while being around one quarter of the clinical staff.

10. There is a disproportionate workload and caseload distribution in Team A. The doctors hold over 100 cases, there is an average of 23 cases for the other team members.

11. The Governance Group did not seek to check that Team A was functioning safely and effectively. The individual managers' concern was on the performance of their staff being line managed and there was little consideration of whole team processes.

12. The CAMHS Governance Group did not recognise, or did not think it was their responsibility, or did not have a way to discuss, the risk to the service arising from the long-term vacancy.

13. Risk management for Team A, from the front line to the Area Management level, was generally considered in terms of making the problem go away, fixing something broken or recruiting to a vacant post, rather than considering the breadth of potential consequences of the identified risk, and taking steps to avert them occurring and monitoring to ensure the system is working safely.

14. The Systematic Review offered in 2019 might have drawn attention to some of the systems and thinking in place that has permitted the development of poor quality and unsafe practice that has occurred.

15. The CAMHS Governance Group was responsible for overseeing the quality of the CAMHS service being provided in the area. There is no evidence to demonstrate that this group sought to check that the Team A was functioning safely and effectively.

16. The service managers have limited quality measures to enable them to gauge team performance, quality and risk. There are nationally approved Key Performance Indicators (KPI's), but these are of limited value as snapshots because they are activity focused.

1.4 RECOMMENDATIONS

35 recommendations have been made, these recommendations stem from the analysis and findings detailed in Section 7 and 9 of this report. They cover areas such as re-establishing trust in the CAMHS service, governance of the service, delivery of clinical services, improved clinical practice and the use of information and communication technology to support the delivery of services.

1. Children and their families should be invited to be part of the governance structure of the CAMHS service. This can be facilitated through linkages with local advocacy services or national groups such as ADHD Ireland. It should be noted that a Service User Representative is included in the recently proposed CAMHS Governance Group.

2. The recruitment of a permanent full-time clinical lead Consultant Psychiatrist must remain a priority for the service to ensure adequate clinical governance structures, leadership and clinical expertise is available to the team in the immediate future. However, this is likely to be another locum post and it is not clear that the post holder would have the support of the team to make changes in practice. Direct clinical management support from the ECD and CD will be necessary to effect change in these circumstances.

3. Consideration should be given to the establishment of a working group to look at the current and future needs of the CAMHS. Current CAMHS models and proposed developments, in Ireland and the UK should be examined. Engagement with service users, family members and other stakeholders should be undertaken as part of this consultation to understand the needs and expectations of the community and establish structures to permit ongoing dialogue.

4. Training in risk and incident management for line managers and front-line staff should include risk identification and reporting, risk analysis, mitigation and development and monitoring of controls. This should be mandatory rather than voluntary and the risk management plans developed should be discussed in management supervision and handed over when post holders change. In this way risks can be managed at the appropriate level, rather than have staff feel they can abdicate responsibility by "putting it on the risk register".

5. In the absence of a full-time consultant within the service, there should be one identified clinical lead for the service with time scheduled to attend the clinic for managerial and for clinical sessions.

6. Recruit a Team Coordinator to support the process of tracking quality standards and performance for the team. The Team Coordinator should also be a member of the CAMHS Governance Group so that there is a direct link from the team into the management structure.

7. Recruit a Practice Manager to review and improve current working practices within the team. Lean processes should be implemented to ensure staff are working efficiently in their area of expertise. This is complementary to the Team Coordinator post.

8. The Team Coordinator, Practice Manager and Clinical Lead should work with the CAMHS Governance Group and the CAMHS Area A Team to implement the CAMHS Operational Guideline 2019.

9. The CAMHS Governance group members should work with the Clinical Lead, the Team Coordinator and the Practice Manager to establish the clinical capacity, (appropriate caseload) and expected throughput of the CAMHS team and supervise their staff using these figures. In that way, the capacity of the team can be understood, any gaps in service provision can be clearly seen and will form the basis of any development funding requests.

10. Once the Team Coordinator and Practice Manager are in post, the team should undertake the externally facilitated "Enhancing Teamwork" initiative as provided by the HSE.

11. The CAMHS team should implement the Key Worker role for all cases.

12. The member of the CAMHS Governance Group should agree and implement a clinical diary and case management system to track appointments and case allocation. This can be a paper or electronic based system and does not need to await the provision of a computerised system.

13. The members of the CAMHS Governance Group, as line managers must take responsibility for the safe and effective management of clinical records and hold their staff to account for breaches of policy and procedures.

14. The Terms of Reference of the existing CAMHS Governance Group must be reviewed and updated. It should be noted that this is in progress. The Governance Group should consider the use of an "Action Tracker" or other device to ensure clear ownership and completion of tasks.

15. Audit training must be provided to the team by the Quality and Department Safety within the CHO, and an annual audit schedule established by CAMHS Teams. Service users should be consulted and included in the audit oversight group. CAMHS appropriate audit tools should be developed. Audit activity should be organised across all teams in CAMHS in order to share understanding and develop collegiate thinking for the service. A member of the CAMHS team should be a nominated representative on the CHO Audit Committee.

16. The service should seek to develop and pilot a new permanent doctor grade at NCHD level for two of the County MHS Service Area A posts in the expectation that these positions will continue to be necessary.

17. A working group should be established to progress a plan for a service re-design to provide an integrated mental health service for 0 to 25-year-olds. Once completed the plan should be submitted to the CHO Management Team for approval.

18. The CHO service should scope out the regulatory requirements for the provision of medical services remotely outside the country, in the EU or elsewhere, with a view to retaining a CAMHS consultant who is able and willing to provide such treatment. If it is feasible, a clinical service should be developed.

19. Consider developing a CAMHS stand-alone management structure which will work alongside the adult mental health service structure.

20. Consider, with or without separate management, developing specialist services within the CHO, to enhance the quality of the service and to broaden the range of senior practitioners who can take on leadership roles within the teams so that the process of setting and tracking quality standards and performance for the team is not located solely with the consultant and the service does not remain dependent in the long term on the limited consultant pool.

21. The Dundee Pathway adapted if necessary for CAMHS, should be the standard model of ADHD assessment and treatment in the service. Use of the QB Test should be integrated into this protocol.

22. Shared care protocols should be developed with GP's for the management of children with ADHD. If this is problematic, because of concerns regarding controlled drugs, local pharmacists could be engaged in this process.

23. Psychotropic medication should only be initiated by, or with the documented express agreement of the Consultant responsible for the child's care. It should not be started in the Emergency Department without oversight and agreement from a CAMHS Consultant.

24. The CHO should consider establishing a Drugs and Therapeutics Committee for CAMHS, or a joint Committee for CAMHS and adult services.

25. Protocols for the use of antipsychotic medication in non-psychotic and psychotic patients should be developed, based on the NICE Guidelines23 and implemented. Practice should be monitored through the use of clinical audit, again as recommended by the NICE Guidelines. Blood tests for the management of antipsychotics should happen at baseline and three months, and at least annually thereafter.

26. The use of psychotropic medication in CAMHS should be audited on an annual basis, using NICE Guidelines in the absence of local protocols and procedures.

27. In the absence of clear shared care agreement for the patient, the doctor who requires a blood test should request it themselves, to avoid the uncertainty about whether a test has been done and whether the results fall within or outside the normal range for the age group.

28. Clinical reports from the MDT should be shared routinely with the GP and with others who may refer children.

29. A protocol for the routine collection of Patient Reported Outcome Measures (PROM's) should be developed to track clinical progress against treatment plans and to inform the understanding of service quality and performance.

30. Treatment and care plans for all children should be updated regularly in consultation with the patient and their parents/guardians. All updates should be communicated with the referring clinician.

31. The CHO should set out specific educational and training expectations for its NCHD's in Child Psychiatry including affiliate membership of the College of Psychiatrists of Ireland and should consider whether this approach should be adopted more widely.

32. The CD for CAMHS should ensure that all NCHD's are meeting their statutory requirements for Professional Competence Scheme (PCS) registration[26].

33. The CHO should consider aligning clinical service plans with professional competence activities, particularly specific training needs and clinical audit. This links back to the recommendations for greater CAMHS autonomy and specialist services above and it will be necessary for consultants, not just NCHD's if coherent service growth and development is to be facilitated.

34. The CAMHS Governance group should explore the options available in ICT to improve the governance, effectiveness, efficiency and accessibility of CAMHS in the CHO. At the very least this should include a shared team online diary and a clinic database built around episodes of care.

35. The likelihood of inadequate supervision of NCHDs in non-training posts in specialist services due to prolonged vacant consultant posts should be brought to the attention of other Chief Officer's and ECD's for consideration and where necessary, risk mitigation.

1.5 INDEPENDENCE

The Review Team was essentially independent of the matters under review; no team members were directly involved in the incident.

2 ACKNOWLEDGEMENT

The author of this report, and through him the members of the Look-back Review Team, would like to thank all the children, young people, and their families for their forbearance during this process and in particular for the clear, thoughtful and constructive feedback on the service that has been given by those who had been invited to attend meetings.

The team would also like to thank the members of Team A and Team B and the managers of the County MHS Area A CAMHS who have participated in the interviews and responded promptly to follow-up questions.

3 OVERVIEW OF THE REVIEW PROCESS

The Clinical Director (CD) for CAMHS was alerted to a potential clinical issue relating to the clinical practice of NCHD1, in prescribing, care planning, diagnostics and clinical supervision by a newly appointed Locum Consultant Psychiatrist (CP1) to Team A on 22/09/2020.

NCHD1 was employed in HSE CAMHS Area A from July 2016 to September 2020, when the agency contract was ended. The CD CAMHS and the ECD3 convened a meeting with Locum CP1 and CP2. The Quality and Safety Advisor (Q&SA) also participated on the call on 24/09/2020 and advised that a Serious Incident Management Team (SIMT) process was required.

Under the reporting of cases of known harm, an initial index case of a child presenting to Emergency Department in Acute Hospital A was discussed. The NIMS reference number for this case is 21331301.

A file examination was undertaken by the CD CAMHS which confirmed that there may have been issues that needed to be addressed and required further assessment.

ECD3 sought advice and briefed the National Clinical Lead on 29/09/2020.

A SIMT was formed on 6/10/2020 chaired by the Head of Service A (HOS A) to examine and determine if the concerns were valid. A decision was made to initiate an independent audit of a sample of 50 cases (10% of Team caseload /20% of the caseload held by NCHD1) to determine if there were grounds of concern. Terms of reference were prepared with Quality & Safety Advisor (Q&SA) input and were approved by the SIMT.

Additional clinical and administrative supports were made available to the team and Locum CP1 commenced a review process of open cases to ensure safety of care plans for existing clients.

A further SIMT was held on 09/11/2020 and reported progress on the independent audit.

The final audit report was issued on the 18/02/2021, it found significant concerns within the sample audit, relating to unsafe prescribing, documentation issues, care planning issues, diagnostics and supervision.

The SIMT met on the 10/03/2021 to discuss the findings. It was also agreed to provide further administrative supports to the team to establish the numbers and patient cohort who may be affected. Further information was also sought from the Head of Quality, Safety & Service Improvement (HQSSI) in relation to a potential lookback review process.

The SIMT met on the 22/03/2021 with the HQSSI having considered the audit report findings. The HQSSI outlined the steps of the HSE Look-back Review Policy 2015 in the context of the action already undertaken in managing the incident in line with the Incident Management Framework 2020. The completed preliminary assessment and sample audit met the requirements of the first two stages of HSE Look-back Review Process. The HQSSI recommended that a Look-back Review Process was required and advised that this would need to be commissioned by the Chief Officer.

The SIMT met again on the 29/03/2021 to determine the scope of the review and prepare and provide handover to the newly formed SIMT chaired by the Chief Officer.

The SIMT chaired by the Chief Officer was convened on 01/04/2021 and it took over management of the incident from that date. Membership included: HQSSI, HOS A, HOS HR, CD CAMHS, ECD3, Communications Manager and Area Administrator. Members of the team commissioned to carry out the look-back review were invited to provide an update to the SIMT at each meeting. The SIMT met on 31 occasions to the end of November 2021.

The requirement for a Look-back Review has been logged on NIMS under "Dangerous Occurrence" incident (NIMS reference number 21330972)

The LBR Team was convened at the end of April 2021.

A check of the Team B CAMHS files identified 35 cases in which NCHD1 had been involved, while they worked there from July to September 2020 and in 2016 and also at University Hospital A. These were reviewed by the Consultant there and any identified problems in the treatment plan have been addressed with the families and children. These files have also been reviewed formally by the LBR Team and described separately here.

4 PERSONS INVOLVED IN THE CONDUCT OF THE REVIEW

Dr. Sean Maskey, Recall Team Lead, Consultant Child and Adolescent Psychiatrist.
Mr. Aidan Murphy, Assistant Director of Nursing, Mental Health Services.
Dr. James O'Mahony, Area Director of Nursing, Child & Adolescent Mental Health Services.
Ms. Kathryn Hallahan, Advanced Nurse Practitioner, Child & Adolescent Mental Health Services.
Mr. Gordon Lynch, Psychotherapist, Registered Psychiatric Nurse (Retired ANP).
Ms. Eithne McAuliffe, LBR Project Lead, General Manager
Ms. Kate Cadogan, Senior Executive Officer
Ms. Marguerite Healy, Staff Officer
Ms. Anne O'Connor, Staff Officer

Additional administration staff were engaged at various times during the review process to support the team with administrative duties such as database management, issuing correspondence to all included within the scope of the lookback review, organising meetings, issuing appointments and issuing minutes of meetings etc.

5 BACKGROUND

Concerns were raised about the clinical practice of a Non-Consultant Hospital Doctor in prescribing, care planning and diagnostics in CAMHS Area A by a Non-Consultant Hospital Doctor (NCHD2) and again by a Locum Consultant, Child and Adolescent Psychiatrist (CP1) in September 2020. The concerns pertained to the practice of NCHD1, who was employed by County MHS Area A from July 2016 to June 2020 as a Senior House Officer (SHO) in CAMHS. These concerns were reported as a potentially dangerous occurrence and managed in line with the HSE Incident Management Framework 2020.

Team A's substantive Consultant post became vacant in July 2016, and it has not been possible to fill this permanent post since then. Therefore supervision arrangements for NCHD1 were put in place whereby they would report to the Team B CAMHS Consultant Psychiatrist (CP2). It is noted that during this period CP2 was covering two sectors (Team A, 0-18 population 18,775, and Team B, 0-18 population 15,752), except during a period of eight months when a locum CP3 was recruited to Team A, and CP2 had responsibility for the Mental Health of Intellectual Disability (MHID) across the county and hospital liaison for child and adolescent psychiatry.

Three locum consultants in all, were employed during this time. One worked with the team for eight months; they were not a specialist in Child and Adolescent Psychiatry, although they had long experience in the field and had agreed to seek specialist registration. However, this was not pursued. Another locum worked for two weeks at the start of 2020; it had been agreed that this would recur every month, but the Covid lockdown prevented this. The third locum arrived after NCHD1 had moved to Team B and they were instrumental in collating the concerns about NCHD1's clinical practice and in bringing these to the attention of senior management, notwithstanding CP2 had previously raised concerns with ECD2 in 2019.

A third consultant post was allocated to the County MHS Area A CAMHS service in 2017 to develop and run the Mental Health of Intellectual Disability and Liaison Psychiatry. A substantive consultant appointment was made in 2017, and the County expected to have a full consultant complement in 2018, however the appointee withdrew their acceptance of the post for personal reasons and the post was never filled. As a result, CP2 continued to have responsibility for the Mental Health of Intellectual Disability (MHID) across the county and hospital liaison for child and adolescent psychiatry.

Team A and Team B had previously been one combined service under Voluntary Service Provider A. Organisationally the service was split under the HSE with the expectation that Team A would move from the shared building to a new site within its catchment area. This process was delayed and the premises that both teams shared became increasingly unsuitable. Team B moved to new accommodation in early 2019, leaving Team A in the original building.

Team A was provided with new premises following the arrival of the new Locum Consultant (CP1), in the late summer of 2020. CP1 worked to remedy the unsatisfactory treatment plans and address the internal waiting list for ADHD treatment, which stood at around 100 cases, before leaving Team A in June 2021.

The demand for CAMHS has been rising steadily nationally and locally for the last 20 years, not least because of a change in the expectations of parents and some reduction in the stigma associated with mental illness.

A review of Team A by a Psychology Manager, as part of the CHO "CAMHS Enhancement Project" in 2017 resulted in the addition of 1.7 Whole Time Equivalent (WTE) clinicians to the team. Two additional NCHD posts have also been provided in County MHS Area A, in recognition of the absence of a consultant and the team has been allowed to backfill gaps in service due to maternity leave.

6 HIGH LEVEL CHRONOLOGY OF EVENTS

6.1 INCIDENT

This incident is the result a large number of events relating to the care and treatment of children, attending the Team A clinic, by a Non-Consultant Hospital Doctor, culminating in unreliable diagnoses, inappropriate prescriptions and poor monitoring of treatment and potential adverse effects. These events exposed many children unnecessarily to the risk of significant harm.

6.2 METHODOLOGY LOOK-BACK REVIEW CLINICAL TEAM

A database was commissioned to record and report the work of the team and the demographic and referral information from the CAMHS Area A database was imported.

The LBR Team has reported progress to the weekly SIMT meeting, giving projected outcome expectations and seeking guidance on process queries as they arose. Case notes were retrieved from the CAMHS Area A file room, Iron Mountain record depository and other locations, CAMHS Area B and Adult Mental Health Services. Further demographic and clinical activity data (diagnoses, medication, and clinician involvement) were extracted from the records and entered onto the database by the HSE administrative staff on the LBR Team.

File received, administration staff prepopulated on database, file marked on database; "For Nurse Manager Review", "For ANP Review" and "For External Consultant Review". A "Date Completed" field was entered after each stage.

Files reviewed in the following Priority as determined by risk:

P1 Active cases in alphabetical order who were seen by NCHD1

P3 Those discharged, commencing with discharges 2021 and working backwards to July 2016 and were seen by NCHD1

P2 Active cases in alphabetical order who were seen by team members excluding NCHD1

P4 Those discharged, commencing with discharges 2021 and working backwards to July 2016 and were seen by team members other than NCHD1.

The paper files were in numerical sections from 1-10 as indicated below:

0 Patient Details and MDT discussions
1 Psychiatry / Initial assessment (IA)
2 Psychology
3 Nursing
4 Social Work
5 Social Care Work
6 SLT
7 OT
8 School / Forms
9 Incoming Correspondence
10 Outgoing Correspondence

Chronological review of file is documented from date of initial assessment up to most recent engagement with Team A, chronology of events include:

- Evidence of assessment workup to support diagnosis
- Diagnoses given
- Dates of medication etc. include details of initiation and maintenance doses of medications prescribed as well as side effects.
- Evidence/lack of evidence of physical monitoring, details of polypharmacy / potential drug interactions
- Details of each medical appointment and outcome of same
- Details of non-attendance at appointments
- Relevant engagement and interventions provided by Team A MDT members
- Any update to risk assessment

Names, addresses dates of birth of the patients along with referral information and discharge status was also recorded.

6.2.1 RISK ASSESSMENT

If there was evidence of risk assessment details i.e., if there was a formal documented risk assessment or risk management plan, or evidence that a verbal risk management plan was given, the relevant box was ticked on the database and documented.

6.2.2 EVIDENCE OF APPROPRIATE CARE PLANNING:

The LBR Team documented evidence of appropriate care planning as evidenced in the file. Such examples included:

- Clinical Interventions: CBT, DBT, Anxiety management groups, parenting groups, behavioural management support, CAMHS OT and SLT assessment and follow up intervention
- Individual intervention/support from individual MDT members

6.2.3 PHYSICAL SCREENING

Evidence of appropriate physical screening was also documented by the LBR Team.
The following headings were used:

- Adequate physical screening

If not, items of concern were flagged:

- Height, weight, BP, Centiles
- Appropriate response
- Physical Health Concerns
- Ongoing Monitoring
- Appropriate response to monitoring
- Evidence of harm
- Evidence of no harm

- Any other comment

6.2.4 MULTISOURCE FEEDBACK

Where there was evidence of multiagency involvement in a case, this field was ticked in the database. These agencies included:

- Disability Services
- Primary Care Services
- School
- TUSLA

6.2.5 MEDICAL NOTES MISSING

Where there was evidence of medical notes missing from a file, this was included in the database. The relevant dates (where known) were documented in the "Issues of note from file review" section of the database. These files were re-reviewed to determine the impact the missing medical information had on the overall outcome assigned to a file. Outcome 5(b) was generated in respect of this for files where it was not possible to infer clinical management from the extant record. It highlights to the consultant reviewing the case that there are gaps in the record that may need to be explored. 5(b) has not been separately described.

6.2.6 URGENT ACTION

The LBR Team documented if any file was urgently returned to Team A. Such instances included:

- Files lost to follow up of clients on medication and stimulant medication that required specific physical monitoring.
- Concerns regarding elevated blood pressures recorded at previous reviews and required follow up.
- Cases where abnormalities in blood results were observed, or urgent requirement for blood results to be repeated i.e. LFT's, prolactin levels, blood sugar levels
- Cases where the level of risk appeared to be high, and were lost to follow up

In all, 12 files were returned for urgent review. The LBR Team is not aware that any child required a change in treatment as a result of this.

6.2.7 ASSIGNING OUTCOMES

The following outcome categorised were developed by the LBR Team approved by the SIMT.

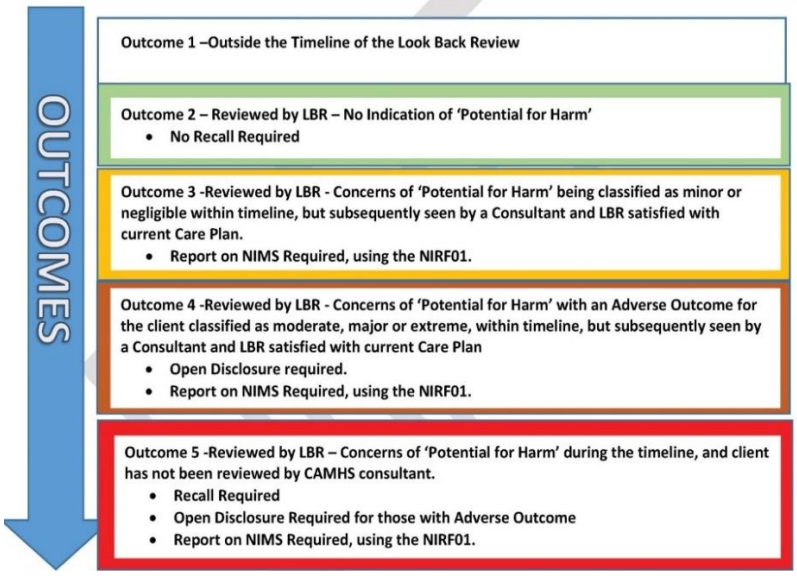


Figure 1: Outcome Categories Developed by the LBR Team

Outcome 1 (O1) designated the record as being outside the scope of the review.

When Outcome 2 (O2) was assigned to a case, the LBR Clinical Team members engaged in peer supervision to discuss the case. If there was any ambiguity about the outcome, this was escalated for Advanced Nurse Practitioner (ANP) Review /Consultant Review. The relevant field was checked on the database, and the entry was dated and initialled by the Nurse Manager. These files were then reviewed by the ANP / Consultant.

Where a provisional Outcome 3 (O3), Outcome 4 (O4) and Outcome 5 (O5, O5B) were assigned, these were automatically escalated for consultant review on the database. The relevant field was checked on the database, and initialled by the Nurse Manager / ANP.

Files that were marked for ANP review were reviewed by a Registered Advanced Practitioner (RANP). The role of the RANP as part of the LBR process was to use their advanced clinical knowledge and skills to aid clinical judgement in the review of files. The RANP is competent in the synthesis and interpretation of clinical assessments and screeners used to aid diagnosis. The RANP used their advanced expert knowledge to identify gaps in assessment workup prior to diagnosis and in provision of appropriate follow up care and monitoring. The RANP is also a registered prescriber and used their knowledge to identify inappropriate prescribing and use of inappropriate pharmacological interventions without an evident rationale / diagnosis. Initiation and maintenance doses of prescribed medications for children/ adolescents supported by an evidence base was also examined and evidence of potential side effects and inadequate monitoring of different medications prescribed was highlighted. All of these individual file review findings were collated, marked “For Consultant Review” on the database, and presented for review by the LBR Consultant.

6.2.8 CONSULTANT REVIEW

Because of the HSE cyber-attack, it was not possible to have remote secure access to the database and the Consultant was provided with pseudonymised snapshots of the file. This was done by stripping out names and address fields and encrypting the files before direct transfer between devices using a VPN connection. Cases that were assigned O3, 4 or 5 were reviewed by the Consultant Child and Adolescent Psychiatrist, along with O2 cases that had been prescribed neuroleptic medication or unusual combinations. The database was locked at the end of the review process, and it is this file that has been used to generate the figures and charts for this report.

The majority of the case reviews were done on site and the clinical file as well as the LBR Team comments were considered. In order to maintain progress, some files were reviewed remotely in conjunction with the Nurse Manager who had the paper file.

The Consultant is an expert, by training and experience, in the assessment and treatment of children and adolescents and is leading clinical teams in the delivery of services in general and specialist CAMHS and inpatient units. They are able to synthesise and evaluate the information contained in and extracted from the records and reach a robust conclusion on the quality of the service provided to each case and the exposure to risk as a result of the assessment and treatment provided and when the information is available, quantify the degree of harm in line with the HSE Incident Management Framework 2020.

6.2.9 RECALL PROCESS

Once the file review had been completed, and the database locked, an interim report was presented to the Review Commissioner so that the process of arranging meetings with children and their families or the adults could begin. This report was produced in parallel along with the further clinical review of the North Kerry Files, described below (10.1).

240 children and young people were identified as requiring a formal open disclosure meeting. Of these, 104 required a clinical recall review. These were carried out independently by the HSE staff, Consultant Child and

Adolescent Psychiatrists, Adult Psychiatrist for those aged over 18 years, and senior CAMHS clinicians, along with senior managers for the Open Disclosure meetings. The teams required an administrator to organise the process and schedule, and re-schedule the appointments and take telephone enquiries and a receptionist to meet and assist families and young people.

The reviews were expected take 60 to 90 minutes, but a wide variation was anticipated with some being straightforward as no untoward events would emerge, and others would be more complex and take rather more time. The clinical teams were expected to conduct initial reviews on 3 to 4 cases per day. It was anticipated that the great majority would not require further clinical action, but that some children may need to be offered further CAMHS intervention and similarly some adults may need access to adult mental health services. Data and information from the meetings will be collated and fed back into the implementation stage of the investigation process.

7 ANALYSIS OF THE INCIDENT

7.1 TIMELINE

This describes the details of the circumstances around the events in Team A between July 2016 and April 2021. Team A had formed by separation of the County MHS Area A service in 2009 into Team A and Team B. The substantive Consultant, CP8, took up post in September 2011.

*Figures in the tables in this section are from the CHO KPI data collected at the time.

7.1.1 2016

2016	Actual Clinical WTE	Referrals	Accepted
Team A	5.59	151	121
Team B	7.58	292	206

Figure 2: Clinical WTE and Referral Data 2016[1]

NCHD1 joined Team B CAMHS in July 2016 as SHO having been in adult mental health services for three years. CP8 left suddenly in July 2016. CP2 agreed to provide consultant and clinical lead cover while the post was advertised, and locums were sought. CP2 noted that they were already extremely busy in their own area, therefore the cover they could provide was limited. CP2 agreed to supervise NCHD1 in Team A who had a registrar contract (in 2020).

In September 2016, MDT members of Team A wrote to ECD1. They expressed concerns about the lack of consultant presence at MDT meetings, the backlog of clients awaiting formal diagnosis, Mental State Examinations (MSE's) being overdue and the backlog of young people awaiting medication reviews. In October 2016, MDT members of the Team A wrote to their HOD's expressing concerns in relation to current working conditions of Team. A meeting was requested with the ECD1 and CP2 to discuss these concerns. ECD1 responded by proposing a private arrangement from a Healthcare provider to "Buy In" psychiatry input for the team. There was also a request that CAMHS Registrars come off the adult metal health service "on call" rota. CP2 subsequently wrote to referring agencies informing them that Team A's routine waiting list was frozen and that cases would be prioritized on the basis of clinical need and risk. This does not seem to have been revoked. Later that month (21/10/2016) CP2 wrote to the team, stating they no longer had capacity to provide input to Team A, but would continue to oversee the cases they had built up over the previous 8 weeks. A risk assessment form was completed by CP2 who rated the risk resulting from the consultant vacancy as maximum in terms of impact and likelihood.

[1] Annual Referral rates are given for whole years for comparison and so the total is greater than the in-scope number.

Limited high-level risks as consequences were identified on the County MHS Area A Risk Register spreadsheet and mitigation was around recruitment to the post, either as a locum or substantive post. However, the interviews with senior management clarified that a number of actions were taken to mitigate the potential risks arising; the CHO CAMHS Enhancement Project enabled identification of gaps in comparison against Vision for Change[1] and recruitment to non-medical positions, the service was allowed to use additional resources to manage emergency cases presenting in the acute wards. Two additional NCHD's posts were subsequently authorised in County MHS Area A CAMHS, bringing the complement to four, and the case was successfully made for an additional consultant post in Mental Health of Intellectual Difficulty (MHID) and Hospital Liaison.

In November 2016 a meeting was held between Team A members and HOD's. It was noted that there was an active caseload of 321 clients attending Team A at this time. It was also noted that 33 cases were overdue MSE, and there were also cases where medication reviews were overdue. CP2 again expressed their concern that they did not have capacity to oversee both services. It was suggested that Team A and Team B become one service until the staffing situation was rectified. A request for an additional "Registrar" was also made at this meeting. It was agreed that MDT members would not have to "sit in" with the "Registrar" for reviews.

7.1.2 2017

2017	Actual Clinical WTE	Referrals	Accepted
Team A	4.75	135	94
Team B	7.88	288	214

Figure 3: Clinical WTE and Referral Data 2017

A follow up meeting was organized between members of Team A and the HOD's in January 2017. The following data was provided: 321 open cases, 130 cases needing MSE follow up and / or medication review, opt in / discharge letters to be sent to 54 clients. It was also suggested that a full-time post of Team Coordinator be created (senior existing MDT member). At this point, NCHD1 moved from Team B to Team A and NCHD2 from Team A to Team B

In May 2017, a follow up meeting was held. It was again noted that CP2 did not have capacity to provide full time cover to Team A but would oversee complex cases. Lack of resources was also highlighted, and the need for cover for administration staff who were due to go on leave. Team A MDT members also noted that staff strain was prevalent due to the existing situation. Team A members requested that the service provide an "emergency service" for a period of time. This was declined by the ECD1. It was noted that the MDT meetings had been attended 12 times out of the last 36 by a doctor. It was also noted that there were many medical appointments, with a backlog ever increasing.

October 2017 Locum CP4 was recruited to the team.

7.1.3 2018

2018	Actual Clinical WTE	Referrals	Accepted
Team A	6.58	133	101
Team B	7.2	298	227

Figure 4: Clinical WTE and Referral Data 2018

Locum CP4 joined the team in February 2018, for a period of 8 months. They were not on the Specialist Register of the Irish Medical Council in Child and Adolescent Psychiatry, although they had long experience in the field and had agreed to seek specialist registration. The senior management team and Human Resources (HR) staff

were aware of the national direction not to appoint doctors to locum consultant posts who were not on the specialist register but considered that the clinical needs and service demands and pressures in Team A warranted an exception. Management practice is for the HOS to be on the interview panel for substantive consultant posts, but not for locum appointments, presumably on the basis that these are temporary arrangements.
CP2 therefore had to supervise Locum CP4 clinically, in addition to their other work. However, CP4 was asked to supervise NCHD1. CP4 became concerned that NCHD1 was not engaged with the Irish Medial Council's Professional Competence Scheme and that NCHD1 was isolated from the MDT and micromanaging patients with medication. Locum CP4 made CP2 aware of this.

Locum CP4 did not pursue Specialist Registration, despite support and encouragement and their contract was not renewed. After Locum CP4's contract ended, case records for 12 children were found to be missing and the assessments and treatment plans had not been communicated to the referrers; this data breach was reported to the Information Commissioner and the poor professional practice to the Irish Medical Council.

In April 2018, as part of the CHO CAMHS Enhancement Initiative, 1.7 WTE staff were recruited (Psychology and OT) with a specific remit of reducing wait lists. Maternity leave cover was also provided for another staff member.

In July 2018 the whole team wrote to the HOS detailing multiple concerns about waiting lists, access to training and development for staff, a fragmented ASD pathway in County MHS Area A, and limited community resources that would otherwise take cases referred to CAMHS. They raised the issue of safety for the patients, through inadequate clinical resources and training, waiting lists, and access to inpatient beds.

In August 2018, there was the sudden and completely unexpected death of a longstanding Team B member who had held the Team Coordinator role.

In October 2018, Locum CP4 left the service. In correspondence from CP2 to ECD2 they again stated they did not have capacity to have significant involvement with Team A. Another request was made to have CAMHS Registrars taken off the adult mental health services on call rota.

Late October 2018, Team A MDT members wrote to ECD2 and CP2 expressing serious concerns about the service. These were: No consultant since 12/10/2018, lack of clinical entries in the file, no letters to GPs re treatment plans, uncertainty re medication prescribed, no medic present at MDT (these issues related to the locum who had left), an increase in the number of high-risk complex cases, current practices are clinically unsafe. The MDT stated they would no longer proceed with the MDT meetings without a medic present.

An email was sent from CP2 in early November 2018 cc'd to ECD2 acknowledging the above concerns, and again stating they will supervise Registrars. CP2 also confirmed that they would consider if Team B Registrars had capacity to give any time to Team A.

A business case was developed and County MHS Area A were successful in securing funding for training to start in January 2019 to provide a Dialectical Behaviour Therapy (DBT) Service in the county. This type of treatment is effective in supporting teenagers with poor emotional control and mental health disorders who are at high risk of serious self-harm and death by suicide. Safety planning for young people who express suicidal thoughts and behaviours often involves hospital admission that brings about a short-term reduction in the risky behaviour but may make its recurrence more likely. While DBT is an effective treatment in the hands of well-trained therapists, it requires significant ongoing training and support to maintain treatment fidelity, contain the high level of stress and emotional demands on the practitioners.

In December 2018 in a meeting with ECD2, CP2 and Team A MDT members, the recent data breach was discussed. Earlier that year, a new consultant had been recruited to County MHS Area A, however they declined the job in December 2018. An urgent meeting was requested with ECD2 by the MDT seeking clarity as to who was the current clinical lead for the team.

7.1.4 2019

2019	Actual Clinical WTE	Referrals	Accepted
Team A	8.98	222	169
Team B	9.17	304	218

Figure 5: Clinical WTE and Referral Data 2019

January 2019, the CAMHS Governance Group was set up. This was chaired by ECD2. It was to "systematically oversee the delivery and provision of an accessible, high quality connected and responsive CAMHS service within the county Mental Health Services". Membership comprised the ECD2 (and subsequently the CAMHS CD), Heads of Discipline, CAMHS Consultants, Director of Nursing, Speech and Language Therapy Manager, the Area Administrator and the Quality and Safety Advisor. Oversight was to be through "objective, quantitative and qualitative outcome measure including, but not limited to, KPI's complaints and compliments, human resource issues, incident reporting and risk register, formal audit of best practice, staff and service user feedback mechanisms."[2]

Around this time sadly there was a death by suicide of a Team A CAMHS patient. NCHD1 had been treating the patient and while there was no suggestion that their practice had contributed to the death, they were reported to have been very distressed and felt responsible. They were advised to seek professional help, but CP2 did not think they followed this advice.

NCHD1 sent an email to ECD2 asking to come off the Adult Mental Health on-call rota, citing workload and multiple family commitments.

March 2019, annual file audit completed and findings given to CP2, copy of audit sheets kept on files.

March 2019, National Pay and Numbers Strategy; recruitment restrictions in place for three months initially and continued.

March 2019, CAMHS Governance Group meeting it was agreed that a team of 3 managers who had received SIGMA Lean Green Belt training[3] be invited to meet the team to look at the processes within the team.

August 2019, further delay in Team B moving to the new location. Email from Team B to CP2 noting absence of response to letter last year to the HOS. Significant concerns regarding lack of staff and very low staff morale noted due to environment, clinical pressure and staff resources.

CP2 became seriously concerned about the prescribing practices by NCHD1 in the autumn of 2019 after a family had queried the treatment and raised this with NCHD1 and ECD2. Following this they took steps to try to improve NHCD1's performance.

December 2019 CAMHS Governance Group Minutes noted that Mental Health Services managers external to County MHS Area A CAMHS, who had received SIGMA Lean Green Belt training, made themselves available however, the team had not engaged with this process as yet.

CP2 and ECD2 both became concerned about NCHD1's practice and extensive clinical work outside the HSE, causing NCHD1 to appear exhausted and advised NCHD1 to take leave and attend Occupational Health. It is noted that NCHD1 took leave from December 2019 to January 2020.

7.1.5 2020

2020	Actual Clinical WTE	Referrals	Accepted
Team A	9.19	226	180
Team B	7.42	280	232

Figure 6: Clinical WTE and Referral Data 2020

March 2020; the global pandemic COVID-19 forced services to change models of care, with telephone / telemedicine, Zoom becoming the most common forms of engaging with clients and their families.

March 2020, Team B moved to a new location.

NCHD1 had been asking to come off the adult mental health on-call rota since the start of 2019. This was resisted by ECD2 as it would have significant adverse effects on the adult service in terms of compliance with the European Working Time Directive. The issue came to a head when the NCHD said they would have to resign if they had to continue being on-call. The ECD was advised also that it would not be possible to continue delivering the Area A CAMH service without this NCHD. It was agreed, in discussion with the acting Head of Service (HOSA) that NCHD1 could be re-employed in the CAMHS through an agency contract.

June 2020, NCHD1's HSE contract ceased, and they were re-employed as an agency locum NCHD from the end of July until October 2020 with no on-call duties.

July 2020, a new ECD3 for County MHS Area A was appointed.

NCHD2 emailed to CP2 on 28 July 2020, advising of multiple serious concerns regarding NCHD1's practice that they saw when they swapped teams with NCHD1. NCHD1, now in Team B CAMHS was instructed not to see new patients by themselves and was to discuss medication changes with CP2.

August 2020, Team A were informed that there may be a locum consultant commencing with the team. List of urgent reviews collated in anticipation of this.

September 2020, new locum Consultant CP1 commenced with Team A. They expressed concern re suitability of team office accommodation.

NCHD1 ceased employment on 10th September 2020.

September 2020, locum Consultant CP1 raised issues of clinical concern regarding NCHD1 with CAMHS CD and ECD3. A decision was made to manage the concerns as a potential incident in line with the HSE Incident Management Framework 2020.The agreed action was that an independent Consultant Child and Adolescent Psychiatrist (CP5) would conduct a random audit of 50 files to determine if there were grounds for concern.
Team A relocate to new office accommodation in October 2020.

7.1.6 2021

YTD 2021	Actual Clinical WTE	Referrals	Accepted
Team A	9.17	231	180
Team B	9.61	212	139

Figure 7: Clinical WTE and Referral Data 2021

February 2021, the random audit was concluded. Significant concerns were identified through this process.

March 2021, change in SIMT process was agreed upon. As of 1st April 2021, the Chief Officer took over as Chairperson of the SIMT and commissioned a Look-back Review of all the files within Team A from July 2016 to April 2021. External Consultant appointed as Clinical Lead to oversee this process, administration and clinical team were put in place.

March 2021 also saw members of Team A and Team B avail of QB testing training.

Over the time period, the substantive Consultant Psychiatrist post was offered to successful applicants on two occasions, in 2018 and 2020, however they both withdrew their acceptance of the post at short notice.

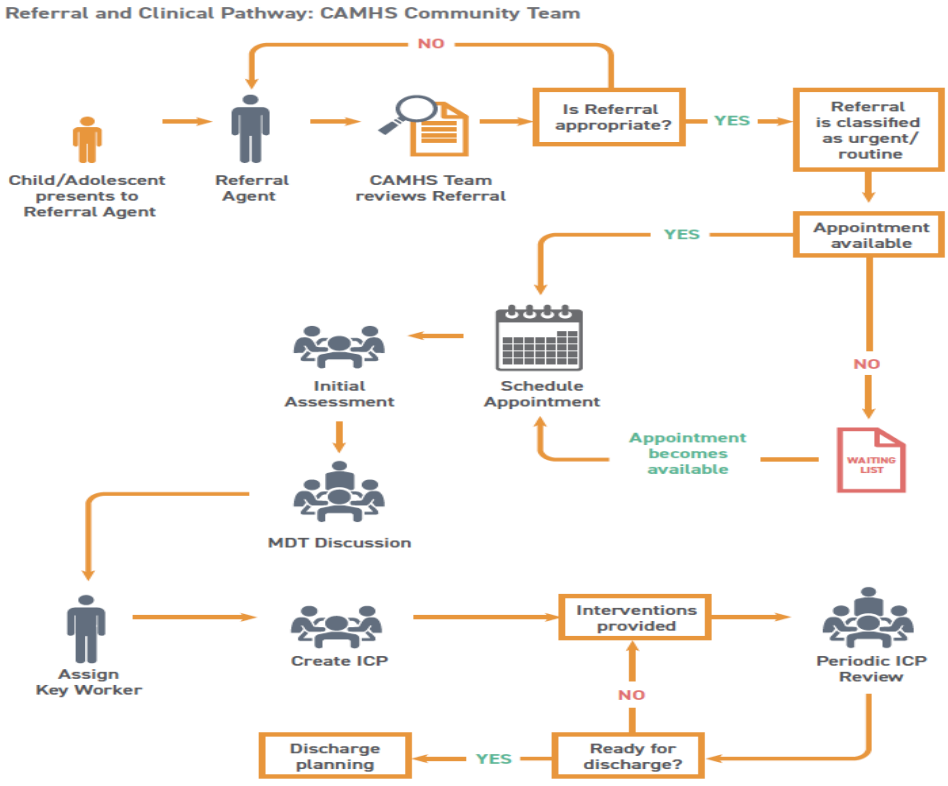
There had been significant expansion of both Teams in terms of non-medical staff from 2009 and the office accommodation that both teams continued to use became increasingly overcrowded and unsuitable, in terms of staff accommodation and patient areas, by 2020.

7.2 PROCESS

It will be useful to describe the clinical process in terms of the patient pathway through the child and adolescent mental health care system as set out in the CAMHS Operational Guideline 2019[4] and described to the LBR Team by the staff.

Children and adolescents are typically not the people who raise mental health concerns; it is normally parents, teachers or other adults who suggested that medical assistance should be sought. These requests are filtered through the family's general practitioner or other approved referrer, into the child and adolescent mental health services or other more general or more specialist provision such as youth counselling or child development services.

Figure 8: Journey through Community CAMHS



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

7.2.1 REFERRALS

The LBR Team identified 994 referrals in the scope of the review. The overall figures included cases already open to the team. From the LBR database referrals to Team A, that is cases accepted plus those referred but not accepted, rose steadily until 2019.

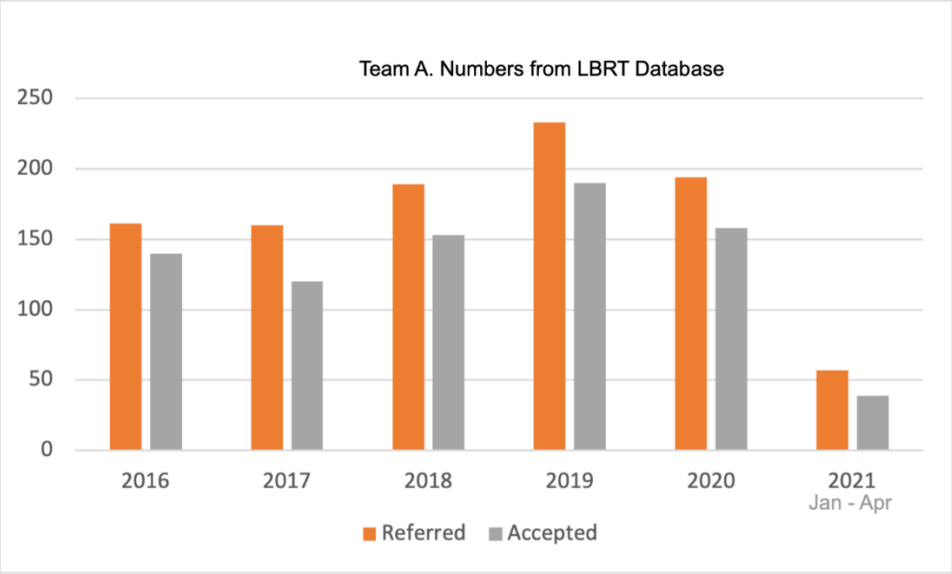


Figure 9: Team A Referral Rates 2016-2020

The Team has a consistently higher acceptance rate than the national and CHO annual percentage, 80% over the 5 years compared with 71% nationally and 68 % for the CHO, both with downward trends. From interviews we learnt that Team A felt they had to take on cases themselves because no one else was going to see them as community resources were limited. Locum CP1 revised the screening process, removing it from the individual team members and taking on the responsibility themselves. This caused some disquiet in the team, not least because of the lack of transparency; there was no method of tracking the progress of a referral through the clinic. However, the rate of referrals that were not accepted did fall in 2021.

From the database, approximately 15 % of referrals were not accepted for treatment and were signposted to other services or the referrer was advised to redirect the request. This contrasts with the KPI rate of 24%, and the referral figures from the database also differ significantly from the referred and accepted figures on the KPI returns. Re-referrals were not identified separately in the LBR database, and this will have increased the percentage of cases accepted. The date the referral received was not recorded on the Team A database and the information had to be retrieved manually from the casefiles or referral records but was not always available. Re-referrals are itemised separately in the KPI's and not included in the acceptance rate calculation, which may account for some of the differences.

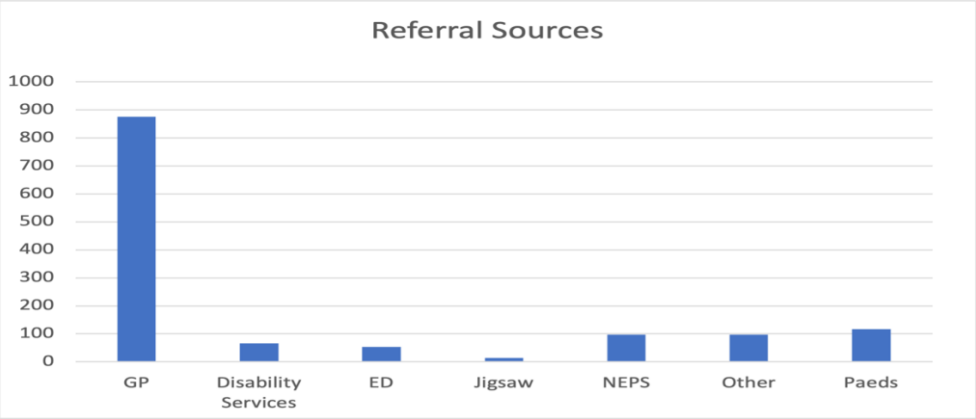


Figure 10: Referral Sources for Team A in Scope of LBR

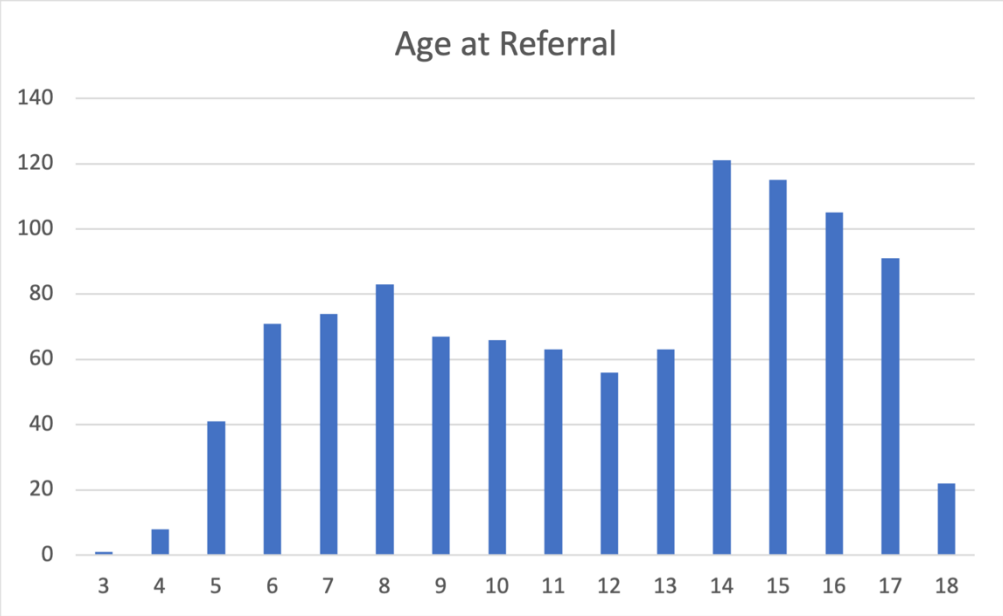


Figure 11: Analysis of Age on Referral

There were two peaks in referral age, 8 years and again at 14 years. There were equal numbers pre and post 13 years at referral.

7.2.3 SCREENING AND SIGNPOSTING

On receipt of a referral, the clinical team reviewed the information to decide if an urgent response was required. The CAMHS Operational Guideline 2019 recommends that this task should be undertaken by a Team Coordinator. Team A has not had a formal Team Coordinator post or role, however in 2016 this role was filled informally by the Social Care Leader until they went on leave. It has then been a rotating post, initially three monthly and quickly reduced as the task interfered with regular clinical and other activities. The final rota, in 2020, changed twice daily. The assessor screens the referral before taking it to the MDT meeting. Any obvious missing information or further enquiry, such as asking schools to provide reports and teachers and parents to complete structured questionnaires about ADHD may be done at this stage. Cases were then discussed by the MDT and accepted and/or further information was sought, or the referrer was sent a letter signposting to other resources.

7.2.4 INITIAL ASSESSMENTS

The initial assessment was written up by the clinicians in most instances. The initial assessments were comprehensive records of the child's development, family circumstances and the presenting complaints. The formulation (case summary) was often limited in scope and did not synthesise the extensive information which had been obtained. The referrer was sent a copy of the initial assessment and usually the parents also. In many cases, a clear diagnosis and treatment strategy was not reached at the initial assessment and follow up work was planned. This often including a school visit, discussion with the child's teacher and sometimes an internal team referral for a specialist assessment by the clinical psychologist, speech and language therapist or occupational therapist. The child's case was then discussed again at the MDT and a plan of action agreed.

The plan of action agreed by the MDT was documented in the MDT section of the file, but not included in the initial assessment report and did not take the form of an Individual Care Plan recommended in the CAMHS Operational Guideline 2019. The family and referrer therefore did not have a clear understanding of the therapeutic plans being developed, therapeutic goals were not well described, and it was very difficult to

ascertain whether these had been met. The team did not use a key worker model but instead families usually raised queries with whoever was the most recent clinician they had seen. Phone enquiries were therefore passed from the administrator to the current "Team Coordinator" and on to the relevant clinician. Unless the case was readily called to mind, the coordinator would have to source the case file before passing on the message because of the lack of a list of case allocations.

7.2.5 ADHD

Where the referral request indicated the possibility of ADHD, comprehensive screening tools were generally sent to the family and school before the child was seen, speeding up the assessment process. The assessment was usually conducted by two people from different disciplines, which can create a more balanced and rounded assessment than if it is done by a single discipline.

The initial assessments included comprehensive individual and family histories. When a psychiatrist was not present, there was usually a subsequent request for a mental state assessment by the NCHD which was frequently completed alone.

If ADHD was being queried, one of the MDT usually carried out a school-based observation, writing up a comprehensive account of the child's behaviour in class and the playground, and discussion with the teacher. This is good practice.

7.3 TREATMENT

The conclusion of the MDT discussion, sometimes including a diagnosis, was fed back to the child and parents at a subsequent meeting and the further assessment or treatment plan explained. The team operated internal waiting lists for referrals and for specialist treatments which were held by the individual clinicians. We were told these varied between five and 40 cases across the MDT.

Cases would be further discussed at the MDT meeting if risk concerns emerged in treatment, if the clinician had queries about the diagnosis or treatment package or when a specialist piece of work concluded. When there was concern about risk to the child from self-harm or suicide, this typically resulted in an NCHD carrying out a Mental State Assessment and discussion of a safety plan with the child and parents.

A good range of psychosocial interventions were provided, from parenting and psycho-educational groups, family work, through to individual Cognitive Behavioural Therapy. The team has also developed a DBT service in the last two years.

The CAMHS specialists would often write comprehensive reports about their assessments and summaries of their interventions. These reports were not routinely sent to the referrer, although they may have been supplied to the family.

Discharge occurred when treatment was no longer considered necessary, or the child had turned 18 or the patient disengaged by failing to attend follow-up appointments. A brief summary of the situation was sent to the referrer as a discharge letter and in some cases, an onward referral to adult mental health services was made.

7.3.1 WAITING LIST

The Look-back Review did not consider this in any detail as it was not pertinent to the terms of reference. Waiting lists are of considerable concern to senior management and the HSE at CHO and National level and receive significant attention as a result. Lists are a demand and capacity issue and various solutions have been proposed to address them. The CHO CAMHS Enhancement Project[5] dealt with this in some detail, considering various options including the Care and Partnership Approach[6] (CAPA). The CAPA trainers use the helpful analogy of traffic on a busy motorway; given each vehicle will need a certain space ahead and behind (for a given speed) there is a fixed number of vehicles that can fit on a length of road. If that is exceeded, traffic slows. If the number

of vehicles exceeds a certain threshold, the amount of slowing causes some vehicles to become stationary for a period and a traffic jam propagates backwards along the road. Similarly in a clinic, as demand begins to exceed capacity, more staff time (administrative and clinical) is allocated to managing the referrals and throughput rather than seeing patients, so reducing staff availability at a time when it is most needed.

Managers would like clinical processes to be as efficient and effective as possible. Many, but not all clinicians share this view; some clinicians will emphasise effectiveness and the need for professional autonomy. CAPA requires a clear understanding of the clinical capacity of the team and central allocation of cases to clinicians with availability, with clinicians giving up a degree of control over their activity through clear job planning. In general, clinical teams do not like this change in culture and practice; resistance can be considerable, and the change process has to be managed carefully, but as long as the team has sufficient capacity to manage the demand, it is an efficient way to deliver a service. If, however, demand exceeds capacity, waiting lists will recur.

7.4 OUTCOMES

7.4.1 NUMBERS

The database had 1,495 entries. 1 was blank and 20 were duplicate entries. 10 files of patients that have been accepted as missing, as is the paperwork for 2 referrals marked "Not Seen" on Team A's database, which indicates they were not accepted clinically. 1,462 cases were screened. Of these, 219 were not accepted as appropriate referrals by Team A and 130 were out of scope of the review. 1113 cases were accepted by Team A.

1,332 cases that had been opened by Team A, including the 219 that were not accepted, were reviewed to assign outcomes, focussing on Harm to a Person and Service User Experience, from the 5 categories of Risk Impact in the HSE Incident Management Framework[7], from negligible to extreme.

NCHD1 was involved in the assessment and/or treatment of 494 cases; 206 were still open during the review and 289 were closed. Of the 494, 227 are in Outcome 4 and 5 and have been recalled for clinical evaluation (102) or Open Disclosure (125).

There are an additional 13 other cases, not seen by NCHD1 that gave cause for concern. 2 are closed and required recall for clinical evaluation and 11 have already been reviewed by a consultant and so have been identified for open disclosure.

22 cases were designated as Outcome 3 and have received letters with a brief explanation of the concerns and an apology. 17 of these were seen by NCHD1, and 5 were not.
In total, of the 262 cases that gave rise to some concern, 244 were seen by NCHD1.

Outcome	All 1462	Running Total	Under 18	18 & over	NCHD1 Involved	NCHD1 %
1 (out of scope)	130	1332	43	87		
2	1070		742	328	250	23%
3	22		18	4	17	77%
4	136		92	44	125	92%
5	104		38	66	102	98%
Total	1462		933	529	494	44%[2]

Figure 12: Summary of Cases by Outcome

7.4.2 MEDICATION

1,113 children were accepted by Team A. 535 children were prescribed medication, 578 were not.

[2] 494 of 1113 accepted cases

6 different groups of psychotropics were used. Antidepressants, hypnotics, mood stabilizers, neuroleptics (antipsychotics), sedatives and stimulants or other medication for ADHD. A few children were occasionally given prescriptions for non-psychiatric conditions, presumably for patient convenience. Many children received more than one type of medication during treatment, sometimes concurrently, so the numbers do not tally across various tables and charts.

Outcome	Antidepressant	Hypnotic	Mood Stabilizer	Neuroleptic	Sedative	Stimulant / other ADHD
O2	158	171	4	75	11	106
O3	10	16		13	1	6
O4	67	112	5	121	20	91
O5	49	57	2	82	13	44
Totals	284	356	11	291	45	247

Figure 13: Numbers of children x medication type.

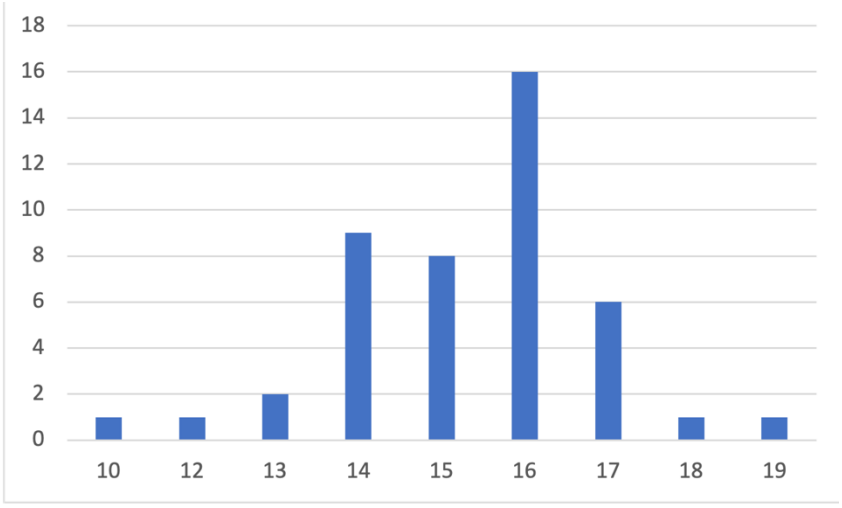


Figure 14: Sedatives by Age at Start

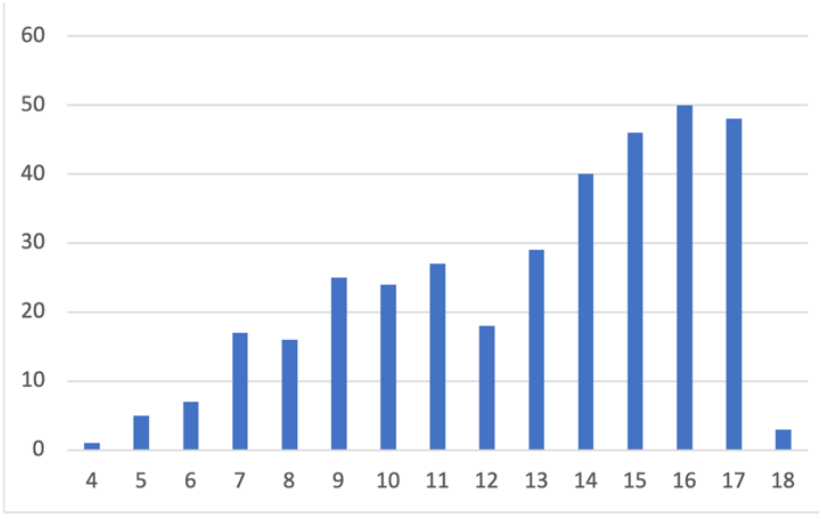


Figure 15: Hypnotics by Age at Start

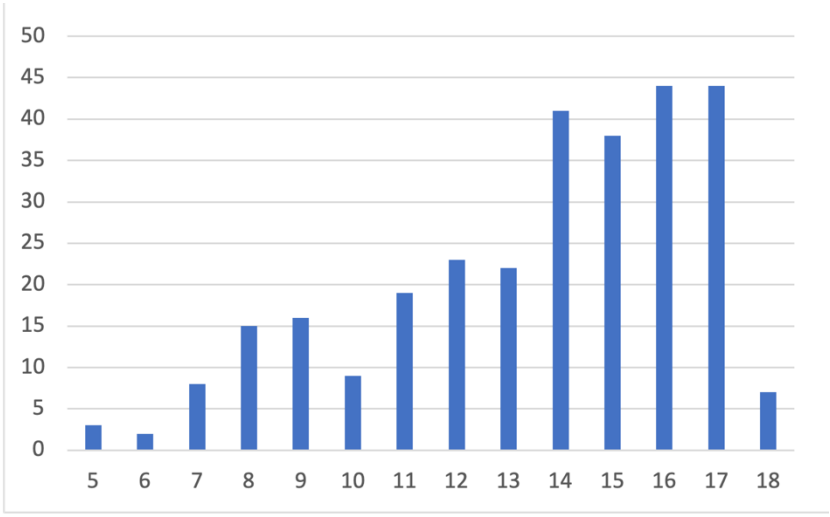


Figure 16: Neuroleptics (antipsychotics) by Age at Start

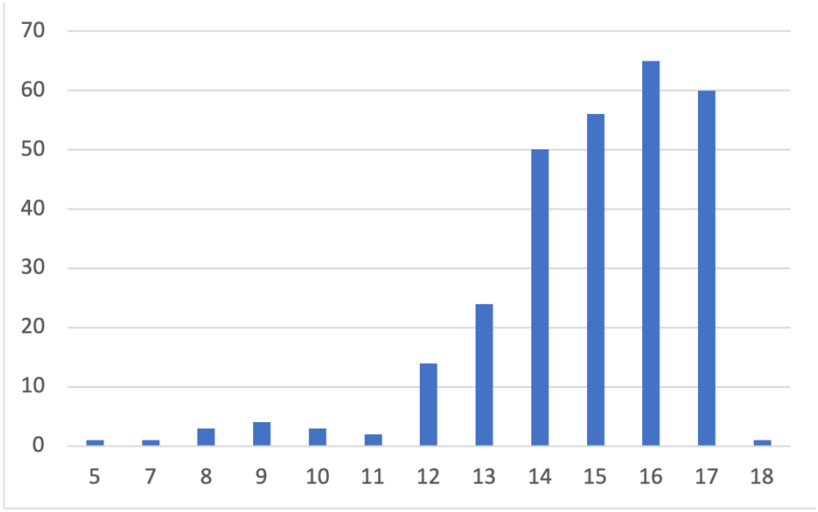


Figure 17: Antidepressants by Age at Start

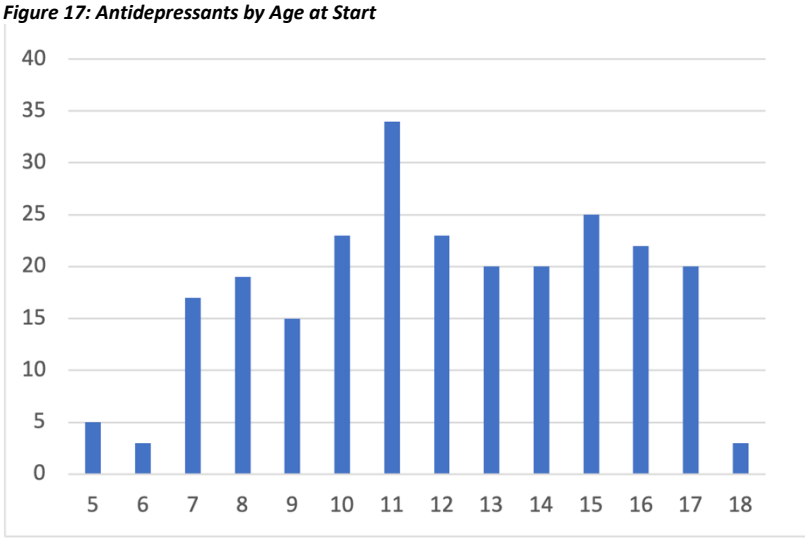


Figure 18: Stimulants by Age at Start

Stimulants are relatively evenly spread by age, when one might expect them to be started more frequently between 7 and 12. The later age of initiation is unusual but given the overall lower than expected rate of treatment with ADHD medication, it is not appropriate to draw conclusions from the small sample. The other medications are biased to teenage years, although there is a cluster of antipsychotic medications used in primary school children associated with treatment for ADHD. The use of hypnotics in the primary age group suggests inadequate access to non-pharmacological sleep management.

Three quarters of the patients taking two types of medication were receiving hypnotics and an antidepressant or a treatment for ADHD, which are not harmful combinations.

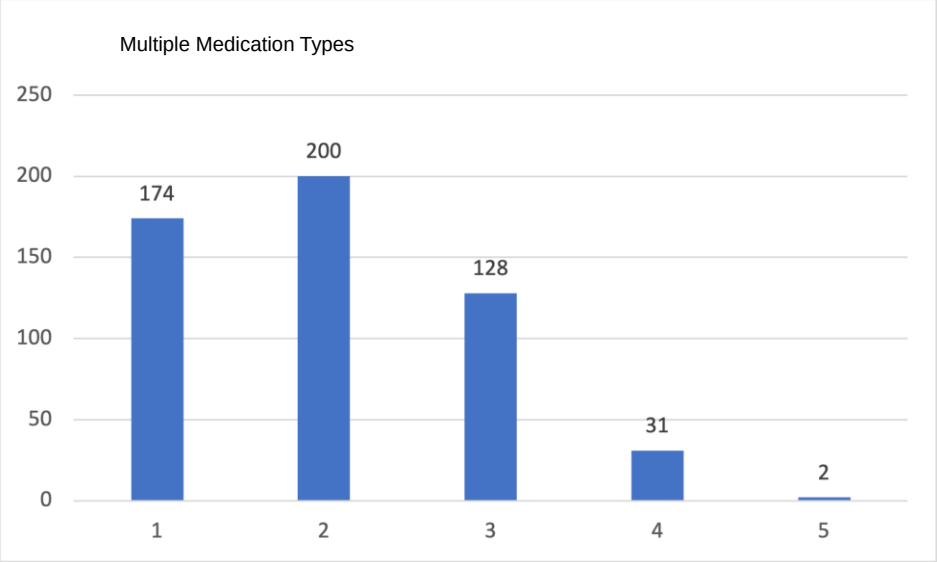


Figure 19: Polypharmacy; Number of children by number of simultaneous medication types

Medications were increasingly prescribed in combination over the 4 years, with a significant reduction in polypharmacy in the latter part of 2020. As medication was reviewed and rationalised by CP1 there was a marked drop in the rate of polypharmacy. Overall, 31 children were prescribed 4 different categories of medication and two, 5 categories of medication simultaneously.

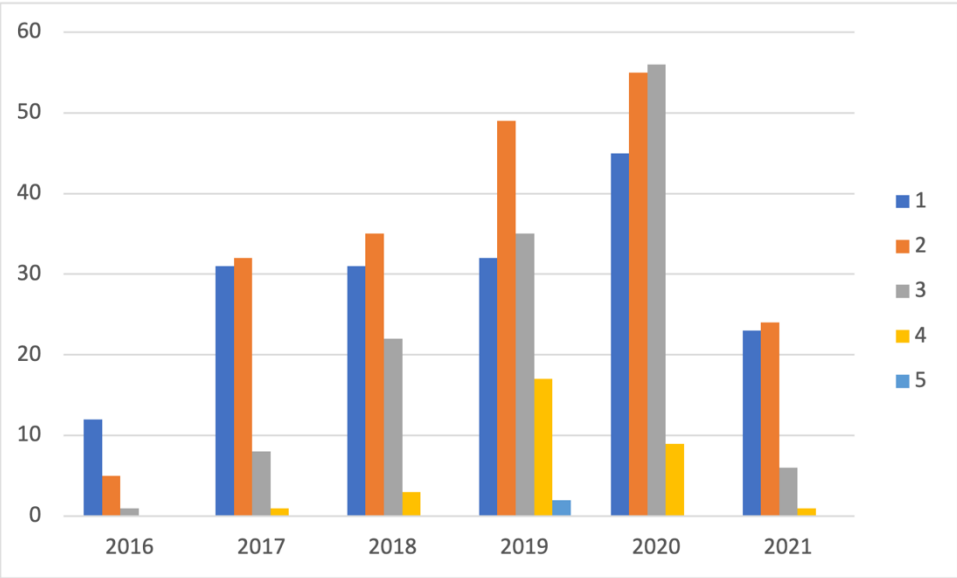


Figure 20: Polypharmacy by Year

7.4.3 LOST TO FOLLOW UP

As of 29th July 2021 the LBR Team identified 131 files which had not been followed up as planned. Often an appointment had been offered in the past and there was no subsequent record of attendance, or another member of the team had completed a piece of work and subsequent treatment was not continued by the multidisciplinary team. For many of the children, the last contact was over 12 months ago, and it was not clear whether the prescribed treatment was still being given by the GP. In all, 105 were categorised as Outcome 2 or 3 and most of these had not been prescribed medication. In the other 26, this contributed to the exposure to the risk of harm.

7.4.4 HELPLINE

The telephone number for a dedicated helpline was published widely when the review was announced, and patient or parents with concerns were advised to call.

Senior clinicians were available to take calls and spoke to 94 people in total.

Week Ending	Team A	Team B	Other County	Total
21/04/2021	29	8	1	38
22/04/2021	13	9	3	25
23/04/2021	7	7	0	7
24/04/2021	0	0	0	0
25/04/2021	0	0	0	0
26/04/2021	0	0	0	0
27/04/2021	1	0	0	1
28/04/2021	2	1	0	3
29/04/2021	0	1	1	2
30/04/2021	0	0	0	0
04/05/2021	0	0	0	0
05/05/2021	0	0	1	1
06/05/2021	0	0	0	0
07/05/2021	0	0	0	0
10/05/2021	0	0	0	0
11/05/2021	0	0	0	0
12/05/2021	1	0	0	1
13/05/2021	1	0	0	1
23/05/2021	0	0	0	0
30/05/2021	0	0	0	0
06/06/2021	0	0	0	0
13/06/2021	0	0	0	0
20/06/2021	0	0	0	0
27/06/2021	0	0	0	0
04/07/2021	0	0	0	0
11/07/2021	1	0	0	1
18/07/2021	1	0	0	1
25/07/2021	0	0	0	0
01/08/2021	2	1	0	3
08/08/2021	2	0	0	2
15/08/2021	0	0	0	0
22/08/2021	0	0	0	0

29/08/2021	0	0	0	0
05/09/2021	1	0	0	1
12/09/2021	0	0	0	0
Total to date	**61**	**27**	**6**	**94**

Figure 21: Summary of Calls to Dedicated Helpline

The Helpline has remained open during the Recall and Disclosure process and will continue in place over the period of the publication of this review.

8 CONCERNS ARISING

8.1.1 REFERRALS

Of the 219 referrals that were not immediately accepted, 24, just under 10% were left "pending", that is, further information was required before a decision was made about the referral by the MDT, but this had not been resolved. These files were labelled "Lost to Follow up" by the LBR Team, a term which indicates a breakdown in the clinical pathway. These cases were flagged to the clinical team to make contact and agree a way forward with the family and referrer. Some of the files dated back to 2019. The remainder of the referrals that were not accepted were returned to the referrer with signposting to alternative resources in a timely manner.

It was the responsibility of the "Team Coordinator" in both Team A & Team B to review these referrals that were awaiting further information. While this is a post that was included in the CAMHS Standard Operating Procedures 2015[8] and subsequent CAMHS Operational Guideline 2019[9] it was never formalised in County MHS Area A. However, both teams had individuals who fulfilled the role informally. In Team A, this was the Social Care Leader who described it as an expanding task over time. While it should have been half of their clinical work, it was frequently 70 to 100%. This changed in 2017 and the other team members took on the role on a monthly rotating basis. However, they found this impacted on other clinical commitments and so it was quickly changed to a weekly, then daily and finally a half daily rota. In addition to screening and reviewing the referral process, the coordinator was often asked to respond to phone calls from parents seeking either simple information such as confirming their appointment date, more complex clinical matters or sometimes support and advice in a crisis. There was significant debate in the team and the CAMHS Governance Group (minutes) about the skills and resources needed for this task/role and whether all MDT members could or should undertake it.

The Team Coordinator task/role was discussed five times in the CAMHS Governance Group. Initially there was some uncertainty about the balance of clinical and administrative duties, however this was resolved. A number of coordination tasks were requested of the administrative team including, follow-up of MDT actions, updating the ADHD waiting list, sourcing old files for new referrals (presumably re-referrals) and updating files in respect of over 18 year olds for external storage, There was further consideration of the clinical role of Team Coordinator, however when it became clear that no backfill would be provided for this, the plan seems to have been dropped.

CP1 revised the role again, so that the Consultant screened all referrals and clinical calls, a process described to us as more akin to that in County MHS Area B.

While this relieved the MDT members of what was seen by some as a burden that interfered with their primary professional role and by others as a level of clinical risk management beyond their role and skill set, the change, while initially well received, generated considerable disquiet and anxiety as the Consultant did not share their thinking and decision making clearly with the team.

We heard different accounts of the threshold for acceptance of referrals from different MDT staff. Some considered that almost all referrals should be accepted on the basis that the less specialist community options such as Jigsaw[10], psychology and counselling services did not have the capacity or resources while others described the threshold as being moderate to severe mental disorders, in line with the CAMHS Operational Guideline 2019. One senior clinician commented "we would be in meetings, and we often said they are not going

to be seen anywhere else if we don't see them." This compassionate view reflects a difference related to views about the need to provide help when requested as opposed to using clear clinical boundaries.

There is also a component of risk management involved although it was not explicit; part of the role of the clinical lead is to take overall responsibility for the care and treatment offered within the team and a decision not to accept a referral exposes the clinicians to criticism from the patient, the referrer and on some occasions that we have seen, influential community figures, who have asked the service to reconsider its decision. CP2 was covering the clinical lead role, but this is not the same as filling the role, and while they were available for clinical crises, they were inevitably less present in the day to day working. The phrase "moderate to severe mental disorder" is easy to use but hard to define around the boundaries; regular consultant presence and input into the team's thinking will normally define this by custom and practice. It is probable that the absence of consistent clinical leadership over this timeframe will have contributed to the lack of clarity for the MDT regarding the acceptance threshold.

The trend locally, in the CHO and nationally is for a reduction in the percentage of referrals accepted as services have become more focussed on episodes of care, interventions and outcomes, typically accompanied by an increase in severity and complexity of the caseload. However it is apparent that Team A has a consistently higher rate of acceptance of referrals than elsewhere. There are two immediate effects of this. Firstly, the demand for clinical services rises unnecessarily contributing to waiting list problems. Secondly, the overall acuity, complexity and risk of the patients seen is less. This can lead to a reduction for the clinician in perceived challenges and improved satisfaction, as a result of more "successful" treatment.

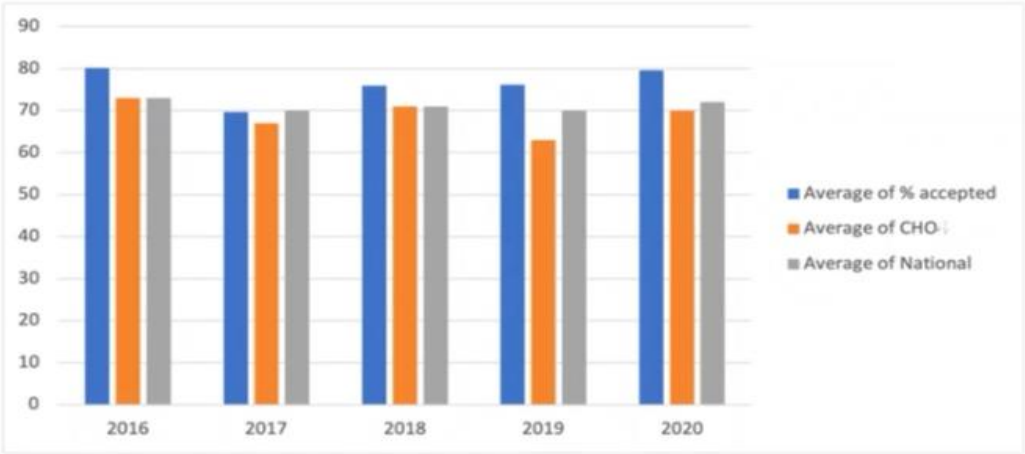


Figure 22: Percentage of Referrals Accepted by Year; Local Regional and National KPI Figures.

8.1.2 ASSESSMENT

713 initial assessments were identified in the timeframe. Consultants were present at 97 and NCHD's 304, so doctors were present at 56% of all initial assessments. NCHD1 was involved in 147 Initial assessments (20%), of which they were the sole assessor in 33. Of these 33; 10 were assigned Outcome 2, 1 assigned Outcome 3, 13 assigned Outcome 4 and 9 assigned Outcome 5. It is not clear whether the Consultants expect doctors to participate in all initial assessments. CP2 spoke about the NCHD's needing to have another team member present at all their assessments. The skills necessary to participate in initial assessments were discussed in the CAMHS Governance Group. CP2 advised that assessments should be done by two staff and a doctor should always be available. In contrast, Locum CP4 and Locum CP1, the long-term locums, both felt that this was unnecessary, and the MDT members had adequate skills. Who should assess is not specified in the CAMHS Operational Guideline 2019.

The team has had a high waiting list throughout this period, reducing but not eliminating it because of wait list focussed activity in 2018 and again in 2020. The KPI's are nationally monitored, and considerable pressure can result on the service managers of the outliers; the CHO was in this position in 2018/19. One of the consequences of a waiting list initiative is often to move the bottle neck from the external, visible, position to an internal, effectively invisible location. This may have happened in Team A; however it is not possible to be certain as the

team do not have a central record of case allocations or appointments. This data has been sought by the area managers, through the Heads of Discipline on the CAMHS Governance Group, but it has not been forthcoming.

The narrative we heard, from Team A members and their managers is the team is very busy and has become increasingly so since 2016. This was explained as a combination of increasing referrals and an under-established team without maternity leave cover. Actions taken to mitigate the risk of operating without a consultant included providing maternity cover and the CHO CAMHS Enhancement Project. However, one of the line managers did not seek to backfill two periods of leave prior to retiring and the new (acting) manager had not been given the information about maternity cover during the brief handover they received and so had not sought to fill the gaps they inherited for several months.

In the absence of staff activity, figures for initial assessments were extracted from the LBR database.

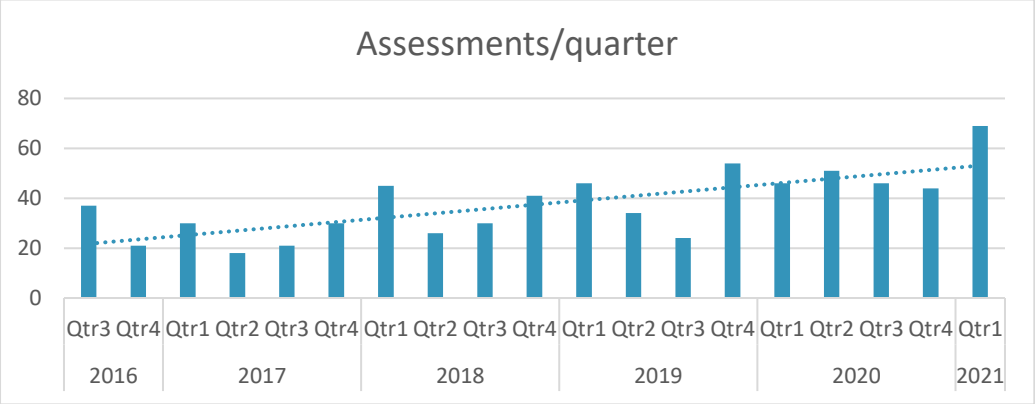


Figure 23: Initial Assessments Conducted by Team A

It is apparent that there has been an increase in the number of initial assessments taking place in Team A since 2016, particularly in Q1, 2021. Staffing has fluctuated over the time; while the whole time equivalent employed figure has increased, maternity leave has reduced availability. Assuming the clinic is open 50 weeks of the year, the throughput of initial assessments has increased from two to five children per week. The service has grown from around 5 in 2016 to 9 in 2020. Typically, assessments are paired; thus, each WTE clinician sees (with a colleague) one new assessment per week on average, which is not generally considered unduly busy.

8.1.3 DIAGNOSIS

The Consultant, CP5 who audited the 50 records summarised the child and adolescent mental health assessment process well in the introduction to their random case review (see Appendix 4). Quoting Professor David C Taylor, 'When faced with a sickness it is necessary to specify the illness to the finest level possible in order to allow rational and precise treatment to be given at the least possible human cost. It is also necessary to consider aetiologies so that preventative practices can be instituted'.

The main diagnostic concerns identified were: labelling a set of behaviours as Attention Deficit Hyperactivity Disorder (ADHD), without adequate evaluation or supporting evidence; conflating emotional and/or behavioural symptoms into a diagnosis without sufficient regard for intensity, duration and triggers for the behaviours; failing to obtain or consider information from the child's school which is significant part of a child's life; failing to reconsider a diagnosis in the light of new information; labelling descriptions of behaviours and emotions as diagnoses and attempting to control these with medication.

Clear definitive stable diagnoses were frequently missing in the case records, particularly for the Outcome 4 and 5 cases. It would be misleading therefore to quantify the diagnostic categories from the records. The LBR Team considered assigning post hoc diagnoses, but decided that, given the often-limited diagnostic information available in the records, this would not be a valid exercise.

The International Classification of Diseases 10th Edition[11] is the European diagnostic framework. Diagnoses are described clearly and quite broadly, for example ADHD, or more strictly Hyperkinetic disorders as: "A group of disorders characterized by an early onset (usually in the first five years of life), lack of persistence in activities that require cognitive involvement, and a tendency to move from one activity to another without completing any one, together with disorganized, ill-regulated, and excessive activity. Several other abnormalities may be associated. Hyperkinetic children are often reckless and impulsive, prone to accidents, and find themselves in disciplinary trouble because of unthinking breaches of rules rather than deliberate defiance. Their relationships with adults are often socially disinhibited, with a lack of normal caution and reserve. They are unpopular with other children and may become isolated. Impairment of cognitive functions is common, and specific delays in motor and language development are disproportionately frequent. Secondary complications include dissocial behaviour and low self-esteem."

This is clear but does not indicate how such a diagnostic conclusion should be reached. There are numerous guidelines available for specific conditions, developed in different traditions. For ADHD, the European Guidelines[12] or the UK's National Institute for Clinical Excellence[13] give specific, quantifiable guidance and recommendations on treatment approaches, along with audit recommendations to ensure clinical services maintain treatment fidelity.

It is not appropriate in the document to describe the Care pathway for ADHD in detail, but it is important to emphasise that ADHD diagnosis in Europe requires impairment in multiple settings and so accurate assessment of ADHD requires gathering information from multiple sources and integrating this with the clinical history and examination of the child rather than simply relying on parental account of the teacher's experience. See Appendix 5; Dundee Pathway[14] which has been used successfully in many settings and is applicable in Ireland.
In many of the Team A cases, the establishment of ADHD as a definitive diagnosis was robust and secure, based on careful evaluation of the child, parental and teacher accounts. However, in a significant number, the Conners[15] screening questionnaires which are used in Team A to form the basis of a comprehensive ADHD were absent or not scored.

This is not to say that all patients diagnosed by NCHD1 were likely to have an incorrect diagnosis. The prevalence rate of ADHD in children attending CAMHS clinics will be at least 30% (Fifth Annual Child & Adolescent Mental Health Service Report 2013) and so if all had an arbitrary label of ADHD applied, it would be correct one third of the time.

Absence of information regarding diagnosis in the record does not necessarily mean the diagnosis is incorrect, but it does mean that it is not robust and will need to be reconsidered.

While the assessments were comprehensive in scope, the failure to synthesise the information and consider alternative explanations for (most commonly) restless behaviour coupled with inattention and distractibility, resulted in a frequent presumption of a diagnosis of ADHD, rather than an anxiety disorder of simple failure to comprehend the task in school. Treatment with stimulants or other medication was frequently initiated by NCHD1 based on parental report and elevated questionnaire scores from parental but not school reports.

NCHD1 did not record their diagnostic thinking in the record; there was an account of recent mood and behaviour, from parents and sometimes the child and a MSE that noted the presence or absence of symptom groups, with minimal evaluation of frequency, intensity or impact on the child. If teenagers expressed concerns about concentration in school, coupled with inattention & restless agitation, treatment for ADHD was often commenced by NCHD1 without reference to the MDT or consultant, on top of the existing treatment for anxiety/depression, without overt consideration of the symptoms being part of the mood disorder, or an adverse effect of the other medications, such as an SSRI or atypical antipsychotic (neuroleptic) being used. Medication in this situation was started either without, or before, an ADHD focussed report from school was obtained. If a questionnaire was returned that did not support the ADHD diagnosis, this did not necessarily result in a reconsideration of treatment.

The result of this was that children were frequently prescribed multiple types of medication at the same time (polypharmacy). An example being a young person soon to be an adult, "diagnosed" with a chronic mood disorder -moderate depressive episode, anxiety disorder with panic attacks in the context of an ongoing CAMHS

assessment and treated with an antidepressant, an antipsychotic, initially low dose risperidone, and guanfacine which is used for the treatment of tic disorders and is a second line treatment in ADHD.

We were told that NCHD1's diagnostic practice around ADHD was questioned by other MDT staff; the response of NCHD1 was to present their summary of the reasons why ADHD is not recognised, and the Consultant, who was present for some of these discussions, did not support the question. The MDT staff who raised this did not feel they had permission to pursue it. CP2 does not recall such discussions and said that their normal practice is to consider the opinions of the MDT members.

The second consistent assessment process from NCHD1 of major concern was that treatment appeared to be aimed at behavioural control and did not follow diagnosis. Children were described as having emotional dysregulation, sometimes qualified by tantrums, meltdowns or irritability. There were factual statements about the child having "maladaptive behaviour strategies", "poor mood regulation, "dysregulation", "irritability" or "overthinking", usually without any indication of the frequency. Antipsychotic medication was often added when this was seen in the record without further explanation or clarification of the target symptoms.

We were told by CP2 that there was some resistance in the MDT meetings to add patients to the internal waiting list when for example CBT had been recommended at the assessment. Instead, the doctor was asked to review the case again in a month. This behaviour was noted in 2016 and we were told it did not change.

8.2 RISK MANAGEMENT AND KEY WORKING

We learnt from CP2 and from the CAMHS Governance Group minutes that some members of the MDT were reluctant to participate in the team coordinator rota, because of the need to make clinical risk assessment; this dated from 2016. Because a Key Worker was not allocated to a patient when they have been accepted, or after the initial assessment, there was no clear process to deal with queries or changes in the clinical presentation, for example a parent telephoning to request advice and help because the child's mental health had deteriorated suddenly. CP2 felt that, because the clinical lead is responsible for the risk in the team, the MDT expected the doctors to pick up these cases. This resulted in the doctor, usually the NCHD being asked to carry out an urgent Mental State Examination to assess risk. In practice therefore the NCHD, and to some extent the Consultant, became key workers for large numbers of cases.

8.3 TREATMENT

The treatment concerns identified were: frequent use of neuroleptic medication to control behaviour and/or subjective emotional distress in children when it is not indicated clinically; incorrect use of class of medication for the symptoms or diagnosis, e.g. neuroleptics/atypical antipsychotics instead of antidepressants or anxiolytics; unnecessary combinations of medications, either of the same or different types, e.g. tranquillisers and stimulants for ADHD; early use of medication, rather than waiting and providing support to allow distress to resolve with time, e.g. after a teenage relationship breakup; failure to adhere to the licenced indications for medication; failure to manage the potential adverse effects of medication through adequate monitoring and recording of physical changes, height, weight, pulse, blood pressure and potential endocrine and metabolic changes in blood profile and failure to obtain reports from the child's teachers about the response to medication for children with an ADHD diagnosis.

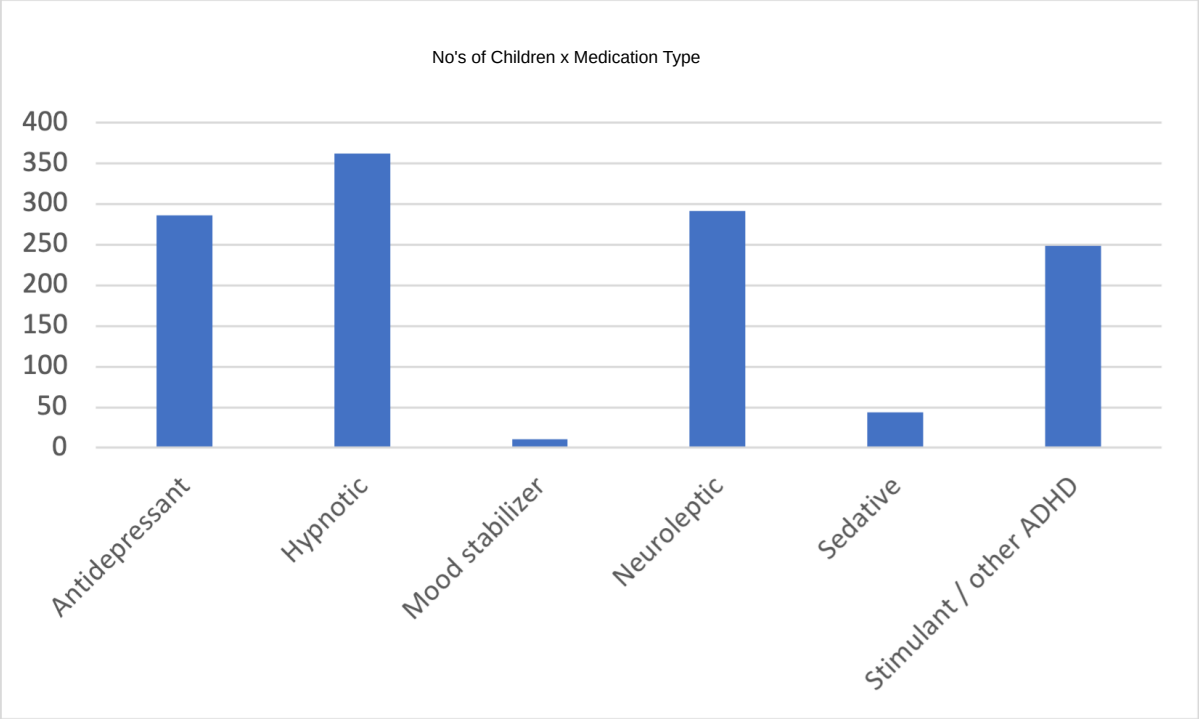


Figure 24: Use of Medication in Team A, 2016-2021

Stimulants and other treatments for ADHD are ranked fourth in the clinic. This is highly unusual in a general Child & Adolescent Mental Health service where one would expect to find medication for ADHD ahead of all other medication types.

Antipsychotic medication use for emotional and behavioural control in children increased throughout Europe[16] and the USA[17] in the 21st century and there has been a consistent, but not necessarily effective, professional and societal drive to reduce this as the evidence base for efficacy is lacking and adverse effects are increasingly recognised. The peak of overall antipsychotic use (very few patients had a psychotic illness) in the USA was in 2009 at 2.7/1000 children, falling to 1.7 in 2017. Use in disruptive behaviour disorders without ADHD, reduced to 22% of the number in 2017 compared to 2009 and in disruptive behaviour disorders with ADHD to 52%. The use in ID and Autistic Spectrum Conditions fell to 43% of the 2009 figure. In contrast rates in Scandinavian countries and Catalonia rates have increased somewhat although the picture is variable[18].

Psychotropic use in children and adolescents in Scandinavia and Catalonia: a 10-year population-based study

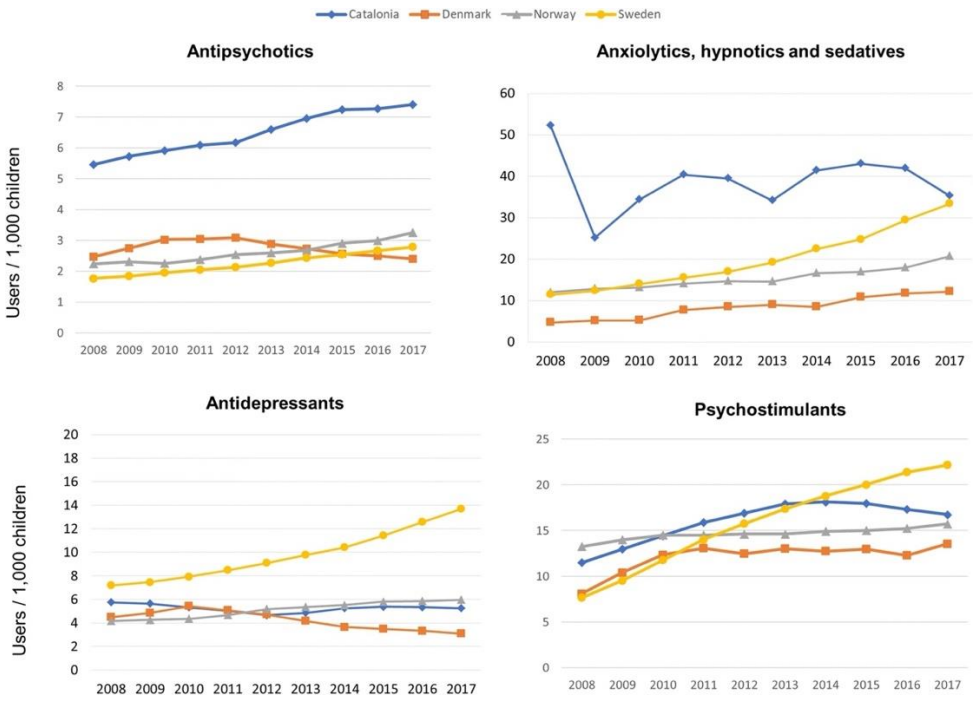


Figure 25: Trends in Psychotropic Use per 1000 Children. Scandinavia and Catalonia

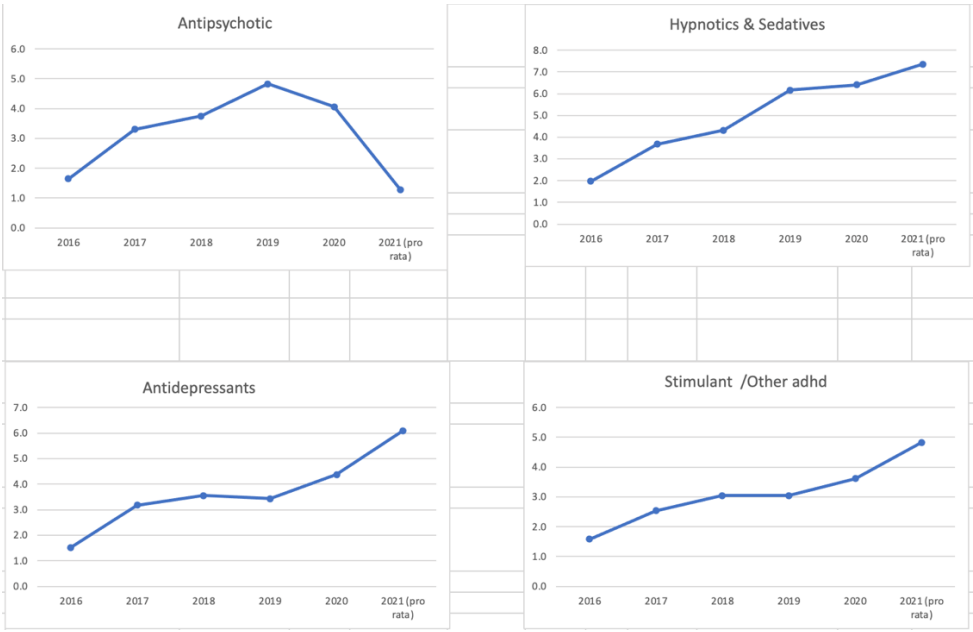


Figure 26: Psychotropic use over time CAMHS Area A

While it is important not to draw too precise a conclusion from a small sample (in Team A's population) it is clear the proportion of ADHD medication used in Team A is far lower than that in Scandinavian countries or Catalonia. In contrast, use of antipsychotic medication falls between that in the two regions and it is around one quarter of the neuroleptic use.

8.3.1 POLYPHARMACY

The use of multiple medication types together was not warranted from the diagnosis or case formulation in around 40% of the children treated in the clinic by Team A.

Polypharmacy greatly increases the risk of unexpected interactions and adverse effects and is a practice that should be avoided whenever possible. The prescribing pattern seen here, one of frequent switching between different medications of the same type and switching between and also adding different types of medication simultaneously, occurs when the prescriber is anxious to contain a situation they perceive as unsafe. Unsurprisingly when several things are being altered at the same time, it is not possible to know which changes (for better or worse) are caused by which medication. In the hope of getting the situation under control, more medications are added, but because the behaviour of the patient is considered unsafe or dangerous, the clinician does not feel safe in reducing any of the medications that are in place.

8.3.2 NEUROLEPTIC MEDICATION

Antipsychotics have been available to psychiatrists since the middle of the 20th century. The original description was as a major tranquilizer before their use became focused as treatments for psychosis. Excessive use resulted in their acquiring a reputation as a "chemical cosh" particularly in long stay institutional settings. The second generation of this medication type has far less immediate adverse effects in terms of sedation, hypersensitivity, movement disorders and autonomic problems. This has resulted in an increase in the use for conditions other than psychosis, particularly children, for behavioural control, in the United States and Europe in the early 21st century. Risperidone has a license in Ireland for use in children in autism and conduct and other disruptive behaviour disorders, with a maximum daily dose of 3.5 mg, and 1.5 mg respectively, for children over 50 Kg. Aripiprazole is also licensed, without dose recommendation. The other antipsychotics are not licensed for use in children. There is increasing evidence for the benefit of olanzapine in the treatment of anorexia nervosa, and it is sometimes prescribed by specialists in that field. There is some evidence for the benefit of risperidone in short term management of disruptive behaviour disorders, as described in a recent Cochrane Review[19] but the authors highlight the concerns about weight gain and are clear that Parent Training is effective and recommend that medication should not be used alone.

The absence of a license does not mean that the medication cannot be prescribed, but it does increase the liability of the prescriber who takes responsibility for the decision. In order to give informed consent, that is to make a decision based on a clear understanding of the risks and benefits associated with the treatment, it is important that the person, typically the parent, understands the licensing and the evidence base for the prescription.

While the second-generation antipsychotics are preferred because they have lower rates of adverse effects, these are still significant and frequent. These medications sedate, and some children are strongly affected, causing a reduction in concentration or sleepiness during the school day. They blunt emotional expression, which is beneficial in reducing abnormal irritability, anger and intense emotional distress, but can be harmful if the result is generalised emotional blunting. Risperidone and olanzapine are likely to cause significant weight gain and risperidone may cause an increase in prolactin, a hormone which causes lactation, in boys as well as girls. Weight gain is associated with metabolic disturbance and dyslipidaemia and type two diabetes mellitus.
In general, the antipsychotics do not have recommended doses for use in the behaviour disorders in children as they are not licensed for this purpose. However, the recommendation is always to use the smallest effective dose. The maximum licenced dose of risperidone for the treatment of disruptive behaviour is less than one quarter of the maximum dose for the treatment of psychosis. Applying this reduction broadly to the other antipsychotics gives maximum doses for olanzapine, 10 mg, aripiprazole, 7.5mg, and quetiapine, 200mg. 18 patients, 6% of those treated with antipsychotic medication without a psychotic disorder were given doses above this at some point in treatment. It will be appreciated that if the treatment is ineffective, and mistakenly applied, the dose is likely to be increased excessively as it will not be effective.

While the great majority of cases did not have excessively high doses of neuroleptics, it is easy to assume that the use of comparatively low dose neuroleptic medication (compared to the doses used for the treatment of psychosis in adults) is unlikely to cause significant harm to children. The published clinical evidence[20] indicates this is incorrect, as do the findings from this review; weight gain when it occurred was rapid, happened early in treatment and with relatively small doses of antipsychotics. Similarly, the elevations in prolactin and lipids were often early in treatment.

While there are benefits to treating disruptive behaviour disorders in children, they are more susceptible than adults to the adverse effects of these medications and considerable care is needed to avoid causing harm. Moreover, the evidence base for long term treatment is very limited. There is some justification for emergency use, when the situation is dangerous, before psychosocial interventions can be put in place, but this should be limited and clearly explained. Careful evaluation of changes in target symptoms is necessary to evaluate effects and balance the risk and benefit of the treatment.

Combinations of medications and simultaneous changes in treatments expose patients to greater risk of adverse effects and make it difficult, if not impossible to decide what change in what drug is useful or causing problems. Any child starting a neuroleptic should have baseline measurements of height, weight, and blood tests to establish metabolic (Fasting glucose and HbA1c), liver function and prolactin status before beginning treatment. Some children are resistant this procedure. However, most are not, and it should not be used as an explanation or excuse to avoid routine baseline measurements. The measurements should be repeated regularly, the advice on frequency varies, but a repeat at three months and then annually is a minimum[21], and growth plotted on a growth chart as it is not possible to guess whether the weight gain seen between appointments is "normal" or reflects abnormal weight gain form appetite increase. Weight gain seen was as much as 20Kg.

The practice in Team A was to request the GP to take bloods, in some but not all cases as treatment was started. There was no systematic check that this had been done and only infrequently were blood results available in the records. Elevated prolactin was identified in 4 cases and galactorrhoea in 3.

There was no evidence of plans to repeat blood tests regularly for those children on antipsychotic treatment. Height and weight were checked infrequently and not plotted on a growth chart. A number of children gained significant amounts of weight, particularly if they were prescribed risperidone. Fortunately, the feedback from the recall and open disclosure interviews is that this reversed when the medication was stopped.

While diagnostic errors are evident, mainly due to the lack of supporting evidence for the diagnosis, establishing harm in relation to treatment, given the inadequate monitoring of adverse outcomes, is more problematic. In many cases, the relevant potential adverse effects were not recorded, or there was no baseline measurement before starting medication so that it is not possible to conclude that the abnormal finding was a consequence of medication. There were 33 cases with definitive evidence of harm that have since been reviewed by a consultant (in the Outcome 4 group) and 13 (O5) that require recall. The most serious adverse effects noted being galactorrhoea in three cases and the most common, excessive weight gain.

We therefore have a group of 92 children (105 less 13 in O5) who were exposed to the risk of harm thorough sub-standard management, which is classified by the HSE as harmful Service User Experience, but it is not possible to judge from the record whether or not Harm to the Person occurred. This group are being invited for recall for a clinical review in addition to open disclosure, which will ascertain the nature of the harm experienced and enable any necessary corrective help, such as medication review or assistance with weight reduction.

8.3.3 ADHD TREATMENT

Psychosocial interventions and information to families and teachers should be offered in conjunction with the diagnosis and treatment of ADHD[22]. The first line medication for ADHD is stimulant medication which is remarkably effective but carries some risk of harm through appetite suppression and increased pulse rate and blood pressure. This is likely to occur for most children, but a very small proportion may have significant changes in pulse and blood pressure. The cardiac risks are thought to increase if there is any evidence of cardiac abnormality or history of sudden death in related young adults and in these circumstances, or if the genetic history is unknown as a result of adoption, an ECG and possibly a specialist paediatric cardiology opinion should be sought.

If significant cardiovascular or weight change occurs, it should be managed by a reduction in dose or change of type of medication. The monitoring recommendation is to check height and weight, and pulse and blood pressure at baseline i.e., before starting treatment. Pulse and Blood pressure should be checked again one week after starting or increasing stimulant medication and regularly thereafter. Height and weight should be checked regularly. Because children grow, and therefore the normal range is age-dependent, it is necessary to track

changes using a growth chart and an age corrected blood pressure chart or tables to ensure no harm is being done. The non-stimulant treatments also affect pulse, blood pressure, and appetite and specific monitoring is also required.

The target symptoms of medication are attention, concentration, distractibility and physical over activity. Many, but not all children with ADHD are also excessively oppositional and are irritable and quick to flare up and have poor social awareness. Parents often describe "walking on eggshells" around the child. There are psychosocial and genetic contributions to this – children with ADHD are very commonly told, "Don't do that…. stop doing that….", and criticised and chastised repeatedly. This contributes to the increased frequency of Oppositional Defiant Disorder and the more severe Conduct Disorder in this group. ADHD impairs social learning as well as academic learning and so effective treatment not only improves academic performance but also social interactions and reduces oppositionality; children have a chance to think about alternative responses rather than simply react impulsively to a request or instruction.

For almost all children with combined ADHD and Conduct disorder (the ICD10 diagnosis which includes Oppositional Defiant Disorder) treatment for ADHD, typically medication and psychosocial approaches combined, is sufficient to resolve the impairment, although symptoms may remain. For a very small number, the addition of a neuroleptic medication for behavioural control may be necessary; it was listed by NICE in the 2016 Guidance, as a "Do not do" instruction[23]. The current NG87[24] 2019 NICE Guidance is very clear that this addition should only be happen following advice from, or referral to, specialist ADHD service. Where such a service is not available, it is reasonable to expect this type of combined treatment to be done by or under the direct supervision of a consultant in child and adolescent psychiatry.

ADHD specific treatments have a solid evidence base, the adverse effects are well understood and treatment using accepted European guidelines is safe and effective. In contrast, the evidence base for antipsychotic medication in children is much less well developed, the adverse effects are more serious, and the long-term effects are unknown in this age group.

Methylphenidate, the oldest and most well-established ADHD medication is inherently short-acting and therefore formulated as a modified release tablets given once a day and lasting 8 to 12 hours depending on the brand. An immediate release form may be given in the afternoon if the modified release medication does not provide adequate cover across the child's day. There is significant risk of causing sleep disturbance if it is given late in the day, although some children do find the reduction in restlessness helps them settle to sleep as methylphenidate clears their system.

Stimulants and other medications for ADHD have daily maximum recommended dose rather than a specific single dose for age. Clinical practice is to titrate medication against response, and because the child spends much of the time at school when treatment is active, it is essential to get clear feedback from the teachers about the child's response. The first medication tried should be increased to regularly until the target symptoms are well controlled, or the emergent adverse effects prevent further increase. If the response is inadequate, a different type of medication which should be tried and again titrated against symptom improvement and adverse effects. At this point, it is essential to review the diagnosis, considering carefully alternative explanations for the presentation. Only then should other pharmacological interventions be considered such as third line ADHD specific treatments, combinations of ADHD medications or the addition of other medication types, in particular neuroleptics.

Evaluation of change is psychiatry is difficult, particularly in children with ADHD, because it is often others, rather than the child who is complaining about the frequency, intensity and impact of the symptoms. Further, because ADHD frequently co-occurs with oppositional behaviour and adults do not clearly distinguish between behaviours due to this and ADHD, it is necessary to use validated symptom charts, rather than a global impression to determine the effect of medication and the need to alter the dose. Regular feedback from the school, using standard questionnaires is necessary, as the purpose of treatment should be to reduce the impairments evident in the school setting with respect to attention, concentration, impulsivity, and over activity. The use of such questionnaires is not evident and there are no requests to the teachers for information about treatment response on the files. Management of medication for ADHD is therefore reliant on observation of the child in the clinic and the child's and their parents' reports, which is not sufficient.

The QB test, a computerised test which gives a quantitative measure of sustained attention that is less influenced by subjective impressions, is being introduced, but was not available during the scope of the Review. The cardiac history and/or simple baseline observations, height weight pulse and blood pressure, were often missing. There was no evidence of discussion about a check of pulse or BP 7 days after starting stimulants. The missing 7-day check was not specific to NCHD1, it does not appear to have been the practice in the clinic during the scope of the Review, and we did not see any evidence of it having been established practice previously. It should be noted that the published audits of other clinics' practice are not necessarily better in this respect[25], but the publication of an audit is a reflection of the recognition of the low quality of the practice and the desire to change it.

When subsequent blood pressure measurements were in the normal range, the missing measurement was not in itself considered as evidence of harm, but as a consistent practice, it falls below acceptable clinical standards. When BP was recorded, it was not compered to age corrected normal values by any of the doctors in the clinic. The significance of elevated blood pressure in childhood in the absence of recognised causes such as renal disease is unclear and sporadic elevation is common. Good practice is to recheck the measurement after 15 minutes, ensuring the child is calm and the BP cuff is the correct size. This did not happen, and it is not possible to say if the elevated BP was sustained. Child psychiatrists usually switch stimulant medications to address this problem when it occurs as a result of treatment. A small number of children were noted to have had elevated BP, systolic above 150 and diastolic above 85, which should have triggered a reaction from the clinician who measured it. This was the most likely reason for urgent return to Team A.

Growth, height and weight, was not measured regularly (3 monthly is recommended by NICE for under 11's and 6 monthly otherwise) and not plotted on growth charts. Appetite reduction and weight loss was infrequent and lower than one might expect in an ADHD clinic. In some, but by no means many cases, referral to a dietician was discussed. Three children had a noticeable weight loss on treatment for ADHD including one very tall child who dropped weight percentiles from 75th to below the 50th. There are two apparent reasons for the low frequency of appetite suppression and weight loss. Firstly, sequential measurements were infrequent so that the problem may not have been visible. Secondly, NCHD1 very often initiated a neuroleptic before or in conjunction with a stimulant medication, and it seems reasonable to conclude that any appetite suppression was countered by the appetite stimulant effect of the neuroleptic.

8.3.4 BENZODIAZEPINES

These are effective sedatives for children and appropriate for short term use, for example as a pre-medication, or other infrequent and relatively short duration fear provoking situation, such as flying. They are addictive and so any benefit will fade with treatment over a few weeks and withdrawal effects can be confused with symptoms of an anxiety disorder. A small number of children can have paradoxical reactions, they become irritable and aggressive rather than calm and relaxed. They should not therefore be regularly prescribed for the management of anxiety or distress in children. They were often used in combination with neuroleptics, greatly increasing the chance of sedation. This combination is sometimes used in inpatient settings to avoid the need to use higher doses of antipsychotic medication in neuroleptic naive patients but is not recommended in community settings.

8.3.5 CONSENT

Exposing children to the risks associated with medical treatment should only be done when the decision makers, parents, or older teens, are able to reach a balanced conclusion about the potential benefits and harms for their individual circumstances. If the diagnostic process is flawed, it is not possible to make a balanced judgement. Similarly, if the treatment is not appropriate, or if the potential adverse effects are not adequately monitored, the risk/benefit ratio changes for the worse. Consent is not simply agreement; parents and young people should understand the purpose and also the risks involved in treatment and the alternatives that are available. We did not see adequate evidence of this discussion in the clinical records either from NCHD1, or other clinicians; a typical comment would be "trial of treatment with … discussed and agreed".

When medication is used off-licence, good practice is that the patient should be informed of this so that they know the greater risk and reduced evidence for the treatment. We discussed this with CP2 who told us that they do not routinely record consent, which is a not uncommon pattern for doctors with routine treatment.

However, they said that they would not routinely explain that a medication is being used off licence as they do not want to cause undue worry or anxiety for the parents. The HSE's National Consent Policy[26] 2013 is clear the relevant information should be provided to parents.

A small number of children were in the long-term care of the State through TUSLA. Consent issues are complex in these situations. We did not find clear evidence that the appropriate consent for treatment had been obtained, and a clear process was not described when we raised this with the social workers on the team.

8.4 SUPERVISION

The LBR Team was not able to interview NCHD1 as part of the process. Non-Consultant Hospital Doctors in Ireland are broadly split into those in formal training programmes and those not, and because of recruitment difficulties, non-training posts are often filled with locums, sometimes from private agencies. It is not clear whether these doctors have a clear career pathway, and they will vary considerably in their experience and previous training. There is an expectation that NCHD's should have weekly supervision with the Consultant, and this appeared to be the case for NCHD1 when they were working on Team B. However, after they moved to Team A in January 2017, this became very infrequent. It is not entirely clear why, and the LBR Team has not had the opportunity to address this directly with the Doctor. Their supervisor CP2, explained that while a time was scheduled weekly, NCHD1 was often too busy or otherwise unavailable, sometimes as a result of rest days after being on-call. They were told consistently that NCHD1 was open, engaging, and hardworking and seemed competent. It seems that a combination of the positive feedback from the MDT, trusting their skills, having an excessive workload from covering the suddenly vacant Team A post and the unfilled third County MHS Area A Consultant post, resulted in the CP2 not being concerned about this first indication that something might be going awry.

NCHD1 was appointed to the post as a Senior House Officer, one level up from intern. This reflects the minimal level of skills and experience required for appointment to the role. However, when CP2 discussed the situation with the ECD2 after CP8 resigned, the 2 NCHD's in County MHS Area A were referred to as Registrars, which implies the doctor has a significantly higher level of skill and experience. NCHD 2 was employed as a registrar, but NCHD1 was not. NCHD1 did ask to be regraded, claiming the support of CP2 in 2019, but this did not happen. The national NCHD contract does not reflect this skill difference, but simply lists two pay scales within the same job description.

CP2 told the interviewers for the HR parallel process investigating NCHD1's performance that they did not discuss NCHD1's level of training and experience, or training needs with them and had not seen their CV, while they attended supervision regularly in Team B. CP2 disputes this and commented that they were aware of NDHD1's previous experience and training. While these NCHD posts are clearly there for service provision and so the expectation is that the bulk of supervision time will be case based, it is difficult to see how a consultant can reliably establish the skill and ability of a junior and therefore their clinical capacity and scope of work, without some discussion of past and training and clinical exposure.

Concerns first became apparent in relation to NCHD1 when CP3, the Locum consultant who was supervising them learnt that they were not enrolled in the Medical Council's mandatory Professional Competence Scheme[27]. CP2 told us that it took some effort on the part of the supervisor to get NCHD1 to enrol. However, although CP2 encouraged them in this when they became their nominal supervisor again in 2019, and directly in 2020, when NCHD1 returned to Team B, CP2 was not aware of the type of medical competence scheme NCHD1 was participating in. CP2 commented that they knew NCHD1 was enrolled in the medical [General Registration] competence scheme.

CP3 also raised concerns in 2018 with CP2 that NCHD1 was micro-managing patients with medication, rather than looking at psychosocial interventions. CP3 was also concerned that NCHD1 was working in isolation from the MDT. CP2 commented that they had instructed CP3 verbally not to allow NCHD1 to see patients by themselves. Participation in follow-up appointments has not been analysed, however there was no change in the number of initial assessments NCHD1 conducted alone in 2018 or 2019, compared to 2017.
CP2 became more directly concerned about NCHD1's practice in 2019, following the death by suicide of a patient NCHD1 was treating. CP2 described NCHD1 as feeling they had to fix patients with medication to prevent such events occurring. CP2 described some clinical justification for treating people with low dose of antipsychotics,

but was clear that overall, NCHD1's use of this was excessive and CP2 told NCHD1 to stop this type of treatment in 2019. The frequency of NCHD1's antipsychotic prescriptions reduced, but still continued.

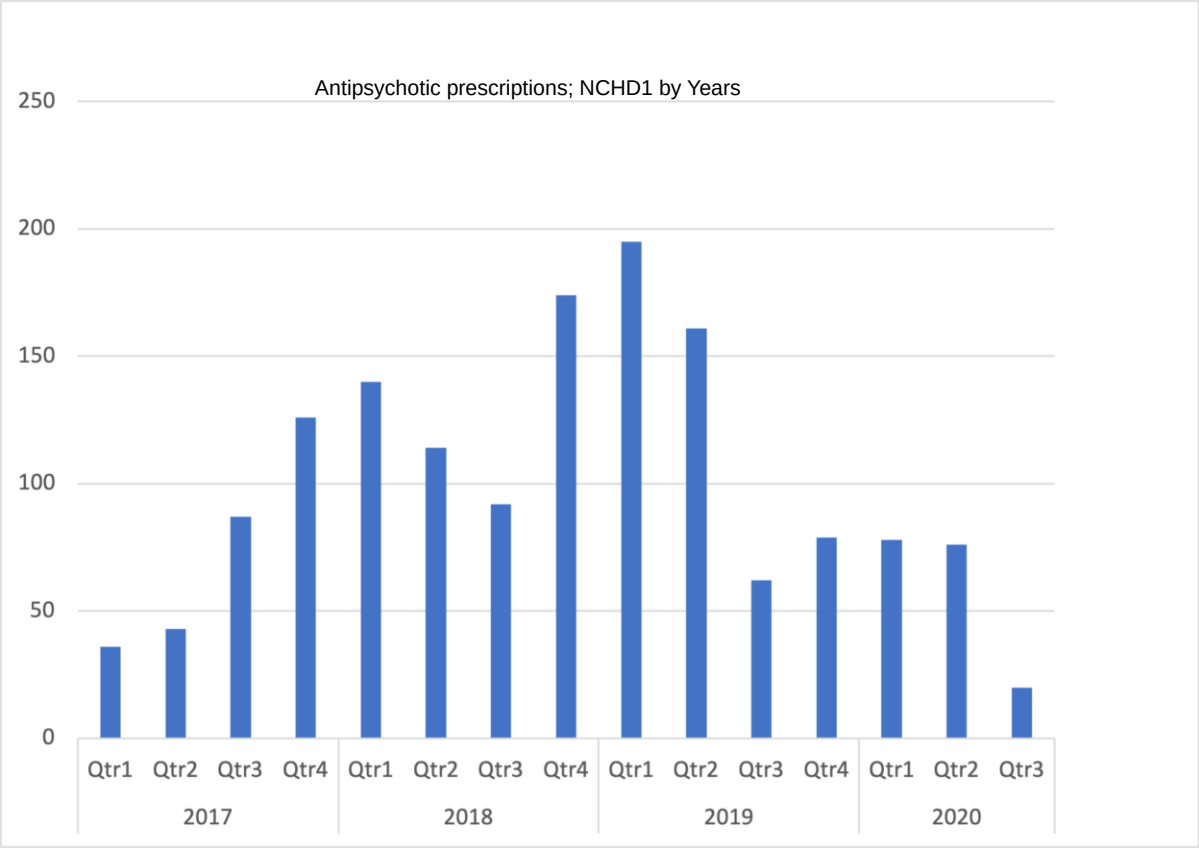


Figure 27: Antipsychotic Prescription by NCHD1, 2017-2020

CP2 said NCHD1 was not coming for supervision, or discussing their caseload with the MDT, partly because they were too busy seeing cases and partly CP2 thought because some members of the MDT were happy to leave a lot of the workload to the doctors. CP2 was also supervising another NCHD who presented much more overt and pressing problems which took up significant amounts of CP2's available time.

CP2 became further concerned later in 2019 when the family of another patient spoke to them because they were very unhappy about the medication that had been prescribed by NCHD1. CP2 involved the ECD2 in September 2019 because of further concerns about NCHD1 giving patients their personal mobile number to contact them and failing to keep records of patient contacts. However, it was not clear who was taking the lead in managing the situation. CP2 described NCHD1 as being almost out of control; certainly, the advice to alter their practice had little impact. CP2 commented that they requested advice from ECD 2 to see if the concerns regarding NCHD1 met the threshold for referral to the Medical Council. However ECD 2 commented that they were not party to any discussion regarding the referral of NCHD1 to the Medical Council.

At that point CP3, one of the on-call consultants in another part of the service had two experiences with NCHD1 in 2019 and 2020 in which NCHD1 did not make records of their clinical work in the patient's notes. On the second occasion CP3 alerted the ECD2 to the problem. CP3 also had the experience of NCHD1 their arriving several hours late for a shift to cover the ward as the SHO on duty on a Sunday, but this was not followed up.

CP2 learnt that NCHD1 was running a private treatment service from their home, sometimes seeing people privately up to midnight, and was also working in a private clinic in another county. CP2 and the ECD2 were sufficiently concerned about their degree of exhaustion that they sent NCHD1 on leave at the end of 2019. NCHD1 does not seem to have understood the concerns about their practice and was focussed on coming off the adult mental health on call rota to solve the problem of overwork. There does not appear to have been any consideration of the requirements of the European Working Time Directive Implementation Guidance[28], limiting

employees to 48 hours work in total in a week. While the Implementation Guidance is explicit in relation to the NCHD 2010 contract, it appears to have been replaced in the 2018 contract by para 10.f. Which requires the NCHD to work exclusively for the HSE[29]. The Human Resources Department within the CHO was not informed. ECD2 commented that they had spoken with HOD and HHR about NCHD1 working outside HSE hours. HOD commented that there and been a phone call from ECD2 asking about the policy for staff engaging in private practice as one of the NCHD's was doing so, but NHCD1 was not identified and HOD did not think it was problematic if it did not interfere with their contractual obligations but did not mention the EWTD. There is no record of a discussion with the HHR on NCHD1's HR file. There does not appear to have been an occupational health referral then; NCHD1 was advised to attend but refused to do so. CP2 suspected that NCHD1 did not stop their other work while on leave.

CP2 said referring the matter to the Medical Council was the ECD2's call. They discussed it but they wanted to give NCHD1 every opportunity to improve as they were hard working. ECD2 commented that a discussion about Medical Council referral did not occur. However, when NCHD1 returned to work in January 2020, their behaviour had not changed. CP2 said that they only became fully aware of NCHD1's prescribing patterns when NCHD1 came to work in Team B in July 2020. CP2 thought it was as if NCHD1 was giving parents a control mechanism if their child's behaviour was out of control. CP2 thought it might be appropriate in an inpatient setting but not in the community.

The LBR Team entered all the prescriptions identified in the clinical records, from the case notes, or copies of the prescription on file, into the LBR Database. This shows whether a consultant's name was linked to the prescription, e.g., if a discussion with a consultant was recorded in the clinical note, or if a consultant prescribed the medications. We found 1,223 initiations of psychotropic medication. 37% had consultant input from the Team A locums, and CP2. This is likely to be an underestimate of the true frequency of consultant involvement; it cannot be an overestimate. CP2 prescribed for 20 of the Outcome 4 or 5 of NCHD1's cases in 2019 and 2020 when CP2 had concerns about their practice. While CP2 certainly had an excessive workload and supervisory responsibilities, it is unfortunate that CP2 did not identify the extent of the poor diagnostic practice, inappropriate anti-psychotic prescribing, and poor monitoring of adverse effects then.

CP2 commented that in 2020 or at the end of 2019 they instructed NCHD1 not to see emergency cases or urgent cases alone, although the practice continued with initial assessments. CP2 gave them a reduced ADHD stable caseload and advised them not to prescribe without their supervision. CP2 took over the clinical case management of any patients where concerns were raised by members of the Team A and corrected any prescribing errors by NCHD1. The MDT members of Team A did not report any concerns about NCHD1's prescribing during interviews with the LBR Team, generally expressing the view that they did not have the skills to make such an assessment.

CP2 commented that in 2019 ECD2 directed CP2 verbally to continue managing Team A emergencies and urgent cases and directed NCHD1 to manage a stable ADHD caseload which was done. However, in 2020, NCHD1 initiated antidepressants for 10 patients and antipsychotics for 19.

CP2 commented that multiple attempts were made to engage NCHD1 in supervision, but they were evasive. Instructions were clear and reiterated on several occasions. CP2 was not aware of the extent of NCHD1's prescribing out of clinic hours by phone and contacting patients on social media until July 2020.

8.5 ADMINISTRATION

8.5.1 CLINICAL ADMINISTRATION

136 files had gaps in the clinical record. Patients in subsequent appointments and phone calls reported that they had had clinic attendances and changes in treatment that were not recorded in the case file and in some cases, gaps in the record were evident from the clinical narrative. A copy of the clinical notes of an appointment was used by the doctors, as the "letter", to inform the GP of treatment and progress and so this communication was also absent. As a result, the GP would not necessarily be aware of a change in treatment, or of risk evaluation. In 44 cases, the missing information could be inferred and was judged not to have indicated exposure to risk, so recall was not necessary. For the 92, it is not possible to quantify the risk and so these cases will be included in

those recalled for clinical review. It is of course possible that there are some cases where there was no evidence that notes were missing, and this may become apparent if some people question the assigned outcome.

The other MDT clinicians did not report regularly to the referrer/GP when they were seeing patients. Typically, a comprehensive specialist assessment was written up and we were told this was usually shared with the parents or the patient if they were older, although copies of correspondence relating to this were not always visible in the record. Team A practice was not to share these reports within the referrer or GP.

8.5.2 ADMINISTRATION AND PROCESS

The administrative team in Team A increased from 1.0 WTE in 2016 to 1.5 WTE in 2019. A database was created for the team when the HSE took over the service. It is essentially a list of names and contact details with some additional information. It is not clear how this was designed; it records the date of discharge, but not the date of referral. If a young person is re-referred, and information has not changed, there is no new entry on the database, until a subsequent discharge.

The LBR Team were made aware on several occasions that case files were required immediately for a patient's appointment due the same day. While Team A administrative team aspire to a computerised Patient Information Management Systems (PIMS), any data management system is only as good as the data it contains. The paper-based desk diary that the administrative team have as their guide to the day's appointment does not contain all the appointments due the next day, as many of the clinicians keep their own diaries and do not transfer the appointments to the clinic office diary in a timely fashion, or at all.

A simple file sign-out card system was recently introduced in an effort to keep track of files. However, clinicians have continued to remove files from the store without recording this. We were told by managers that perhaps another system was required, with the implication that the current one was somehow inadequate, rather than bypassed. The suggestion that the filing room door should be locked was not well received. The administrative team and their managers were not sure who could authorise a change to the access code to the filing room or how to implement such a change process.

We learnt from interviews and CAMHS Governance Group minutes that this is a longstanding problem and administrative staff frequently hunt through the building searching for case files that are needed urgently. This adversely impacts the service user experience and cause the front desk staff to appear incompetent as patients are arriving "unexpectedly" and their notes must be found, and it contributes to the stress and wasted time for the administrative staff. An email to team from the lead clinician CP2 in 2017, before the clinical files were found to have been lost, addressed this issue.

"This is a final plea to everyone to please carry out the above to enable the smooth running of the service. [Two staff] very kindly came in on Sunday on their own time to cancel clinics for Monday 16th October. They spent 2 hours running around the building looking for files which were found in nearly everyone's desks and again found that some clinicians had not filled out their appointments for this week. The administrative staff have enough to do without chasing us for files and are highly embarrassed when people ring up checking their appointment times and the diary is blank. Can we all try to ensure we are keeping in line with HSE policy re file storage and working together to ensure we can deliver the service effectively."

10 open case files remain missing, despite extensive searches and other efforts being made to locate them and two referrals are unaccounted for. The Team A clinic has now had two Data Protection breaches when numbers of files have been lost; while the investigation of the first breach resulted in recommendations and the issue being entered on the clinic's Risk Register, the significant aspects of the behaviour of team members regarding file security does not appear to have changed.

131 open case files were identified which had not been followed up as planned. Often an appointment had been offered in the past and there was no subsequent record of attendance, or another member of the team had completed a piece of work and subsequent treatment was not continued by the multidisciplinary team. For many of the children, the last contact was over 12 months ago, and it was not clear whether the prescribed

treatment was still being given by the GP. In all, 105 were categorised as Outcome 2 or 3 and most of these had not been prescribed medication. In the other 26, this contributed to the exposure to the risk of harm.

The 105 cases which are not being recalled through the LBR process have been flagged with Team A as needing a clinician to make contact, by phone in the first instance, to ascertain whether the child continues to take medication if it was prescribed, and whether a service is still required, and then to offer follow-up with Team A CAMHS or formally close the case. This task has been taken on by CP6, a CAMHS Consultant, who is an additional resource from outside the service has been undertaking this work at weekends.

This problem is the result of clinicians, predominantly, but not exclusively, NCHD1, failing to keep track of their outstanding clinical tasks. There is no administrative process that provides systematic support with this as there is not an up-to-date list of clinicians allocated to cases and no central record or diary of planned activity. Therefore, when a telephone call is taken and the caller is seeking clinical advice, the call is passed to that ½ day's team coordinator. If the caller cannot recall the name of the person they have seen recently, the coordinator has to locate the case file, identify the clinicians involved and take a message for them. This is costly and inefficient with a high-risk of communication breakdown.

A recurring theme from early feedback in the recall meetings is the difficulties that families have in contacting Team A. They described telephoning repeatedly, because the lines were engaged, and on occasion the telephone ringing out.

We were told that there is a 6 to 12 week wait for typing; as a result, many of the clinicians type their own initial assessments, which is an inefficient use of expensive resources.

The clinical records the LBR Team handled were paper records in card files retained with metal spring clips. These worked well physically until they became over filled, estimated to be 10 % of the records, at which point the file integrity failed and the contents fell out easily, potentially becoming jumbled or lost. The records are structured in date order according to discipline, except the MDT and medical entries which are in reverse date order so that the most recent record is at the front. Overall, this made tracking the clinical narrative very challenging and in addition, the date sequence was often jumbled.

The LBR Team along with the ECD3 and CD CAMHS have advised the SIMT from very early in this process that Team A needs clear leadership to implement the essential changes in the processes and procedures that are necessary to support the delivery of an effective clinical service. The thinking has been that this should be a management role in addition to the clinical support being provided at consultant level. It has become clearer during this process that the part time availability of different consultants, while addressing the immediate clinical gaps and supporting the NCHD's, has not given the whole team the reassurance and direction that is required every day.

A Practice Manager has now been allocated to the team and a Team Coordinator is being recruited. While these are temporary appointments, they are expected to be replaced with substantive positions in the near future.

8.6 CAMHS GOVERNANCE GROUP

This group was set up by the ECD2 in 2019 in response to concerns that CAMHS do not have a voice in the Area Management within the county. The group is responsible for both Team A and Team B and comprises the line managers of the MDT staff, the Consultant Child and Adolescent Psychiatrist CP2, the Area Administrator and the Q&SA for Mental Health Services, and is chaired by the ECD2 and/or the CAMHS CD more recently. It has a broad remit in quality and governance.

At interview it was very clear that the absence of a clinical lead, the consultant child and adolescent psychiatrist, was a long-standing concern for the group. They were clear that this created clinical pressures for Team A and had strongly supported the additional staffing resources that were provided to address this.

The absence of a consultant was rated 25/25 on the Risk Register – high likelihood x high impact. However, almost all the clinical managers had not considered the nature of the risk, outside the impact on clinical activity and throughput, i.e., the Key Performance Indicators (KPI's).

The Consultant is the clinical lead as defined by Vision for Change and legislation and the absence of a clinical lead means that there is no-one, in the words of Vision for Change, to "articulate the collective vision of the team and ensure clinical probity" (VfC, 9.3). This articulated vision was missing for Team A, which contributed to their sense, rightly or wrongly, of being junior partners and having less access to training and development than Team B. It also left the CAMHS Governance Group without a key component to inform them of the team's status.

This is a complex role, encompassing clinical and managerial leadership and advocacy for the service and service users, teaching, training and supervision generally and specifically for junior medical staff, and consultancy, that is the provision of specialist thinking and advice to others in the team and outside it. As the clinical lead the consultant carries and is seen to hold, the ultimate responsibility for the clinical care of the patient within the team. As the senior manager within the team, the consultant has a significant role in setting and maintaining standards of professional, clinical and corporate practice. The absence of a substantive post holder will cause a degradation of the service in all these areas at greater or lesser rate. The CAMHS Governance Group did not consider how this might impact team practice and behaviour.

When we asked about actions taken by the team to mitigate the risk, we were repeatedly told about efforts to recruit to the vacant post, which is a resolution or removal of the problem, not a way to reduce the likelihood of harm resulting from the extant risk. Risk mitigation was not a topic in the CAMHS Governance Group discussion. When pressed, the managers did describe other ways of running a service in the absence of a consultant, but there was a strong feeling of an inability to effect change. This was presented by two managers as a frustration that they did not have the budgetary control to effect change. However, it seems more likely that this was a tangible explanation for the sense of frustration at not being able to effect change because if the managers who are in a position to restructure and redesign service delivery want to do so, change can occur. Another member described the Governance Group as a forum to raise issues for higher management to take on.

Two senior members referred back to the Consultant as the clinical lead when asked where the responsibility for governance and quality of service in Team A lay. There was no suggestion that the role or tasks might be excessive for one person across two teams, but rather a reference to professional behaviour prohibiting a person from taking on a task that they could not fulfil. They were clear that the responsibility lay within the medical establishment. This is strictly correct given the Vision for Change description of the clinical lead role and its grounding in legislation. An obvious implication is that the different disciplines were not working cooperatively, but rather observing another group, the medical staff, struggling with their problem. Certainly, the managers do not, at any point, seem to have said clearly that the situation was untenable or intrinsically unsafe. However, the Governance Group did offer the Sigma Lean training and encouraged the implementation of the Team Coordinator role. However, these ideas were not taken forward by the team; CP2 was the voice for the team in declining this on the basis that the team was too stretched already to consider new ways of working.

We learnt that one of the teams in County MHS Area B appointed a Clinical Coordinator to cover significant aspects of the organisation, leadership and governance role when the team was without a consultant psychiatrist for an extended period. This proved to be an effective and safe approach; however, it was predicated on a particular individual who had considerable experience as a Team Leader in CAMHS in the UK where this role has been firmly established for many years.

The measures available to monitor the quality of the service being provided were the KPI's, incident reports and complaints. KPI's essentially measure productivity, which is throughput against staff numbers. They are a measure of quality in so far as access to services is a component of service quality and the waiting list element tracks this. However, without a continuous review of trends, it is very difficult to determine whether the quality of the service is rising, falling or is unchanged. The KPI data was reviewed in isolation from previous reports, and compared with Team B data, but do not seem to have been considered systematically over time. There is reference, for example, to a high rate of rejected referrals in Team B that was explained as an anomaly caused by the referral practices of paediatricians in the hospital.

Incident reporting was very infrequent, and the low level did not in itself give cause for concern. We understand that this is similar across other CAMHS teams. In contrast, the MDT staff told us that they had raised numerous concerns about the state of the building and the absence of a consultant and that they formally recorded these issues on the Risk Register. It is surprising therefore that, given the perceived risks in the clinic, the team were not reporting, and the CAMHS Governance Group were not seeing, any obvious problems or complaints resulting from these risks.

A common theme from the clinical managers in the group was that they were not hearing about problems in the team. One commented that Team A would sometimes take problems directly to the ECD2 and the line manager might only learn of them at that point. Another told us that they expected staff to bring things to them and said, "I don't go looking for problems."

The Governance Group members generally described Team A as being under significant pressure from the referral rate and the caseload. However, until the CAMHS CD was appointed in 2020, there was no-one with a view of CAMHS performance at a granular level in the group who might perhaps have questioned the assertion of excessive workloads.

In the absence of leadership, a team becomes a group of individuals, with different objectives and interests. The CAMHS Governance Group did not have a clear coherent view of Team A presented to them and did not seem to integrate their line management and team governance roles. This disconnect is exemplified by the planning of leave and working patterns; each discipline submits their annual and leave requests to their line managers, and they are agreed within that formal relationship. There has been no consideration or discussion of leave planning at the CAMHS Governance Group and the availability of staff from other disciplines was not been considered when agreeing leave.

Similarly in relation to caseloads, the managers were concerned that their staff were not subject to excessive workloads, but there has been no effective consideration of the capacity of the team and how overall workload and clinical risk is balanced. This has contributed to the medical staff carrying excessive caseloads, at consultant and particularly at NCHD level.

The Governance Group recommended that the team access the SIGMA Lean program, which is delivered by the HSE, however there was considerable resistance to this from the team and from the Consultant who was concerned that they did not have the time available to take out from clinical work. The proposal had been to help the team look at ways to work more efficiently and to improve administrative and clinical management processes. The management group experienced similar resistance to the introduction of the Key Worker role which is set out in the CAMHS Standard Operating Procedure 2015 and CAMHS Operating Guideline 2019.

We learnt from the CD that it has been very difficult to get clear recommendations for the MDT's caseloads from their Head of Discipline. It is hard to see how it is possible to define the capacity of a clinical team without understanding the capacity of the individual members. Equally it is hard to understand how a line manager can be confident that the staff are working effectively and efficiently if they do not know the activity and can use capacity for the individuals. ECD3 was eventually provided with the activity and internal waiting lists for the team members this year. The caseload at end of April 2021 ranged from 10 to 45 with a mean of 23 per clinician. None of these appear excessive. Three clinicians had no internal waiting list, and the Speech and Language Therapist had 112 cases waiting for assessment. The clinicians were not comfortable to discuss their caseloads during the interviews with the Look-Back Review Team as they did not feel it was within the terms of reference. We were told however that the caseloads were "manageable". The non-medical clinicians distinguished between their own caseloads and the work generated by initial assessments and the Team Coordinator role. The latter was generally perceived to be a burden and interfered with the primary task. In contrast, the current NCHD on the team, NCHD2 told us they had a caseload of around 130, which is excessive.

8.7 SENIOR MANAGEMENT

The interviews with staff at this level were more reassuring in terms of the understanding of the risks arising from the absence of the Consultant and actions in place to mitigate these. Actions described included the local CHO CAMHS Enhancement Project, resulting in a staffing uplift and exempting some posts from the national

controls on recruitment for maternity cover, allowing young people presenting in crisis to be contained in the hospital wards in the short term, rather than returning them quickly to Team A, increasing the number of NCHD's in the county with the expectation of reducing the supervising consultant's clinical workload, developing the DBT service for a small number of very high-risk cases and using Graduate Vocational posts in order to understand activity, performance and good practice, to review and streamline processes and to introduce an electronic diary system in CAMHS teams across the CHO; this initiative was planned for 2020, but Covid-19 intervened. However, these actions were not captured as risk mitigations in the Risk Register and do not seem to have been understood in that way down the management line, or at least they were not described to us as actions that had been taken to reduce the risk of a gradual degradation of service quality occurring in the absence of a clinical lead. It was implicit, in that the relief of management pressure to hit targets would allow leaders to focus on other things, but in a service where the one consultant is overloaded clinically and so most of the available time is devoted to clinical work, it is unlikely to be sufficient to allow the Consultant to maintain adequate governance.

The long waiting list in the CHO drew the attention of national managers in 2019. Help was offered in the form of a systems analysis of the CAMHS service[30] and support from a CAMHS Consultant who was very experienced in change management and productivity. However, their initial presentation was not warmly received, and the service considered that there was little being offered that was not already in planning or in place, and the offer was declined.

The limited availability of service quality measures was problematic. The managers did not have robust measures to be clear that the changes they were making and the money they were spending was producing desired outcomes, improving clinical care and reducing risks.

CP3 became ECD3 for County MHS Area A in July 2020. The handover from ECD2 did not include any concerns about NCHD1, only the lack of a consultant post for Team A. ECD3 was very concerned about the effect on governance of the long-term lack of the clinical lead and the apparent lack of understanding of the risks to the quality of service by the senior managers and the focus on recruitment as the solution; ECD3 thought it was a significant issue for CAMHS.

The position of County MHS Area A CAMHS in the CHO Mental Health management structure is ambiguous and leads to questions being passed between different people due to uncertainty about roles and responsibilities and some frustration was expressed to us at interview regarding this. This may also contribute to the desire of the clinical team to bypass their line managers and the CAMHS Governance Group and address their concerns directly to the ECD as they have done on several occasions.

One consistent theme from the medical managers was that they were unclear about their relationship with the Senior Managers and the professional Heads of Discipline in terms of how to effect change, not least because the Senior Managers i.e. Head of Service and General Manager appeared to control the budgets and expenditure, although the managers themselves were constrained by central directives. This does not fit with the medical managers' roles and responsibilities in their job descriptions. The new medical managers have had to "hit the ground running" as a consequence of the disruption and demands caused by the Covid pandemic in Ireland and the need to respond to the National Health Crisis. This switch to a more centralised command and control management model, will have interfered with the relationship and systemic learning that normally takes place for new post holders, at whatever level.

It is of concern that we have learnt that three consultants in the County MHS Area A have tended their resignation in the last year. Independently, they described this resulting from actions that had been agreed to support their work, such as backfilling clinical posts, being repeatedly delayed, or put off. Of perhaps greater concern is the fact that this resulted in the actions happening, which gives a sense that the agreed changes were possible, but not desired, by their managers.

9 REVIEW OUTCOME FINDINGS

9.1 STATEMENT OF FINDINGS

1. No extreme or catastrophic harm had occurred in the 1,332 cases considered between July 2016 and April 2021.

2. There were 227 children managed by NCHD1 where the diagnosis and/or treatment exposed them to the risk of significant harm by way of one or more of the following: sedation, emotional and cognitive blunting, growth disturbance and serious weight changes, metabolic and endocrine disturbance, and psychological distress. The medicalisation of ordinary emotional responses in children and their suppression by medication, risks delaying or damaging the development of skills in the self-regulation of emotions which normally happens as children mature.

3. 13 other children were found to have been unnecessarily exposed to a risk of harm under the care of other doctors in the service.

4. There was clear evidence of significant harm caused to 46 children in the files that were reviewed. This included galactorrhoea (the production of breast milk), considerable weight gain, sedation during the day, and elevated blood pressure. This figure of 46 will change as new information becomes available from meetings with the children, young adults and parents affected.

9.2 KEY CAUSAL FACTORS

1. The diagnoses of ADHD, particularly for secondary-school children, was frequently made without adequate evaluation and/or without the required level of information in relation to their presentation in school from their teachers.

2. Feedback from teachers was not requested as part of the management of treatment response for ADHD. There was evidence that this was the practice of the doctors who were prescribing for ADHD in general rather than being confined to NCHD1.

3. There was evidence of inconsistent and inadequate monitoring of adverse effects of medications, this included:
   a. Children started on stimulants did not routinely have a baseline pulse, blood pressure, height or weight measured and charted, to establish pre-treatment values.
   b. Children started on antipsychotics did not routinely have a baseline blood test to establish pre-treatment values.
   c. There was no expectation of checking pulse and blood pressure seven days after starting stimulant or increasing the dose.
   d. Repeated height, weight, pulse and blood pressure measurements were erratic and not plotted on developmental charts.
   e. The patient's GP was asked to do the blood tests in some but not all instances when children were started on antipsychotics. There were no results of this on file in the majority of cases. The tests were not routinely repeated at regular intervals.

4. It is a reasonable assumption, but cannot be confirmed because NCHD1 was not available to be interviewed by the LBR Team, that they were intending to help, not harm, the patients they treated and that the exposure to risk and harms occurring were as a result of a lack of knowledge about good practice. While the NCHD contract specifies involvement in education and training, these requirements are generic and could be met by any faculty registration for NCHD's on the General Division of the Irish Medical Council Register. There was no contractual requirement, or support and monitoring through supervision, to develop skills in the sub-specialty of child and adolescent psychiatry.

9.3 KEY CONTRIBUTORY FACTORS

1. There was an absence of a Consultant Clinical Lead for Team A which contributed to this failing to deliver and sustain a high-quality service. CP2 agreed to cover the gap in service in 2016, in the reasonable expectation that it would be a short-term solution, while a replacement was sourced, either by recruiting to the substantive post or by employing a locum. When this did not happen, there was no clearly documented reconsideration of the risk or change in the mitigating controls or measures in place.

2. The absence of a consultant in Team A meant that there was not regular, effective oversight of NCHD1's work through formal supervision and frequent joint working with a senior doctor.
    a. Supervision of NCHD1 did not identify the extent of their experience, skills, ability or limitations or the problems as they developed in 2017 and 2018.
    b. When concerns about NCHD1's practice were first described by CP4 in 2018, no effective action was evident to address them.
    c. Concerns regarding prescribing by NCHD1 were clearly identified in 2019. The supervising consultant and the ECD2 in the main, "advised", rather than directed changes in practice to prevent further problems.
    d. NCHD1 was known to have been working excessive hours and to be tired, if not exhausted, at work.
    e. Internal processes and procedures to address these types of problems through Occupational Health and Human Resources were not activated.
    f. There was no systematic supervisory check of the prescribing practice, or more broadly the quality of service provided by NCHD1, by their consultant and the ECD2.
    g. In 2020 NCHD1 was recognised as hardworking and still considered an important asset to the service. Despite the concerns that ECD2 had attempted to address recently, because of the perceived threat to service continuity, they agreed that NCHD1 could come off the adult mental health on-call rota by moving to an agency locum post.
    h. The serious concerns about NCHD1's practice were not handed over to ECD3 in the summer of 2020.

3. The service has not implemented many of the recommendations of the CAMHS Standard Operating Procedure 2015 or the subsequent CAMHS Operational Guideline 2019.
    a. Having clear treatment plans that are updated regularly and shared with the patient, their family and the referrer
    b. Appointing a Key Workers to all cases, which would improve communication and case management, share the caseload with the doctors and reduce the risk of cases being lost on the treatment pathway
    c. Appointing a Team Coordinator which would share the governance role with the Consultant covering the clinic and reduce the risk of gradual degradation of service quality, focussing on clinical practice
    d. Appointing a Practice Manager which would share the governance role with the Consultant covering the clinic and reduce the risk of gradual degradation of service quality, focussing on administration and organisation.

4. The proportion of referrals accepted by Team A was noticeably higher than the National and CHO average and has not reduced in line with the other services.

5. 10% of the referrals which were not accepted were not dealt with promptly and were left awaiting a decision on acceptance

6. Despite several efforts documented over the past five years by the line managers, the Team A team does not keep a shared diary. Reception staff do not know who is coming in for appointments, those in coordinator roles cannot quickly identify who is working on a case, and cases are lost from the clinical pathway.

7. Line managers have not been able to enforce the policy on case-record management. The administrative office/record store is open to all clinicians who can and do remove files without signing them out. Neither staff nor managers knew how to authorise the file room door being locked as a possible solution; clinicians saw record management as an admin problem and administrators did not think clinicians would agree to such changes and there was no sense that safe practice adhering to the HSE policy would occur.

8. Records management processes were not robust within the service. Clinical information was not always recorded in the appropriate patient record, and there is evidence of 2 missing referrals and 10 full case records. Missing records have been reported in line with the HSE Data Protection Policy 2019[1.] 136 files had gaps in the clinical record and for 92 of these, the absent information contributed to the need for recall as it was not possible to be sure the child had not been exposed to harm.

9. Doctors were present in 56% of initial assessments, while being around one quarter of the clinical staff.

10. There is a disproportionate workload and caseload distribution in Team A. The doctors hold over 100 cases, there is an average of 23 cases for the other team members.

11. The Governance Group did not seek to check that Team A was functioning safely and effectively. The individual managers' concern was on the performance of their staff being line managed and there was little consideration of whole team processes.

12. The CAMHS Governance Group did not recognise, or did not think it was their responsibility, or did not have a way to discuss, the risk to the service arising from the long-term vacancy.

13. Risk management for Team A, from the front line to the Area Management level, was generally considered in terms of making the problem go away, fixing something broken or recruiting to a vacant post, rather than considering the breadth of potential consequences of the identified risk, and taking steps to avert them occurring and monitoring to ensure the system is working safely.

14. The Systematic Review offered in 2019 might have drawn attention to some of the systems and thinking in place that has permitted the development of poor quality and unsafe practice that has occurred.

15. The CAMHS Governance Group was responsible for overseeing the quality of the CAMHS service being provided in the area. There is no evidence to demonstrate that this group sought to check that the Team A was functioning safely and effectively.

16. The service managers have limited quality measures to enable them to gauge team performance, quality and risk. There are nationally approved Key Performance Indicators (KPI's), but these are of limited value as snapshots because they are activity focused.

10 OTHER ISSUES RAISED DURING THE INVESTIGATION AND OPEN DISCLOSURE PROCESS

10.1 TEAM B FILES WITH NCHD1 INVOLVEMENT

10.1.1 BACKGROUND

NCHD1 moved to Team B in July 2020 under the direct supervision of CP2 until their contract was terminated in September 2020. They were involved in the care of 35 cases under Team B.

10.1.2 METHODOLOGY LOOK-BACK REVIEW CLINICAL TEAM

The team followed the methodology above, creating and populating a specific database for these records, matching the structure of Team A files.

The analysis of the records followed the same process described above, but was restricted to those cases in which NCHD1 was involved.

The team did not interview Team B members regarding this tranche of cases and no findings have been made with respect to wider causal or contributory factors.

10.1.3 OUTCOMES

- Team B identified 35 patients as having had contact with NCHD1.

- 14 cases were assigned to Outcome 2, three to Outcome 3, 14 to Outcome 4 and three to Outcome 5. 49% of the cases reviewed have therefore been assigned to outcomes indicating exposure to the risk of significant harm.

- One record could not be fully evaluated because the first part of a two-part record could not be located, and this has been reported as missing using the HSE Incident Reporting process. The information that is available in the file would lead to an Outcome 2 allocation.

- One of the O4 and two of the O5 cases are now aged 18 or over.

- 54% were referred by their GP.

- 22 of the 34 cases had their initial assessment in 2019 or 2020.

- NCHD1 was only involved in one of the initial assessments.

- NCHD1's actions were a significant cause of the assignment of the outcome 11 of the 17 cases assigned Outcomes 4 or 5, predominantly through unnecessary treatment with antipsychotic medication. The other 6 cases, which were essentially monitoring deficiencies, were attributable to the other doctors. It should be noted that NCHD1's time in the clinic was brief and so these issues, compared to the other 6 less serious ones, accumulated in a very short time period.

- One child had transient galactorrhoea as a result of treatment with risperidone by NCHD1.

- Monitoring of the treatment for ADHD with feedback from teachers was infrequent.

- Monitoring of potential adverse effects of medications, with regular height, weight, pulse, and blood pressure measurements as well as blood tests where necessary, was sub-standard.

Given the small sample size, it is not useful to present a further analysis of the figures.

10.1.4 CONCERNS ARISING

- One child had transient galactorrhoea, and another an elevated prolactin level, as a result of treatment with risperidone initiated without justification by NCHD1.

- Monitoring of the treatment for ADHD with feedback from teachers was infrequent.

- The pattern of concerns in the cases in which NCHD1 had involvement was not different to that seen in their Team A cases; unjustified diagnoses of ADHD, unnecessary combinations of multiple medications, poor monitoring of ADHD treatment, and inappropriate use antipsychotic medication with poor monitoring of potential adverse effects.

- As with Team A medical treatment, the monitoring of adverse effects of medication was poor; 6 of the 34 cases had monitoring concerns attributable to other doctors. While some patients had regular measurements, for many others it was erratic and inconsistent. There was no evidence that results

were plotted on relevant centile charts to allow for age and five recorded elevated blood pressure readings were not checked as good practice indicates.

10.1.5 STATEMENT OF FINDINGS

1. There were no distinct and separate findings from the review of the 35 cases from Team B.

2. There was clear evidence of harm in 7 children, two had endocrine disturbances that should have resolved with cessation of medication and 5 had significant weight gain as a consequence of medication.

3. The pattern of concerns in the cases in which NCHD1 had involvement was very similar to that seen in the Team A cases, unjustified diagnoses of ADHD, unnecessary combinations of multiple medications, poor monitoring of ADHD treatment, and inappropriate use antipsychotic medication with poor monitoring of potential adverse effects.

10.1.6 RECOMMENDATIONS

1. Team B is included in the scope of the CHO and County based recommendations.

2. Particular attention should be paid to the recommendations in the Clinical Practice, and Use of Information and Communications Technology sections of the report.

10.2 FEEDBACK

Comments at the first 100 meetings with patients and/or their parents their generated repeated concerns about communication breakdowns in Team A. These included:

- Telephone calls not being answered
- The phone line being engaged repeatedly
- Telephone calls not being returned

Further information regarding informed consent and NCHD1's boundaries around clinical work have arisen and are being addressed by ECD3.

Parental reports suggest that the frequency and degree of sedation, resulting from antipsychotic use was greater than was apparent from the clinical records.

Several parents reported that their child's weight gain reversed when they stopped taking the medication.

11 RECOMMENDATIONS

11.1 TRUST

While nearly 1,100 people have received letters from the Chief Officer of the CHO recently reassuring them that the treatment they or their child has received has not given any course for concern, the service has had to apologise to 240 people for the risks they have been exposed to unnecessarily and in some cases the harm which resulted. The matter has been discussed in the local and national press and there will have been an inevitable loss of trust in the Child and Adolescent Mental Health Service in Team A. Rebuilding trust has to be a primary focus of the service in considering how to take forward these recommendations. The childrens' and the parents' voices have been quiet in this review. If the service is to rebuild their trust, children and their families must be involved in the process, rather than experience it as something being done by the "they". It is the first of the Recommendations of the Quality and Patient Safety Initiative[31], after it has addressed structural organisational change. Patient participation in governance holds clinicians and managers to account directly for the decisions they make and actions they take.

1. Children and their families should be invited to be part of the governance structure of the CAMHS service. This can be facilitated through linkages with local advocacy services or national groups such as ADHD Ireland. It should be noted that a Service User Representative is included in the recently proposed CAMHS Governance Group.

2. The recruitment of a permanent full-time clinical lead Consultant Psychiatrist must remain a priority for the service to ensure adequate clinical governance structures, leadership and clinical expertise is available to the team in the immediate future. However, this is likely to be another locum post and it is not clear that the post holder would have the support of the team to make changes in practice. Direct clinical management support from the ECD and CD will be necessary to effect change in these circumstances.

3. Consideration should be given to the establishment of a working group to look at the current and future needs of the CAMHS. Current CAMHS models and proposed developments, in Ireland and the UK should be examined. Engagement with service users, family members and other stakeholders should be undertaken as part of this consultation to understand the needs and expectations of the community and establish structures to permit ongoing dialogue.

11.2 GOVERNANCE AND TEAM PROCESS

The most obvious predisposing factor for this situation is the absence of a substantive Consultant Child and Adolescent Psychiatrist in Team A since 2016. As a consequence, the Consultant for Team B has been the nominal clinical lead but has already a busy full-time role in their own team. CP2 agreed to cover the absence of Team A CAMHS consultant and subsequently some additional NCHD time was allocated across the two teams to support this.

The focus of attention from the clinicians and line managers has been to resolve the problem by recruitment. Insufficient understanding, recognition and attention has been given to the indirect and slowly developing risks arising from the absence of the clinical lead role and ways to mitigate that risk.

4. Training in risk and incident management for line managers and front-line staff should include risk identification and reporting, risk analysis, mitigation and development and monitoring of controls. This should be mandatory rather than voluntary and the risk management plans developed should be discussed in management supervision and handed over when post holders change. In this way risks can be managed at the appropriate level, rather than have staff feel they can abdicate responsibility by "putting it on the risk register".

At interview, many of the clinicians expressed significant concerns regarding their exposure to clinical risk of a patient in their care coming to harm, as they have had extended periods without a consultant and clinical lead. This has contributed to non-medical staff relying on the available junior doctors, who have a supervisory relationship with the Consultant, either the locum or CP2, to contain that exposure, which contributes to the

very high medical caseload. Recently, cover has been provided by several consultants from County MHS Area B, working part time in Team A during the week and at weekends.

5. In the absence of a full-time consultant within the service, there should be one identified clinical lead for the service with time scheduled to attend the clinic for managerial and for clinical sessions.

The CAMHS Operational Guideline 2019 describes how to deliver a safe, effective and efficient service. It relies on a consultant to deliver the service and to be the Clinical Lead, with the authority and responsibility to do this. However, the substantive Team A consultant post has been vacant for five years and it is unrealistic to think it is going to be filled soon. The immediate competitor for child and adolescent psychiatrists in Ireland is the NHS in the UK. The demand there is about to rise as the austerity measures which have been in place since 2010 are rolled back and the extensive impact of COVID on child mental health are becoming apparent. While these has been some protection to clinical services during this period, CAMHS funding has been significantly curtailed because a large proportion of CAMHS funding comes to services through the CAMHS Grant, which is a Local Authority provision and has not been protected. Recruitment in Ireland is therefore not likely to improve soon. Therefore, alternative or supplementary governance arrangements need to be developed in order to address this, unless and until there is a change to the legal and regulatory system that requires a consultant psychiatrist to be the clinical lead.

The CAMHS Operational Guideline 2019, following a Vision for Change, is clear that all teams should have a Clinical Team Coordinator whose role should include referral triage, in conjunction with the consultant, waiting list management and team meeting organisation and liaison and coordination with GP's and other organisations. This sharing of the tasks of governance, as opposed to the responsibility, reduces the load on the lead clinician.

6. Recruit a Team Coordinator to support the process of tracking quality standards and performance for the team. The Team Coordinator should also be a member of the CAMHS Governance Group so that there is a direct link from the team into the management structure.

Adapting and developing the procedures and practices of the service has not been possible for Team A. However, change is necessary if the system is to function safely and effectively. Similarly, Vision for Change recommended the linked role of Practice Manager, working with the Team Coordinator and Consultant. It is salutary to realise that the same recommendations are being made fifteen years later.

7. Recruit a Practice Manager to review and improve current working practices within the team. Lean processes should be implemented to ensure staff are working efficiently in their area of expertise. This is complementary to the Team Coordinator post.

It is essential to understand the clinical capacity of the team in order to determine the clinical need and performance expectations. These are implicit in Vision for Change which sets out staffing levels for a given population and need to be made explicit for the team so that the expected caseloads and throughput can be understood. The process of determining demand and capacity can be done using toolkits such as CAPA or another flow model[32].

8. The Team Coordinator, Practice Manager and Clinical Lead should work with the CAMHS Governance Group and the CAMHS Area A Team to implement the CAMHS Operational Guideline 2019.

9. The CAMHS Governance group members should work with the Clinical Lead, the Team Coordinator and the Practice Manager to establish the clinical capacity, (appropriate caseload) and expected throughput of the CAMHS team and supervise their staff using these figures. In that way, the capacity of the team can be understood, any gaps in service provision can be clearly seen and will form the basis of any development funding requests.

Change is difficult and Team A has been through multiple changes and challenges in the recent past. Help will be needed to allow the team to adapt to new ways of working and new expectations.

10. Once the Team Coordinator and Practice Manager are in post, the team should undertake the externally facilitated "Enhancing Teamwork" initiative as provided by the HSE.

Several of the case management processes in Team A service are inefficient or ineffective; as a result, 131 cases were lost to follow-up, (many simply requiring discharge back to the referrer), case records were often missing from the record store and 10 casefiles and 2 referrals were lost. In part this is a result of the absence of a key worker to take responsibility for each case and in part because procedures are not followed.

11. The CAMHS team should implement the Key Worker role for all cases.

12. The member of the CAMHS Governance Group should agree and implement a clinical diary and case management system to track appointments and case allocation. This can be a paper or electronic based system and does not need to await the provision of a computerised system.

13. The members of the CAMHS Governance Group, as line managers must take responsibility for the safe and effective management of clinical records and hold their staff to account for breaches of policy and procedures.

14. The Terms of Reference of the existing CAMHS Governance Group must be reviewed and updated. It should be noted that this is in progress. The Governance Group should consider the use of an "Action Tracker" or other device to ensure clear ownership and completion of tasks.

To deliver a high-quality service, clinicians need to understand the process of assessment and treatment and of equal importance, their practice must remain congruent with the treatment program or protocol. Unless there are regular checks on treatment fidelity, it is likely that clinicians will drift away from the specified model with a consequent reduction in treatment effectiveness. Fidelity is maintained by a combination of supervision and audit that is checking that the intended treatment plan, including necessary monitoring is happening in accordance with the protocol and reviewing and revising processes if it is not.

15. Audit training must be provided to the team by the Quality and Department Safety within the CHO, and an annual audit schedule established by CAMHS Teams. Service users should be consulted and included in the audit oversight group. CAMHS appropriate audit tools should be developed. Audit activity should be organised across all teams in CAMHS in order to share understanding and develop collegiate thinking for the service. A member of the CAMHS team should be a nominated representative on the CHO Audit Committee.

If the service is unable to recruit to the County MHS Area A posts in the next year, and continues to struggle to fill other consultant posts, it must consider significant service redesign across the CHO to prevent similar problems developing again in governance and supervision. Provision of the Vision for Change roles of Practice and Business Manager across the CHO CAMHS teams would help to mitigate the concentration of Governance responsibility and leadership in the consultant. The new CAMHS CD post is intended to review CAMH service organisation but has of necessity so far been diverted into managing the impact of COVID. It is expected that this task will be prioritised with the goal of balancing the requirements of a consultant delivered service and the continuing non-availability of consultants in post.

11.3 CLINICAL SERVICES

County MHS Area A is short of two CAMHS Consultant posts. Providing more NCHD's, which are service delivery posts without many prospects for career advancement, does not address this; the training and experience required for the posts does not match the skills required for the independent practice that can occur when the system and the individual doctor is under pressure to meet activity targets and reduce waiting lists. The latest NCHD[33] review recommends "the introduction of a new permanent doctor grade in the HSE to replace the short-term contractual nature of non-training posts". Such a post, delivering a specialist clinical service and supervised by a CAMHS Consultant, would create stability for the doctor and the team. The role and post holder would then have a clear long-term purpose, and the specific training needs of the individual could be clearly linked to specialty service needs and service development plans. Moreover, a small pool of permanent CAMHS Doctors in the CHO, below consultant level would be able to provide more robust clinical cover to meet gaps in service, in conjunction with Team Coordinators.

NCHD's typically do not progress into training posts. Their access to a specialist training is limited by the nature of the role and their registration. There is an alternative route to the specialist register through equivalence, based on assessment of training and experience which may be open to doctors holding permanent non-consultant posts could improve the numbers of applicants to substantive posts in the future.

16. The service should seek to develop and pilot a new permanent doctor grade at NCHD level for two of the County MHS Service Area A posts in the expectation that these positions will continue to be necessary.

Given the limited pool of applicants for the CAMHS consultant posts in the county consideration should be given to other ways to source consultants. To address the concerns and difficulties in the transition of adolescence to adult mental health services at the age of 18, the Youth Mental Health Task Force[34] has recommended that the upper age range for CAMHS should change from 18 to 25 years. Sharing the Vision has followed on by recommending that a pilot reconfiguration should be established to allow a better understanding of the needs and resource requirements of such a service. It would be appropriate to appoint a consultant trained in adult mental health to such a post, with the expectation that the focus was on adolescents and young adults rather than children. Such a service would greatly extend the selection pool for recruitment to CAMHS.

17. A working group should be established to progress a plan for a service re-design to provide an integrated mental health service for 0 to 25-year-olds. Once completed the plan should be submitted to the CHO Management Team for approval.

One of the perceived barriers to recruitment in the county is its location. Potential applicants in Europe or elsewhere may not be able or willing to relocate to the West of Ireland. There have been many trials of remote treatment by telephone or more recently video conferencing facilities and the combination of significant developments in internet browser technology and the enforced social distancing brought about by COVID in 2019 have encouraged, persuaded, or forced many health care providers to adopt this approach. It is not without problems, from poor broadband speeds at a local level, to cyber-attacks on the national infrastructure. CAMHS services are particularly suited to telemedicine as children and adolescents are far less disconcerted by the experience than many adults. There is no restriction in providing care services remotely within Ireland, however there will be territorial data limits and registration requirements that it will be necessary to meet if a consultant is practising outside of the jurisdiction[35].

Experience to date suggests that the majority of follow-up appointments can be managed satisfactorily by remote contract. Current experiences of assessment suggests that it is harder to establish a therapeutic relationship and in some cases this may not be satisfactory. The literature has not yet developed to evaluate the recent explosion in routine delivery of treatment in this way, something which until last year was the domain of enthusiastic individuals and teams, but considerable learning has taken place over the last year which is being processed now[36].

The knowledge developed so far has been about the delivery of clinical services, their quality and effectiveness and patient experience. There has been little attention to remote governance, which is a key component of the consultant role. One option would be to contract for clinical services, without any expectation that the consultant took a role in the running of the clinical team in the county, in much the same way that consultant time can be brought in from the private sector to address a clinical need without changing the governance arrangements within the service. Another would be for the consultant to visit in person at intervals, to address the governance tasks and those clinical exchanges that are better managed in person.

18. The CHO service should scope out the regulatory requirements for the provision of medical services remotely outside the country, in the EU or elsewhere, with a view to retaining a CAMHS consultant who is able and willing to provide such treatment. If it is feasible, a clinical service should be developed.

Raising the level of skills and experience in the service by adding staff with expertise in specific aspects of CAMHS will further reduce the burden of oversight on the lead clinician.

ADHD represents around one third of CAMHS referrals and demand for assessment and treatment is increasing. The Admire ADHD service in Dublin has adapted the Dundee pathway for use in Ireland effectively. The model

describes both the process of assessment and treatment and gives detail about the necessary establishment, capacity and expected productivity of the model. Developing a specialist team for the assessment and initial treatment of ADHD across the county, led by an ANP prescriber, using the Admire model will allow a sustainable increase in the quality and efficiency of care. Using this model, the ADHD assessment would be undertaken, medication would be started and titrated until symptoms are stabilised, psychoeducation and behaviour management provided, and the child or adolescent handed back to the generic CAMHS teams for follow up medication reviews and occupational therapy, speech and language therapy and psychology input for any comorbidities.

The CHO already has an ANP prescriber in County MHS Area B who is working with the outpatient teams across the CHO to standardise practice in the assessment and management of ADHD. Developing a specialist service in County MHS Area A would build on this. The CHO has invested in the QB test, an objective continuous performance measure of attention and concentration which allows treatment to proceed without regular feedback from a child's teacher about the impact of medication performance socially and academically in the school setting, which can be difficult for busy teachers to provide frequently.

Currently CAMHS has 10 comparatively small independent generic teams across the region. The populations served (2020 figures from CHO KPI returns) range from 9000 to 24000 with an average of just under 17000. There are sufficient children in need of services, and clinicians in the CHO, to develop specialist teams from within the existing establishment. This would allow staff to develop and retain skills in conditions that are seen less frequently, such as eating disorders, obsessive compulsive disorders, early onset psychosis in conjunction with adult services, gender dysphoria and medication resistant cases of e.g., ADHD and mood disorders.
A significant task for the newly created CD post was to work with senior management to develop a new management structure for CAMHS in the CHO. The revision of CHO CAMHS organisational structure has been delayed by the demands of the COVID response, but also the difficulty in integrating a new management structure effectively into the CHO organisation.

A hierarchical "chain of command" is, notionally, simple to adapt and expand; one simply decides where a new functional unit fits with respect to authority and responsibility. In contrast, for a system that has several different modes of authority and responsibility, financial, managerial, professional, and clinical, sometimes with conflicting goals and priorities, changing the position of the component parts is a much more challenging process. The paper by Michael Byrne[37] provided a useful and in-depth analysis of multidisciplinary interactions in Irish Mental Healthcare; in the end, having the will and determination to make systems work is probably more important than the theory. Creating a governance structure alongside or below the existing Area management level will continue the uncertainty about the authority and responsibility that has been problematic for the CAMHS Governance Group. Given the size of the CAMH service in the CHO, considerable differences of practice, systemic relationships with other agencies and service user expectations, it would seem reasonable to integrate CAMHS into a CHO Area level with an ECD and CAMHS Director of Nursing and CAMHS specific discipline leads.

19. Consider developing a CAMHS stand-alone management structure which will work alongside the adult mental health service structure.

20. Consider, with or without separate management, developing specialist services within the CHO, to enhance the quality of the service and to broaden the range of senior practitioners who can take on leadership roles within the teams so that the process of setting and tracking quality standards and performance for the team is not located solely with the consultant and the service does not remain dependent in the long term on the limited consultant pool.

11.4 CLINICAL PRACTICE

The assessment and treatment of ADHD has caused significant problems at both stages of care, as has the process of starting and monitoring antipsychotic medication.

21. The Dundee Pathway adapted if necessary for CAMHS, should be the standard model of ADHD assessment and treatment in the service. Use of the QB Test[38] should be integrated into this protocol.

22. Shared care protocols should be developed with GP's for the management of children with ADHD. If this is problematic, because of concerns regarding controlled drugs, local pharmacists could be engaged in this process.

23. Psychotropic medication should only be initiated by, or with the documented express agreement of the Consultant responsible for the child's care. It should not be started in the Emergency Department without oversight and agreement from a CAMHS Consultant.

The Irish National Formulary is not intended to be a comprehensive treatment guide for the psychotropic medication in children and adolescents. Given the multi-national training of the doctors working in the CHO, it is likely, in the absence of an approved source, that they will select from the variety of international professional standards, NICE, European Guidelines, American Academy of Child and Adolescent Psychiatrists to inform their own practice. There is obvious value in standardising practice, to improve quality, monitoring and consistency of care across the CHO.

24. The CHO should consider establishing a Drugs and Therapeutics Committee for CAMHS, or a joint Committee for CAMHS and adult services.

25. Protocols for the use of antipsychotic medication in non-psychotic and psychotic patients should be developed, based on the NICE Guidelines[23] and implemented. Practice should be monitored through the use of clinical audit, again as recommended by the NICE Guidelines. Blood tests for the management of antipsychotics should happen at baseline and three months, and at least annually thereafter.

26. The use of psychotropic medication in CAMHS should be audited on an annual basis, using NICE Guidelines in the absence of local protocols and procedures.

27. In the absence of clear shared care agreement for the patient, the doctor who requires a blood test should request it themselves, to avoid the uncertainty about whether a test has been done and whether the results fall within or outside the normal range for the age group.

The MDT members offer complex specialised assessments for the children they see. These are written up as technical reports and usually shared with the patient or parents, but not normally with the GP and other referrers. This is a considerable loss of valuable information to the care network, to which the GP should be central.

28. Clinical reports from the MDT should be shared routinely with the GP and with others who may refer children.

The KPI's are the primary measure of a clinical team's functioning. However, they are only indirect measures of service quality in that they describe accessibility to the service by waiting times and throughput by intake and discharge. The clinical intent and the patient's experience are missing. Shared Treatment Plans from the CAMHS Operational Guideline 2019 sets out the understanding of what is to happen and its timescale. Service user experience, when combined with clinical outcome ratings by clinician, child and parent provides a much richer and more nuanced report of service quality and therapeutic change[39]. Simple clinician provided metrics such as the Children's Global Assessment Scale[40] (CGAS) typically overestimate improvement and may underestimate initial severity. The widely used and well-established parent, child and teacher reported Strengths and Difficulties Questionnaire is more robust and introduces a patient reported measure of change. It is also an effective measure of change in treatment[41].

29. A protocol for the routine collection of Patient Reported Outcome Measures (PROM's) should be developed to track clinical progress against treatment plans and to inform the understanding of service quality and performance.

30. Treatment and care plans for all children should be updated regularly in consultation with the patient and their parents/guardians. All updates should be communicated with the referring clinician.

When the NCHD appointment is intended to be a long-term position, the NCHD must be expected to develop the skills necessary for the delivery of the service with progressively less consultant supervision over the course of a three-year contract. This should be through informal teaching during clinical encounters and supervision, self-directed learning and access to a relevant peer group and courses, within the College of Psychiatrists of Ireland.

31. The CHO should set out specific educational and training expectations for its NCHD's in Child Psychiatry including affiliate membership of the College of Psychiatrists of Ireland and should consider whether this approach should be adopted more widely.

The Irish Medial Council requires all doctors to engage in a Professional Competence Scheme (PCS) in order to have their annual registration renewed. NCHD1 was not doing so in 2018. It is not clear how long this had been the case or whether this affected the NCHD's registration. It advises that "Health service managers should consider how this new system can best integrate with local clinical governance systems and clinical directorate arrangements. For example, an employer may request that a doctor provide evidence that they are pursuing a professional competence scheme as part of an annual clinical appraisal process; maintenance of professional competence activities, such as clinical audit, may reflect local service needs as part of a clinical directorate business plan.

32. The CD for CAMHS should ensure that all NCHD's are meeting their statutory requirements for Professional Competence Scheme (PCS) registration[26].

33. The CHO should consider aligning clinical service plans with professional competence activities, particularly specific training needs and clinical audit. This links back to the recommendations for greater CAMHS autonomy and specialist services above and it will be necessary for consultants, not just NCHD's if coherent service growth and development is to be facilitated.

11.5 USE OF INFORMATION AND COMMUNICATIONS TECHNOLOGY TO SUPPORT HEALTHCARE

There are a number of ways to use ICT to support and enhance the clinical process. The simplest systems to implement are direct swaps of paper-based lists. Patient Information or Patient Management systems collate relatively stable data – names addressed and dates primarily in order to keep track of patient flows. At the very least the Team A database should be updated so that it can fulfil this task effectively. Similarly, for the day to day running of the clinic, an electronic shared diary e.g., Microsoft Outlook will greatly reduce the amount of time wasted and embarrassment involved in patients arriving "unexpectedly" for a scheduled appointment. Some CAMHS teams in the CHO have implemented this type of system and it would be easy to replicate.

Much more complex Electronic Health Records (EHR) are available, either as generic tools, to be adapted to local needs or bespoke systems designed from scratch. The latter approach should probably be avoided, not least because the CAMH service is in a degree of flux and designing an EHR to reflect current practice would be aimed an at outdated target once it was delivered. Scoping the introduction of an EHR in CAMHS should be on the agenda of the CHO CAMHS Governance Group.

At a clinical level, there are numerous ICT tools that are helpful in different ways. Some clinicians are excellent typists, others are not. Data capture by voice, through remote transcription services where the audio recording is securely transferred to suitable transcribers is a high quality (low error rate) but relatively expensive process, although it is still likely to be cost effective compared to an expensive clinician typing with 2 fingers. Electronic transcription can be done with dedicated software such as Dragon Dictate, which learns individual users' pronunciation and vocabulary, with integrated software in programmes like Microsoft Office or Operating System integration on modern Windows desktop machines or on handheld devices. As services move towards EHR's it is essential, if potential performance gains are to be realised, that the data capture process is as efficient as possible.

ICT tools to enhance the clinical process again either replicate the paper-based approach, such as the computerised scoring of the Conner's Questionnaire for ADHD or set out to add new dimensions to patient assessment and management. The Development and Wellbeing Assessment[42] (DAWBA), developed by Prof

Robert Goodman, who is also responsible for the SDQ, is moving to this latter approach. It was designed and tested to be a robust epidemiological diagnostic tool generating ICD 10 and DSM V codes to understand the mental health of the UK child and adolescent population and was the basis of platform for the National Mental Health of Children and Young People Surveys [43]. For the assessment of new patients, or indeed for comprehensive reviews of existing patients, parents, teachers and young people over 11, complete online independent reports on a secure portal using structured questions and free text. The questions are available in multiple languages and their typed free text responses can be parsed by an online language translation tool, greatly improving accessibility for some groups. The software collates the structured data and produces probabilities of disorders, grouped by ICD/DSM codes. The range of conditions covered allows it to be used as a signposting tool to the most appropriate service, e.g., CAMHS, Neurodevelopmental or Behaviour Management services and for risk screening for waiting list management. When the patient is first assessed, considerable background and collateral information is already available to the clinician reducing the assessment to diagnosis time in straightforward cases.

Telemedicine, that is remote contact using telephone or more recently video technology, is particularly helpful in areas where there is a long travel time to clinics. It is not suitable for all cases but can be an efficient was of gaining access to limited specialist resources. The resistance to its use is often greater among clinicians than patients. The evidence review for the Vision for Change Refresh[44] is cautiously optimistic about this approach. The diagram below, taken from that document shows the potential range and overlapping uses of ICT in mental health. The COVID epidemic, by causing people to socially distance if not isolate, encouraged or many people to access remote technology using platforms such as Zoom, and mental health delivery switched to an online first approach. Web browser technology has shifted recently so that the dedicated device-specific software that was needed a few years ago to connect securely with patients, is no longer necessary. This has removed a significant impediment to the use of telemedicine services.

Guidelines for the use of telepsychiatry are available from the Royal College of Psychiatrists website[45].

34. The CAMHS Governance group should explore the options available in ICT to improve the governance, effectiveness, efficiency and accessibility of CAMHS in the CHO. At the very least this should include a shared team online diary and a clinic database built around episodes of care.

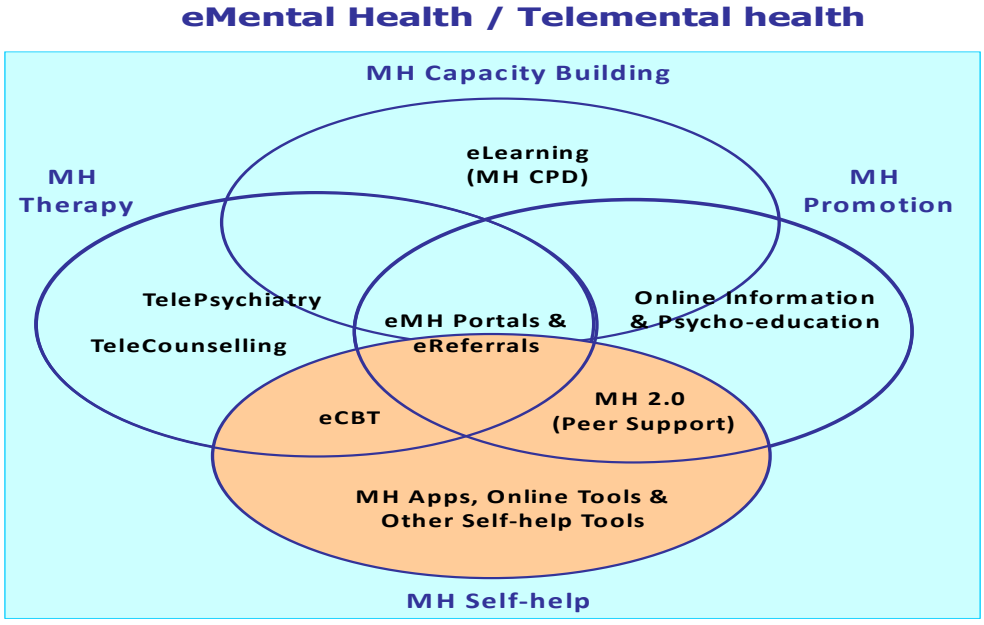


Figure 28: Potential uses of ICT in child mental health service delivery.

11.6 LEARNING

Serious concerns around the specific NCHD's clinical practice were identified in 2019, which were described in email correspondence and escalated to the ECD but were not resolved. It appears that the supervising consultant from Team B, who was covering the vacant Team A consultant post and a service gap in the Mental Health of Intellectual Disability and Liaison Psychiatry, and the ECD who was not experienced in the sub-speciality, did not have the capacity to performance manage the NCHD effectively when it was required.

Given wider national consultant recruiting issues, this type of problem is probably not unique to County MHS Area A CAMHS and may be occurring in the HSE system in other disciplines, particularly when an NCHD is working long-term in a non- training specialist post, allowing them to develop confidence without specialist knowledge.

35. The likelihood of inadequate supervision of NCHDs in non-training posts in specialist services due to prolonged vacant consultant posts should be brought to the attention of other Chief Officer's and ECD's for consideration and where necessary, risk mitigation.

12 APPENDIX

12.1 INVESTIGATION TERMS OF REFERENCE FOR RECALL STAGE

Investigation Terms of Reference for the Recall Stage
NIMS Reference No: 21330972

Introduction

These are the terms of reference for the Recall Stage of a Look-back Review Process commissioned by the Chief Officer into potential clinical issues relating to the clinical practice of NCHD1 in prescribing, care planning, diagnostics and clinical supervision in CAMHS Area A.

Purpose

The purpose of the Review is to:

- To establish the facts relating to the incident
- To identify any findings which caused and factors which contributed to these findings
- To make recommendations which when implemented would serve to reduce the risk of a similar incident occurring in the future in line with the Incident Management Framework (2020)
- Complete a recall stage in line with the Look Back Review Policy (2015) by undertaking an examination of the patient/ service user and/or review relevant patient information/ results in line with the Look-back Review Work Plan (Appendix 1)
- Identify actions to be taken as a result of the findings of the Recall stage of the Look-back Review Process.
- Implement any corrective actions as appropriate and will communicate any additional actions to be taken to the Safety Incident Management Team for further action.

Scope
The time frame of this Review including the recall stage will include all children seen CAMHS Area A between the 1st July 2016 to 19th April 2021.

Please note:
- The *"time frame"* in question here is the *"scope in time"* for the Recall Stage that was determined by the findings of the Audit Stage The timeframe must be the shortest sufficient period of time to ensure the purposes of the Recall stage as outlined will be achieved.
- The final timeframe will be stipulated and adhered to unless good and valid reasons for extending this timeframe become apparent during the recall process.

The Review & Recall Team members
The Locations and Membership of the Recall team are as follows:
- Dr. Sean Maskey, Consultant Psychiatrist & Recall Team Lead
- Mr. Aidan Murphy, Assistant Director of Nursing, Mental Health Services
- Dr. James O'Mahony, Area Director of Nursing, Child & Adolescent Mental Health Services.
- Ms. Kathryn Hallahan, Advanced Nurse Practitioner, Child & Adolescent Mental Health Services
- Ms. Eithne McAuliffe, General Manager
- Ms. Kate Cadogan, Senior Executive Officer
- Ms. Marguerite Healy, Staff Officer

Through the Commissioner of the Look-back Review, the Recall Team will:
- Be afforded the assistance of all relevant staff (including former staff) and other relevant personnel.
- Have access to all relevant files and records (subject to any necessary consent/data

protection requirements including court applications, where necessary).
- Should immediate safety concerns arise, the Recall Team Lead will convey the details of these safety concerns to the Commissioner as soon as possible.

Note:
One Recall Team has been identified to commence the Recall stage of this Look-back Review Process in CAMHS Area A. The number of people assigned to the Recall Team / number of Recall Teams required was determined by the Look-back Review Commissioner following the outcome of the Audit stage of the Look-back Review Process. This will be kept under review and additional resources will be put in place as necessary.

Review methodology
The review will follow the systems analysis review methodology in line with the HSE Incident Management Framework (2020)

The recall stage will follow the methodology as per the HSE Look-back Review Process Guidelines (2015) and will be cognisant of the rights of all involved to privacy and confidentiality.

The Recall stage will commence on 19th April 2021 and will be expected to last for a period of approximately 4 months, provided unforeseen circumstance does not arise.

The Recall Team will advise the Look-back Review Commissioner on the follow–up required, which may include:
- No further action required;
- Update of patient records and reassurance to patient (i.e. that care provided to patient was appropriate and no further action is required)
- Recall/ referral of patient for further assessment, investigation and treatment.

The Recall stage may identify that an incident occurred to a patient during the course of their treatment and care. Any incidents which are identified by the Recall stage (not identified previously) should be reported and managed in accordance with the current HSE Incident Management Framework 2020.

Once the Review including the recall stage has been completed a detailed and **anonymised** report will be completed and presented to the Commissioner in line with the governance approval process for final report (Appendix 2). This report will include:
- Details of the facts relating to the incident
- Any findings which caused and factors which contributed to these findings
- The results /findings of the recall stage
- Actions taken to date to address the recall stage findings
- Recommendations which when implemented would serve to reduce the risk of a similar incident occurring in the future

Note:
The anonymised report may be published. No guarantee can be given by the HSE that information received as part of a look-back review process will be fully protected from legal discovery and/or disclosure.

Recommendations and Implementation
The report, when finalised, will be presented to the Commissioner of the Look-back Review Process. The identification of learning and recommended necessary changes to practice and procedures locally and systemically will be included in the Look-back Review Process Report.

The Commissioner of the Look-back Review Process will ensure that local managers responsible for the services included in the Look-back Review Process implement the recommendations of the Look-back Review Process.

The Commissioner will also communicate nationally applicable recommendations to the relevant National Directors for national implementation.

Peer review publication of issues relating to the Look-back Review Process, for instance; the development of an audit tool, logistics, communications etc. may be required.

Communication Strategy for the Recall stage of the Look-back Review Process.
A communication strategy will be determined, the CHO Communications Manager, will be appointed for the purpose of co-ordinating communicating information pertaining to the Recall stage to the patient/family/staff member(s) affected by and/or involved in the Recall-stage.

Reference:

- HSE Incident Management Framework 2020
- HSE Look-back Review Process Guideline (2015)

12.2 LBR TEAM STANDARD OPERATING PROCEDURES

Standard Operating Procedure Look Back Review (LBR) CAMHS Area A, issued with TOR 26th April 2021

Amended 29th April re P2

Process Stratification

Time frame for Review:
Clients seen by Team A between July 2016 to 19th April 2021

Lookback to take place on 1,450 Charts
Using Data Base provided as of 19th April 2021 of 2,038
Excluding those with discharges pre July 2016 and not on current list.

Prioritisation process for LBR
Priority 1 - Active Files in alphabetical order who were seen by NCHD3
Priority 2–Active Files in alphabetical order- Clients reviewed by other Team Members
Priority 3 -Those Discharged, commencing with Discharges 2020 and working backward to July 2016 and who were reviewed by DK
Priority 4 - Those Discharged, commencing with Discharges 2020 and working backward to July 2016 who were reviewed by other Team Members.

What LBR looking for

- Demographic and referral Date & source
- Treating Physician
- Medical Assessment Details
- Diagnosis
- Medication
- MDT intervention
- Appropriate Care Plan
- Discharge Plan
- Ongoing medical notes present in file.
- Correlation between, MDT input, medication and medical notes.

Data Gathering Process:

- Establish a database with fields agreed with Dr Maskey, initially in excel until a Bespoke Access Data Base set up and installed.
- All LBR will commence reviewing current files
- Initial data fields populated by non- Clinical staff
- Cross reference Diary entries for clinics with Database to ensure capture of all relevant clients.
- File Access and Storage in compliance with HSE policy
    - Current Team A files are stored in a secure file room in alphabetical order and the LBR can access these files as required. No active files will be stored in LBR room.
    - Non-Current files to be sought from Iron Mountain and stored in the LBR which will be locked at all times when unoccupied.
    - Separate procedure on Transfer of Files to Consultant in place if required.
- Admin Staff update relevant non clinical fields on Database
- Categorise files as P1- P4
- Categorise Status as Active, Discharged, Lost To Service.
- On review by Clinicians assign an Outcome
- Complete LBR Outcome Sheet.
    - **IF Lost To Service**
        - Determine if for discussion with Team A in terms of Lost To Service
        - If no explanation from Team A then
        - Finalise LBR Outcome Sheet and file in client file
        - Letter to issue to client requesting their confirmation of engaging with team or not.
        - LBR complete NIRF Form and notify QPS to upload to NIMS
    - **IF Critical and in need of immediate recall**
        - Link with Clinicians in Team A
        - Arrange for Letter to issue inviting for recall
        - LBR Complete NIRF Form and notify QPS to upload to NIMS
    - **Others**
        - Arrange for relevant letter depending on Outcome
        - LBR complete NIRF Form for Outcome 3,4 &5 and notify QPS to upload to NIMS
- **Open Disclosure Meeting** to be arranged depending on outcomes and finding of Adverse IMPACT for Outcomes 4 and 5.

CAMHS Area A Lookback Review Process

Decision Making Process

- Files reviewed by MH Senior Nurse Managers as first line clinical review.
- Pending complexity of Medication &Treatment Plan - file forwarded for expert Clinical CAMHs Nursing review.
- If Reviewed by Expert Clinical CAMHS Nursing staff, they will consult with External CAMHS Consultant to determine the requirement for call-back and prioritisation of same.
- Database will be reviewed by External Consultant CAMHS on an ongoing basis as fields completed, and he can request to review any client file other than those already referred to him for review.

OUTCOMES

Outcome 1 –Outside the Timeline of the Look Back Review

Outcome 2 – Reviewed by LBR – No Indication of 'Potential for Harm'

- No Recall Required

Outcome 3 -Reviewed by LBR - Concerns of 'Potential for Harm' being classified as minor or negligible within timeline, but subsequently seen by a Consultant and LBR satisfied with current Care Plan.

- Report on NIMS Required, using the NIRF01.

Outcome 4 -Reviewed by LBR - Concerns of 'Potential for Harm' with an Adverse Outcome for the client classified as moderate, major or extreme, within timeline, but subsequently seen by a Consultant and LBR satisfied with current Care Plan

- Open Disclosure required.
- Report on NIMS Required, using the NIRF01.

Outcome 5a -Reviewed by LBR – Concerns of 'Potential for Harm' during the timeline, and client has not been reviewed by CAMHS consultant.

- Recall Required
- Open Disclosure Required for those with Adverse Outcome
- Report on NIMS Required, using the NIRF01.

Outcome 5b -Reviewed by LBR – Concerns of 'Potential for Harm' during the timeline, and client has not been reviewed by CAMHS consultant. Medical notes missing

- Recall Required
- Open Disclosure Required
- Report on NIMS Required, using the NIRF01.

Daily Review Check & Weekly Look Back Team Meetings

- Review meeting of LBR takes place once per week to consider and update provided to commissioners (CO, HQ,SSI & HOS A):
  - Progress review in past week and overall in relation to % of files reviewed
  - Project Risk Review – time frames, resources etc
  - Findings of note
  - AOB
- Daily review check 4.30pm daily
  - Ensure all groups have returned completed database updates to Database Holder.
    - Issues of note for the day.

Process for communication and call back

Letters to issue from Commissioner of Review i.e. CO

Letters to be drafted by QPS and Communications and based on the 5 potential outcome categories

Letter to be issued to all clients in batches i.e. firstly those who require open disclosure meeting and secondly, those where no issue was found.

Letters to those now over 18 and attending an adult MH service, firstly contact the existing MH team to seek advice on best process of notification.

Letters to those now over 18 but not engaged with adult MH service.

In General

Those Requiring call back to be given date and time of appointment within the letter.

Open Disclosure Meeting to be offered to all those who may have experienced 'potential harm with an Adverse Outcome'.

Those requiring a Recall –

- If under, this will be provided by the CAMHS Area A service
- If over 18 and engaging with Adult MH Services a review appointment will be offered by their existing MH clinical team.
- If over 18 and not engaging with Adult MH Services an appointment will be offered at the MH Assessment Hub.

Those not requiring call back to be offered other supports e.g. counselling service and information line.

Overall summary report on file lookback compiled when all files reviewed.

Extract from IMF 2020 HSE Risk Impact Table

1. IMPACT TABLE

	Negligible	Minor	Moderate	Major	Extreme
Harm to a Person	Adverse event leading to minor injury not requiring first aid. No impaired Psychosocial functioning.	Minor injury or illness, first aid treatment required. <3 days absence. <3 days extended hospital stay. Impaired psychosocial functioning greater than 3 days less than one month.	Significant injury requiring medical treatment e.g. Fracture and/or counselling. Agency reportable, e.g. HSA, Gardai (violent and aggressive acts). >3 Days absence. 3-8 Days extended hospital Stay. Impaired psychosocial functioning greater than one month less than six months.	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling. Impaired psychosocial functioning greater than six months.	Incident leading to death or major permanent incapacity. Event which impacts on large number of service users or member of the public. Permanent psychosocial functioning incapacity.
Service User Experience	Reduced quality of service user experience related to inadequate provision of information.	Unsatisfactory service user experience related to less than optimal treatment and/or inadequate information, not being to talked to & treated as an equal; or not being treated with honesty, dignity & respect – readily resolvable.	Unsatisfactory service user experience related to less than optimal treatment resulting in short term effects (less than 1 week).	Unsatisfactory service user experience related to poor treatment resulting in long term effects.	Totally unsatisfactory service user outcome resulting in long term effects, or extremely poor experience of care provision.
Compliance (Statutory, Clinical, Professional & Management)	Minor non compliance with internal PPPGs. Small number of minor issues requiring improvement.	Single failure to meet internal PPPGs. Minor recommendations which can be easily addressed by local management.	Repeated failure to meet internal PPPGs. Important recommendations that can be addressed with an appropriate management action plan.	Repeated failure to meet external standards. Failure to meet national norms and standards/ Regulations (e.g. Mental Health, Child Care Act etc). Critical report or substantial number of significant findings and/or lack of adherence to regulations.	Gross failure to meet external standards. Repeated failure to meet national norms and standards/regulations. Severely critical report with possible major reputational or financial implications.

12.3 ABBREVIATIONS USED IN THE REPORT

ADHD	Attention Deficit Hyperactivity Disorder
ANP	Advanced Nurse Practitioner
ASD	Autism Spectrum Disorder
CAMHS	Child and Adolescent Mental Health Service
CAPA	Care & Partnership Approach
CBT	Cognitive Behaviour Therapy
CD	Clinical Director
CP	Consultant Child and Adolescent Psychiatrist
CHO	Community Healthcare Organisation
DBT	Dialectical Behaviour Therapy
ECD	Executive Clinical Director
ECG	Echocardiograph
EHR	Electronic Health Records
GP	General Practitioner
HOD	Head of Discipline
HOS	Head of Service
HSE	Health Service Executive
HQSSI	Head of Quality, Safety & Service Improvement
ICD10	International Classification of Diseases, Tenth Revision.
ICT	Information Communication Technology
KPI	Key Performance Indicator
LBR	Look-back Review
LFT	Liver Function Test
MDT	Multidisciplinary Team
MHID	Mental Health of Intellectual Disability
MHS	Mental Health Service
MSE	Mental State Examinations
NCHD	Non-Consultant Hospital Doctor
NIMS	National Incident Management System
OD	Open Disclosure
OT	Occupational Therapy/Therapist
RANP	Registered Advanced Nurse Practitioner
QB Test	Quantitative Behaviour Test. Diagnostic screening tool to aid assessment of ADD/ADHD
QPS	Quality and Patient Safety Department
Q&SA	Quality & Safety Advisor
SHO	Senior House Officer
SLT	Speech and Language Therapy/Therapist
SIMT	Serious Incident Management Team
TUSLA	Child and Family Services Agency
VFC	Vision for Change
WTE	Whole Time Equivalent

12.4 DIAGNOSTIC PROCESS CAMHS

The Medical Model has been defined as follows 'When faced with a sickness it is necessary to specify the illness to the finest level possible in order to allow rational and precise treatment to be given at the least possible human cost. It is also necessary to consider aetiologies so that preventative practices can be instituted' (Professor David C Taylor).

Child Psychiatry progresses by means of history taking working through possibilities in genetics, obstetrics, neonatology, paediatrics and child development before turning more formally to the mental states of both parents and child. There is careful, neutral, structured listening which is alert to possible aetiologies and potential therapies.

There is the taking of the history of the presenting complaint, of the child and the family as a developing system with an emphasis on medical, psychiatry, family and child development (physical, emotional, cognitive, social and educational).

There is the gathering of collateral information from schools and any current or previous involvements with professional services.

There is the child mental state examination with its emphasis on physical appearance; separation; relating; orientation; central nervous system functioning; intelligence; speech and language; reading, writing and mathematics; motor and sensory coordination; memory; quality of thinking and perception; fantasies and inferred conflicts; affect and mood; object relations; drive behaviour; defence organisation; judgement and insight; self-esteem; adaptive capacities; positive attributes.

There is the time-honoured sequence of Assessment, Diagnosis and Treatment each step more difficult than the previous and never to be done out of sequence such that the precept of 'first do no harm' (primum non nocere) is maintained.

The use of a Multi Axial Diagnostic Classification System, whilst not obligatory in clinical practice, can be a useful tool, if used correctly, to maintain safety of practice and to make sure that important conditions or influences on Mental and Behavioural Disorders in childhood aren't missed or underestimated. Thus whilst after an Assessment a Diagnosis of a Mental or Behavioural Disorder might validly be made it is constrained by the knowledge contained in an understanding of the child's general cognitive development, any specific delays in general cognitive development (speech and language, motor, and academic attainments), any medical conditions (particularly long term conditions and those affecting brain function) and the psychosocial stressors the child is exposed to within their family (which can include their parents, sometimes unknowingly), school and community.

The understanding and amelioration of these other influences separate from the formal Diagnosis is long understood to be a prime Treatment Aim of CAMHS Services and as important as any other more direct evidence-based therapies with the child (to include the use of trials of medication).

12.5 DUNDEE PATHWAY

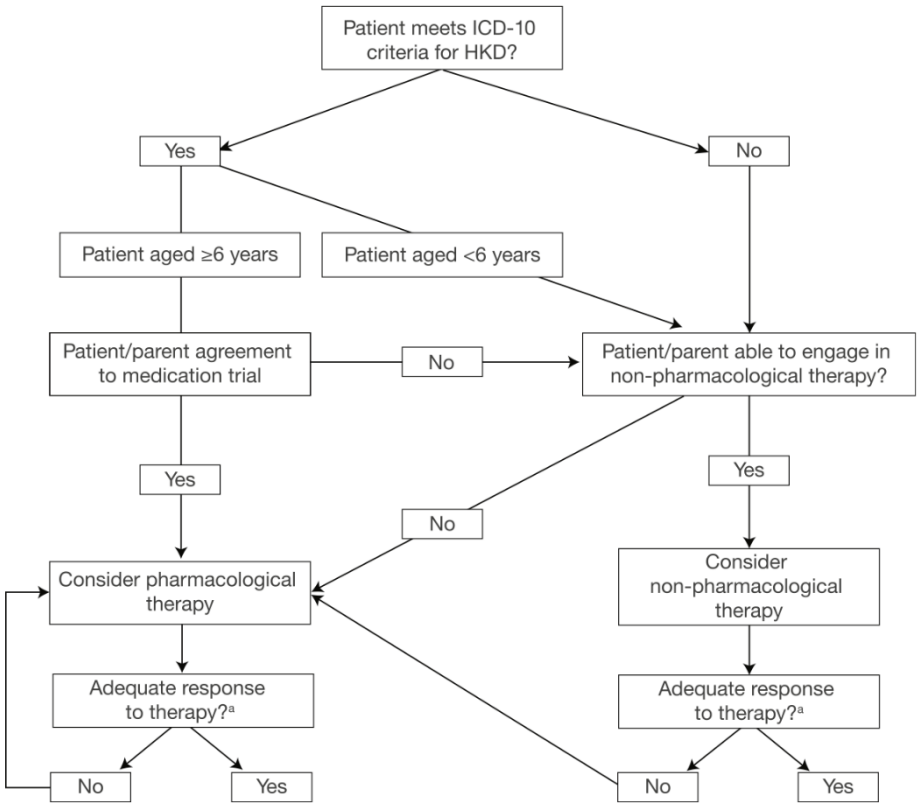


Fig. 2 DACCP treatment algorithm: selection of pharmacological versus non-pharmacological therapy for patients with ADHD. [a]For the evaluation of treatment response, please refer to section 'How do we define optimal/adequate/inadequate response?'. For non-pharmacological therapy, treatment response is reviewed at the end of a course of therapy (programmes are usually 10–12 sessions) and annually thereafter. The use of medication as first-line treatment does not preclude combining this with a non-pharmacological approach]. *ADHD* attention-deficit/hyperactivity disorder, *DACCP* Dundee ADHD Clinical Care Pathway, *HKD* hyperkinetic disorder, *ICD* International Classification of Diseases

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