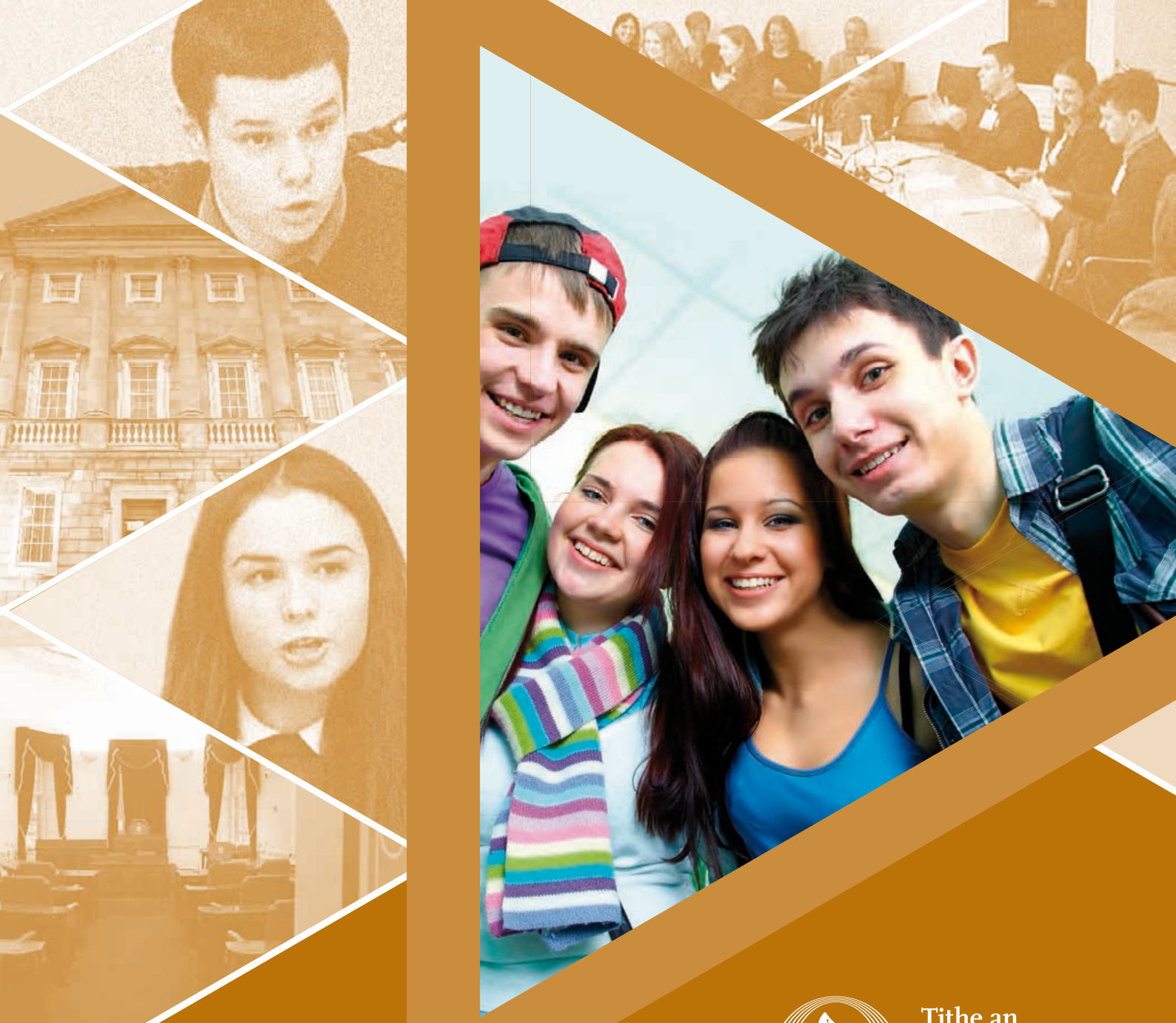

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Deireadh Fómhair 2017

Seanad Public Consultation Committee Report on Children's Mental Health Services

October 2017

Contents

Submissions received by the Committee are published separately to the website with the Report.

Official transcripts of the meetings of the Committee on 29th June and 6th July are also published separately to the website with the Report.

Glossary of Abbreviations

CAMHS	Child and Adolescent Mental Health Service
CHO	Community Health Organisation
DOHC	Department of Health and Children
GP	General Practitioner
HSE	Health Service Executive
ICGP	Irish College of General Practitioners
WHO	World Health Organisation

Members of the Seanad Public Consultation Committee

CHAIRMAN
Paul Coghlan
Leas-Chathaoirleach
Fine Gael

RAPPORTEUR
Joan Freeman
Independent/Taoiseach's Nominee

Catherine Ardagh
Fianna Fáil

Jerry Buttimer
Fine Gael

Maria Byrne
Fine Gael

Martin Conway
Fine Gael

Mark Daly
Fianna Fáil

Máire Devine
Sinn Féin

Colette Kelleher
Independent/Taoiseach's Nominee

Denis Landy
Labour

Pádraig Ó Céidigh
Independent/Taoiseach's Nominee

1. Chairman's Introduction

Awareness of the importance of mental health and wellbeing is a topic that is receiving more and more attention throughout society today.

The World Health Organisation has identified mental health as one of the most important public health issues that even the poorest society must promote, protect and invest in.

Our level of mental health can change as we go through life. It can get better or worse at different times as we journey through the years. Different stages and events in life can impact on our mental health and wellbeing.

Research indicates that mental health problems tend to begin when we're young, and that by the age of 13, one in three young people is likely to have experienced some type of mental distress. This is the time, therefore, when support and resources are vitally needed. Early intervention when a child is in crisis is essential. Every child deserves a fair start in life. Delay in the provision of appropriate care can result in a child's condition worsening.

When choosing a topic for public consultation, on the proposal of Senator Joan Freeman, the Seanad Public Consultation Committee unanimously selected the topic of Children's Mental Health Services in Ireland, given the importance each and every member of the Committee afforded the issue. Mental illness should be treated no differently than physical illness. We all know somebody in our family or community who is affected by mental health issues and the effects of this on the family and friends cannot be overstated.

In its invitation for submissions, the Committee agreed that all stakeholders be invited to participate in this public consultation, so that the Committee could get to hear from users of the service, the service providers, the clinicians and psychiatrists, and from the policy makers. The members of the Committee, across all parties and groups, were of the one view that they were undertaking this public consultation with all stakeholders to seek to ensure that real and meaningful improvements can be brought about in the provision of children's mental health care in Ireland. The Committee undertook its work on a consensus and collaborative manner.

The Committee received a phenomenal response to its invitation for submissions and I wish to thank all of those who participated in the process. I particularly wish to thank all the witnesses who appeared before the Committee, in both public and private session, to give their views on the children's mental health services. Through sharing their experiences, the witnesses set out the reality of those in need of mental health services and those providing these services, as well as hearing from the policy makers. It was a unique opportunity to consider and hear from all facets in the debate.

I was particularly grateful to the parents who presented to the Committee. Your courage and strength were an inspiration to us all as it can be a most distressing and difficult experience for families seeking mental health services. I wish also to acknowledge the hard work and dedication of the service providers and advocacy groups, CAMHS, clinicians, doctors and psychologists, and policy makers. I particularly wish to thank then newly appointed Minister Jim Daly, Minister State at the Department of Health with special responsibility for Mental Health, for engaging so quickly with the Committee following his appointment to what is a very challenging and important brief.

In the course of the Committee's hearings it became apparent that there was a commonality of themes emerging on the issues that needed to be addressed to bring services up to the standard recommended in the current national mental health policy *A Vision for Change*. It is important that we also acknowledge the positive improvements that have been made notwithstanding the gaps still existing. Politically we must now all work together to achieve the real and meaningful improvements that are required to help our vulnerable children given that research indicates that there is an increase in the number of young people experiencing mental health difficulties. The evidence presented to the Committee showed that if we invest in early intervention, then we will make savings into the future as the number of crisis cases presenting will be reduced.

During this Seanad and Dáil term, the issue of mental health has received greater prominence. Indeed the Ceann Comhairle has recently convened a Symposium on Mental Health in Dublin Castle, and the Committee on Education and Skills has published a Report on Positive Mental Health in Schools. A new Special Joint Committee on the Future of Mental Health Care has also been established which aims to achieve cross-party agreement on the implementation of a single, long-term vision for mental health care and the direction of mental health polity in Ireland. The Department of Health is simultaneously conducting a review of "A Vision for Change".

I believe that the recommendations set out in this Report are a valuable and timely input into the review of mental health services currently under way. I hope that the recommendations in this Report will be taken on board by the Government, and I look forward to engaging with the Minister of State at the Department of Health with special responsibility for Mental Health when the report is debated in Seanad Éireann.

Finally, I would like to pay particular tribute to Senator Joan Freeman for proposing this topic for discussion and for acting as Rapporteur in the drafting of this Report, which was adopted by the Committee at its meeting on 11th October, 2017. Senator Freeman is to be commended for her tireless work in helping vulnerable people in our society. I also wish to thank all the members of the Committee for their engagement in this public consultation.

Senator Paul Coghlan
Leas-Chathaoirleach of the Seanad and Chairman of the Committee

October 2017

2. Rapporteur's Preface

The Seanad Public Consultation Committee's *Report on Children's Mental Health Services* ("the Report") comes at a time when the adequacy of child and adolescent mental health services ("CAMHS") in Ireland is widely accepted as falling short of the targets recommended in *A Vision for Change* – the Government's blueprint policy for mental health services in Ireland, published in 2006[1]. Eleven years on, the contents of this Report outline the extent to which existing services must be urgently adapted to deliver on this 'vision' by incorporating written and oral recommendations received by the Committee.

The United Nations children's emergency report *Building the Future,* published in the weeks before the Committee sat, recognised that out of 37 nations, Ireland has the fourth highest teenage suicide rate in the developed world[2]. The report further highlighted that Irish children aged between 11 and 15 are the second highest in Europe presenting with emotional issues on a weekly basis. More than ever before, children in Ireland are vulnerable to mental health issues.

The increase in mental health problems and the child population in Ireland are not matched by an increase in services. In fact, the submissions received by this Committee reflect a reverse trend in overall budget funding for services. The percentage of the total health budget for mental health has decreased from 13% in 1984 to 7.3% in 2004, to the current 6.1%. This allocation of funding is in stark contrast to many other western European health systems, such as those in France, Germany and the United Kingdom, where spending on mental health services is approximately 10% to 12% of their overall health budget on mental health services. This chronic underfunding is a repeated failure by State agencies to build the necessary capacity to provide adequate mental health services to children and adolescents.

In the weeks prior to the Committee's oral hearings, which took place on the 29th June 2017 and 6th July 2017, one of four child inpatient units in Ireland for acute mental health problems closed 11 beds, lowering the national bed compliment in Ireland, with a population of 1.25 million children, to 48 beds. The reasons for the closure cited by the Government were "nurse shortages"[3].

1 *DOHC (2006), A Vision for Change, Report of the Expert Group on Mental Health Policy.*

2 *Innocenti, Florence (2017), Building the Future: Children and the Sustainable Development Goals in Rich Countries, Report Card no. 14, UNICEF Office of Research. See Figure 3.2, p. 22.*

3 *See comments of then Minister of State for Mental Health and Older People, Helen McEntee. Link to news article accessed on 10/08/17: https://www.irishtimes.com/news/health/half-beds-at-children-s-mental-health-unit-to-close-due-to-nurse-shortage-1.3092525.*

To put this reverse trend in context, in 2006, *A Vision for Change* recommended 100 inpatient beds in Ireland for a child population that was 21% smaller than our child population in 2017. Demand for services has considerably increased since that time. The child population has increased by approximately 216,000 since 2006[4]. Current research suggests that by the age of 13 years, one in three young people in Ireland are likely to have experienced some type of mental disorder[5]. By the age of 24 years, that rate will have increased to over one in two[6]. As a society, we are regressing in the provision of those services.

The most appropriate yardstick by which the success of CAMHS can be measured is by reference to the submissions the Committee received from parents. This is the first time the Houses of the Oireachtas have invited in members of the public to hear their experience of mental health services in Ireland – a long overdue exercise. Mothers and fathers have first-hand experience in recognizing some of the obstacles in accessing mental health services at a time of crisis and an even more hard-earned understanding of what would improve the delivery of those services. I hope, as Rapporteur, that this Report gives due consideration to those submissions and reflects what is necessary to meet those basic needs.

The percentage of the total health budget for mental health has decreased from 13% in 1984 to 7.3% in 2004, to the current 6.1%. This allocation of funding is in stark contrast to many other western European health systems, such as those in France, Germany and the United Kingdom, where spending on mental health services is approximately 10% to 12% of their overall health budget on mental health services.

4 *See submission of Dr. Matthew Sadlier, IMO, Day 2 of Oral Hearings.*

5 *Cannon M, Coughlan H, Clarke M, Harley M & Kelleher I, The Mental Health of Young People in Ireland: a report of the Psychiatric Epidemiology Research across the Lifespan (PERL) Group Dublin: Royal College of Surgeons in Ireland, p. 37.*

6 *Ibid.*

Report on Children's Mental Health Services

Equal attention is also given to the service providers and lobby groups who gave detailed and experienced submissions to the Committee about ways to improve the existing Child and Adolescent Service. While the contents of this Report are highly critical of the structure of CAMHS service delivery, none of these criticisms are directed at the staff of that organisation who are equally concerned about the success of its operation[7].

The Government recently made a number of commitments to improve the availability of mental services for children through its commitment to invest a further €47 million in CAMHS over the next five years. These commitments also include the creation of a 29-bed CAMHS inpatient unit at the new Children's Hospital which is due to open by Q3 2021. This service will increase the bed compliment in Ireland; but ignores the HSE's chronic inability to recruit nurses and child psychiatrists to commission these beds. Crucially, there is no bed without a nurse or doctor to operate it.

The submissions received by the Committee reinforce previous findings that there is a chronic failure by the HSE to recruit psychiatric nurses and consultant child psychiatrists to operate the existing bed compliment in Ireland, matched with a refusal to alter pay agreement structures and working conditions to attract employment.

The Report's chapter on 'recruitment' addresses the reasons behind job dissatisfaction in community-based aspects of psychiatry. It is hoped that the recommendation to implement the final report of the Strategic Review of Medical Training and Career Structure Working Group will go some way towards meeting those difficulties. While some of the recommendations made in the Strategic Review are being implemented on a piecemeal basis, the more far-reaching recommendations have not been actioned and in particular the recommendation to eliminate the two-tier pay structure that sees consultant psychiatrists who qualified in 2012 on a salary 30% less than their counterpart. Pay parity is needed between equally qualified staff.

The submissions also show that there are a number of practical and short-term ways in which the quality of mental health services could be improved. Take for example the issue of waiting lists for child assessments in Ireland. At the time of writing this Report, there are 2,818 children waiting clinical assessment by a consultant child psychiatrist in Ireland. Some 218 of those children have been on that waiting list for over a year. This is largely due to the fact that there are insufficient numbers of child psychiatrists to carry out those assessments across multiple CAMHS areas. In her submission to the Committee, Professor Joyce O'Connor, Chair of the expert and policy group which formulated *A Vision for Change* suggested to delegate the clinical assessments to other members of the multidisciplinary CAMHS team at tier 2. For example, the psychiatric nurse who forms part of the team. This would be a practical change would could be implemented in a cost-effective and almost immediate basis.

7 *Dr. Blánaid Gavin emphasized this crucial point in her oral submission to the Committee. See p. 6 of 71 of the transcript of the hearings on day 2.*

It would be remiss of me not to briefly acknowledge the large areas of service provision that fall outside of this work, including provision of treatment for 18-25 year olds. While this falls outside the CAMHS model and the scope of this Report, it is worth mentioning that we are behind other European Countries in catering for the transition from adolescent services to young adult lifestyle.

Lastly, I would like to acknowledge the exceptional strength of the parents who submitted and presented to the Committee. Your spirit and courage is what motivates change and your resilience is remarkable. I would like to acknowledge also the parents who gave evidence in private sessions. This need for privacy alone, once again illustrates the whole sensitivity and stigmatising of the topic of mental health. These parents felt obliged to speak in private for two main reasons: firstly the fear of a negative reaction from service providers as they (the parents) would be seen as 'complaining'. This might then lead onto even more delays for help for their children. The other fear was that if these parents spoke in public – the child's peers' may react in a negative fashion and for the older children, parents were afraid that the disclosure of their mental health would impact future employment. Parents who have children with mental health difficulties are faced with a double edge sword – the stress and trauma of trying to get help for their children, and the judgemental reaction of our world.

The preparation of this Report would not have been possible without the invaluable oral and written submissions from parents, advocacy groups for children, including the Children's Rights Alliance, the Ombudsman for Children, the Mental Health Reform Group, the Irish Society for the Prevention of Cruelty to Children, Dr. Geoffrey Shannon, Gareth Noble and BeLonG. Invaluable contributions have also been provided by key stakeholders in mental health services such as the Mental Health Commission, the College of Psychiatrists of Ireland, the Irish Medical Organization and the Irish College of General Practitioners.

The Committee also received considerable insight from consultant child and adolescent psychiatrists working in both the private and public sectors, GPs, primary care staff including psychologists, social workers and psychotherapists. Special thanks are particularly due to Bridget Doody and Martin Groves, and their staff, who managed the consultation process with exceptional professionalism and Senator Coughlan who chaired the proceedings. I would also like to thank Anita Finucane and Claire Chambers who assisted me with the research and compilation of the Report.

As Rapporteur, It is my hope that the recommendations by this Committee go some way towards re-thinking the vision for mental health services for children in Ireland in the near future, with a renewed energy to aim for the impossibly high standard of treatment we demand for our own children.

I echo the wise words of Dr. Geoffrey Shannon in his submission to the Committee – when the State offers to provide a public health service to a child and fails to deliver that service, it has failed that child twice. That can have devastating consequences. These are some of the most vulnerable children in society. How they are treated and the experiences they have now will have massive implications for their future and, consequently, massive implications for our society. They will become our teachers, politicians and policymakers. They have much to offer our society and how we treat them now is vital.

The vision in *A Vision for Change* should not just be a vision, it should be a reality.

The Seanad Public Consultation Committee recommends that this Report be considered in the proposed review of *A Vision for Change*.

Warm regards,

Senator Joan Freeman
Rapporteur to the Public Consultation Committee on Children's Mental Health Services

October 2017

As Rapporteur, It is my hope that the recommendations by this Committee go some way towards re-thinking the vision for mental health services for children in Ireland in the near future, with a renewed energy to aim for the impossibly high standard of treatment we demand for our own children.

3. Executive Summary of Recommendations

Theme 1: Recommendations on Access to Mental Health Services for Children

Key Recommendation 1.1	Primary Care should be urgently staffed with the level of psychologists recommended in *A Vision for Change* and updated in accordance with child population data in 2017
Key Recommendation 1.2	Clinical Assessments at Tier 2 should be delegated to Psychiatric Nurses to immediately reduce CAMHS waiting lists
Key Recommendation 1.3	Initial Assessments ought to be considered as a means of triaging waiting lists and filtering referrals to appropriate services
Key Recommendation 1.4	Waiting Lists should be triaged in accordance with urgency and need
Key Recommendation 1.5	CAMHS referral criteria should be expanded to include children with intellectual disabilities
Key Recommendation 1.6	CAMHS must be extended nationwide to children up to the age of 18
Key Recommendation 1.7	Admissions to Adult Psychiatric Units should be prohibited
Key Recommendation 1.8	CAMHS out-of-hours service must be extended across all Community Health Organisation (CHO) areas for acutely ill children and adolescents
Key Recommendation 1.9	CAMHS ought to measure geographic need for services and distribute services in accordance with need and not solely population size

Theme 2: Recommendations on Recruitment

Key Recommendation 2.1	180 child and adolescent psychiatrists in post by 2020 applied by reference to need in each CHO area
Key Recommendation 2.2	The two-tier remuneration for nurses and consultants qualified post-2012 should cease

Theme 3: Recommendation on Outcome Monitoring by CAMHS

Key Recommendation 3.1	Outcome indicators should be measured by those embarking on CAMHS and reported annually with the CAMHS Report

4. Introduction

The Seanad Public Consultation Committee was established by the Seanad in 2011 as a contribution to a broader process of reform and with a view to opening access to Seanad Éireann and its work.

The Committee's purpose is to provide for direct engagement and consultation between members of the public and the Seanad through a process which involves inviting submissions from members of the public on a specific issue related to its legislative powers or an issue of public policy. The Committee considers submissions made to it, invites contributors to present to it at public hearings which are held in the Seanad Chamber and publishes a report for debate by the Seanad or referral to the relevant Oireachtas Joint Committee.

The Committee has examined a range of broad socio-economic issues since it was established. These include the rights of older people; prevention of cancer through lifestyle changes; Ireland's compliance with the International Covenant on Civil and Political Rights; and farm safety.

This Report consolidates the overarching themes and recommendations made in the submissions received by the Seanad Public Consultation Committee in respect of its public consultation on Children's Mental Health Services. The Report identifies recurring shortfalls in the existing CAMHS model in *A Vision for Change* by reference to those who most encounter its operation: parents and service providers. The recommendations made by the Committee are aimed at providing practical change to the existing service with particular weight given to meeting the needs of parents who encounter the service during crisis and with a view to adapting the existing model to provide a more timely and efficient quality of service.

The CAMHS Delivery Structure

A Vision for Change is the policy framework for the delivery of mental health services including child and adolescent services for a ten-year period to 2016. The 'vision' was one of de-institutionalisation of mental health services, with community services taking the lead and a recovery-based orientation. *A Vision for Change* resulted in the creation of Ireland's first specialist Child and Adolescent Mental Health Service. The CAMHS framework is based on a three-tiered model of care which describes the referral pathway for a child presenting with mental health problems, depending on the severity of their needs. Each tier in succession represents more acute needs:

1. *Access to Services*

Theme one of the Report groups the submissions in relation to effective access to primary care services. Tier 1 primary care services represent the first line of response for a distressed child and is staffed, among other specialisms, with clinical and community psychologists. Fully resourced primary care is universally acknowledged in the submissions as the area most in need of financial resourcing. That this is the optimal way of treating children is recognized by the HSE in their submission to the Committee which observes that over 90% of mental health needs can be successfully treated within a primary care setting, with less than 10% being referred to specialist community based mental health services[8]. The effectiveness of first line treatment is reinforced by international best practice which recognizes that "integrated primary care for mental health is not only the most desirable approach; it is also a most feasible approach"[9].

Despite the effectiveness of primary care, the Committee heard that there is an 18-month waiting list to see a primary care psychologist in Ireland. There is no primary care psychology service in North Dublin for children under the age of 18 for referral[10]. This is not reflective of all CHO areas; there appears to be a disparity in treatment in different parts of the country based on the ability to recruit psychologists and consultant psychiatrist to a given area. The Committee heard that the difficulty of recruiting staff was particularly felt in Cork, Tipperary, Monaghan, Wexford and North Dublin. Criticisms were also made of the application of services based on population as being a crude yardstick in measuring medical need when certain areas for socio-economic reasons may be in need of more than one psychologist.

8 *Health Service Executive, Annual Service Plan 2017 (2016), p. 26.*

9 *World Health Organisation, Integrating Mental Health into Primary Care: A Global Perspective (2008) WHO, Geneva.*

10 *McGee, Sinead, Chairperson of the CAMHS Carer's Forum, Day 1, 29th June 2017. See p. 20 of 60 of Transcript.*

The Committee heard submissions that without the appropriate level of psychologists in Tier 1, a child's condition can be exacerbated by delays incurred by long waiting lists for treatment. Consequently, this results in an increase of referrals for assessment to Tier 2 and oftentimes, the worsening of the child's condition. The repercussion of inadequately staffed Tier 1 services on Tier 2 delivery is encapsulated in the latest available data which shows that between January and March 2017, 2,818 children remain on CAMHS waiting lists awaiting clinical assessment[11].

A central finding in this Report and indeed numerous reports published before now, is that there is an urgent need to fully staff the primary care sector to respond effectively to children and adolescents at risk of mental health problems.

The Committee heard how other areas of primary care deserve further attention and in particular the resourcing of general practices. The submissions from the Irish College of General Practitioners ("ICGP") make the point that 90% of referrals to Tier 2 treatment are made by GPs in primary care. GPs also fill the gap by providing out-of-hours treatment in areas where no such treatment exists. The lack of reimbursement for GPs in Ireland for their participation in the current model is also identified in the submissions as a fundamental barrier, among others, to the efficiency of the CAMHS model in Tier 1.

A key standard of the Mental Health Commission's Quality Framework for Mental Health Services in Ireland is that "*mental health services must be accessible in the community*" and that "*quality service is dependent on access to that service*"[12]. The importance of timely access to Tier 2 services is highlighted by the more acute needs this Tier is intended to address, including treatment of disorders such as moderate to severe depression, mood disorders, psychosis, anxiety disorders, moderate to severe eating disorder and suicidal behaviours and ideation where intent is present[13].

Tier 2 consists of specialist CAMHS triage teams made up of one of each of the following specialisms: Consultant Psychiatrist, Doctor in training, Clinical Psychologist, CAMHS Nurse, Social Worker, Speech and Language Therapist and Occupational Therapist. Within each CAMHS team, the clinical lead role is carried out by the CAMHS Consultant Psychiatrist. In accordance with this, each child and adolescent attending CAMHS must have a named consultant who is responsible for overall care and treatment and who is responsible for carrying out the child's mental health assessment upon referral[14]. The Committee heard that this was a particularly challenging hurdle in light of existing difficulties to recruit consultant child psychiatrists.

A number of obstacles are identified by parents in Section 5 of this Report as barriers to accessing CAMHS:

i. **Too narrow referral criteria**
ii. **Poor staffing capacity**
iii. **Dependency on Child Psychiatrists for Assessments**
iv. **Lack of out-of-hours crisis service**
v. **Lack of information about CAMHS**

11 *Department of Health Submission to the Committee.*

12 *Mental Health Commission Quality Framework for Mental Health Services in Ireland (2007).*

13 *HSE, Child and Adolescent Health Service Standard Operation Procedure 2015-2017, p. 15.*

14 *HSE, Child and Adolescent Health Service Standard Operation Procedure 2015-2017, p. 12.*

A recurring obstacle encountered by parents who made submissions to the Committee included the use of the diagnostic referral criteria which had the effect of excluding children with co-morbid symptoms from treatment. The ICGP guidelines note that "referral of Children and Adolescents to local Child and Adolescent Mental Health Services (CAMHS) ... is reserved for children and adolescents who have been diagnosed with a psychiatric (Axis 1) disorder"[15].

The referral criteria exclude children and young people with autistic spectrum disorders, emotional difficulties, behavioural problems, developmental difficulties and intellectual disabilities unless there is a clear mental health component. One parent gave evidence that her child remained on the waiting list only to be transferred to a disabilities waiting list upon assessment. This resulted in duplication of waiting times for treatment. Where a child or adolescent has intellectual disability and mental illness, the Committee heard that there is often no clarity over responsibility[16].

Theme 1 of the Report addresses the much-highlighted issue of CAMHS waiting lists. A significant recommendation made to the Committee by Professor Joyce O'Connor was that the formal assessment by clinical psychiatrists at Tier 2 could be delegated to psychiatric nurses or indeed other members of the multidisciplinary team. The Committee recognises that this would serve to dramatically decrease waiting lists in light of the on-going difficulty of recruiting child psychiatrists and would operate as a cost-effective solution to excessive waiting lists. The Committee strongly recommends that the Government give consideration to this proposal as a timely way of addressing waiting times.

Theme 1 of the Report also treats the recurring problem of out-of-hours emergency care at weekends and night time. At the time of writing, there are 15 counties in Ireland without out-of-hours services for children[17]. Parents gave evidence of waiting in excess of two weeks for crisis emergency treatment.

If emergency beds are not available there must be clear service protocols for CAMHS to follow which only allow admission to an adult psychiatric unit in exceptional circumstances. A concrete recommendation made is that emergency services must be made available in all CHO areas.

One of the largest barriers to accessing mental health services apparent from the submissions is the absence of inter-agency cooperation between Tier 1 and Tier 2 CAMHS. This is contrary to the recommendation of *A Vision for Change* which provided that "seamless mental health services should be available in a continuum stretching from the community at large to primary care and specialist mental health services"[18] . The Committee repeatedly heard from parents and service users that inter-agency cooperation hampered the delivery of services.

The Committee heard evidence to the effect that seamless treatment is not consistently provided between CAMHS areas, particularly in instances where a child from one CAMHS catchment is sent to another CAMHS catchment. This appears to place the best interests of the child as a secondary consideration to the dictates of the model structure for no objective reason other than that is what is prescribed by the model.

15 *ICGP, Child and Adolescent Mental Health: Diagnosis and Management (2013), p. 1.*

16 *Lennon, Sarah Inclusion Ireland, Oral Submission, Day 1, Transcript, p. 35.*

17 *See Parliamentary Question and response received by Deputy James Browne, TD: http://oireachtasdebates.oireachtas.ie/debates%20authoring/debateswebpack.nsf/takes/dail2017071300120.*

18 *DOHC (2006), A Vision for Change, Report of the Expert Group on Mental Health Policy, p.15.*

The Report also deals with testimony from the parent of a distressed child from Wexford who was sent to CAMHS in Cork and declined admission because she was from a different CAMHS catchment area. The Children's Ombudsman, Dr. Niall Muldoon, told the Committee that he received numerous complaints about CAMHS teams refusing to take referrals from other CAMHS teams when a child moves house. He described these as "systems issues"[19].

The Committee received submissions that there is a lack of conformity between CAMHS and the disability service where a child presents with co-morbidities involving a mental health diagnosis and an intellectual disability. The impression given is that in some instances either CAMHS and/or the disability service do not cooperate together to provide comprehensive and timely treatment to children with a dual diagnosis but rather the existence of a dual diagnosis can be used by one service to exclude a child from treatment and transfer them to another service with equally long waiting lists. This criticism of the CAMHS framework went unchallenged by the HSE representatives present. Dr. Geoffrey Shannon rightly made the point "that agencies operating under the umbrella of protecting vulnerable citizens need to work together seamlessly to protect children"[20].

The Committee acknowledges that organisations such as Jigsaw have provided an excellent model of interagency cooperation between Tier 1 and Tier 2 services, however this begs the question as to why the same level of cooperation cannot exist between the CAMHS and disability service. The Committee strongly recommends that interagency collaboration be encouraged to develop child focused treatment that meet the complex mental health needs of children who may have multiple diagnosis.

2. *Recruitment*

Theme two of the Report focuses on submissions received in relation to staffing and recruitment obstacles in the CAMHS community. What is most apparent from the submissions is that working pay and working conditions are below international standards of remuneration in equivalent fields and is one of the leading causes of recruitment obstacles in this area.

The Committee heard evidence to the effect that the recommended 127 specialist CAMHS teams in *A Vision for Change* have not been met. The Committee heard that there are 67 CAMHS teams in operation. Not all of these operate to full capacity and there are significant geographic variances in provision. The Committee heard, for example, that there are no services for those aged 17 in north Tipperary because the HSE has not been able to fill a clinician's post there. Achieving the full staff complement of CAMHS is vital to ensure children and young people are not put at risk by waiting too long for support. Reducing these waiting lists requires on-going investment in recruitment.

The Committee received submissions referring to the recommendations made in the Strategic Review of Medical Training and Career Structure ("the MacCraith Report") in 2014. The MacCraith Report gives clear and practical guidelines on how to ensure that doctors trained in Ireland are retained. However at the time of publication, the taskforce implementing the findings do not appear to have implemented recommendations which directly appear to hamper recruitment efforts, namely the unequal pay division for new consultants, who since qualifying in 2012, receive a salary that is approximately 30% less than their counterpart who qualified pre-2012. The Committee recommends that the Strategic Review Committee implement the findings of the MacCraith Report in respect of consultant pay conditions.

19 *Muldoon, Niall Dr., Ombudsman for Children, Day 2, Transcript, p. 36.*

20 *Shannon, Geoffrey Special Rapporteur on Child Protection, Day 1, Transcript p. 18.*

Theme two further addresses the chronic underfunding of mental health services. At present, there are approximately 1.15 million people under the age of 18 years in Ireland. It is estimated that 115,000 have a mental health illness, causing some impairment, and 23,000 children have severe and disabling mental health problems. In the HSE's service plan for 2017, funding for mental health services made up just 6.1% of the HSE's total operational budget. This is significantly less than the 8.24% of total health fund spending that should be directed to mental health services, as set out in *A Vision for Change* in 2006.

The absence of funding is directly attributable to the poor recruitment and retention of consultant psychiatrists. The HSE Mental Health Division submission to the Committee notes that only 46% of out-patient specialist community CAMHS teams recommended in *A Vision for Change* exist in addition to a collection of generic CAMHS in-patient units which in 2017 fall far short of our existing population[21]. There are approximately 34.1 whole time equivalent psychiatrists in Ireland across all CHO areas[22].

At present, there are approximately 1.15 million people under the age of 18 years in Ireland. It is estimated that 115,000 have a mental health illness, causing some impairment, and 23,000 children have severe and disabling mental health problems.

3. *Outcome Monitoring in CAMHS*

Theme three of the Report deals with the necessity for CAMHS to publish CAMHS-specific quality standards and guidelines owing to the fact that there is no quality and outcome monitoring system for CAMHS in Ireland. This has a dual purpose. It has the purpose of recognising and rightfully commending the excellent work that is on-going in CAMHS, and the effectiveness of the multiple evidence based treatments that are available and from which children benefit.

The Committee heard submissions to the effect that the national audit of waiting times for CAMHS done in 2012-2013 showed that 50% of people were seen within a month and that 70% were seen within three months, but these figures, while sub-optimal in themselves, mask another problem in that they do not demonstrate the variability between one area and another. Furthermore, these figures do not accord with recent reports from GPs of their experience of waiting times, most especially in areas of deprivation. There is evidently a need to closely scrutinise and monitor the CHO areas most in need of services and to apply funding to those areas accordingly.

21 *Department of Health Submission to the Committee.*

22 *FOI request c381/17.*

The necessity of a Report based on oral and written representation from parents is highlighted by the absence of an outcome monitoring system for CAMHS in Ireland. The annual report on the development of CAMHS has not been updated since 2014. There is no service data recorded in the CAMHS Annual Report 2012-2013 and it does not include service user clinical outcomes which may indicate the effectiveness of CAMHS treatment. The Committee recommends that the CAMHS annual reports be furnished for the intervening years and that a new section be incorporated involving the findings from assessments on service user outcomes.

The Committee received considerable assistance from the CAMHS Independent Parents' Survey compiled by CAMHS for Parents[23] for the purposes of informing the Report in the absence of any objective user data to date.

Scope Methodology and Structure

This Report presents an overview of the submissions received from parents, service providers and lobby groups operating within the mental health service in Ireland. By reference to these submissions, the Report highlights the challenges faced in implementing the targets of *A Vision for Change* and recommends ways in which challenges might be overcome in the short-term. There is a particular focus on the concept of delivering practical change within the existing structure which can be felt by parents and children embarking on those services. This Report is hugely assisted by desk research and examines national policy instruments, Government reports, operating procedures and independent reports which have already amassed significant research on the operation of CAMHS.

23 *CAMHS Independent Parents Survey (2017).*

5. Theme 1: Access to Mental Health Services for Children

Overview: *This section focuses on obstacles faced by parents accessing child mental health services in Ireland. Barriers identified in the submissions include the absence of psychologists at primary care level, the length of clinical assessment waiting lists and inflexible entry criteria and referral pathways to specialist services being applied to exclude children.*

Key Recommendation 1.1 Primary Care should be urgently staffed with the level of psychologists recommended in *A Vision for Change* and updated in accordance with child population data in 2017.

The Strategy on mental health in primary care in Ireland is adopted from both a national primary care strategy and the Government's mental health policy *A Vision for Change*. 'Primary care' refers to health care delivered in local communities by GPs, public health nurses, social workers, psychologists and others in non-specialist settings. For most people who experience a mental health difficulty, their first port of call for professional support will be their local GP. It is estimated that in total that the primary care system addresses 90% of mental health difficulties in Ireland[24]. Despite this reliance, the Committee heard submissions which suggest that the primary care psychology service remains seriously under-resourced[25].

Sinéad McGee, Chairperson of the Dublin City and County CAMHS Carer's Forum, told the Committee that there are no psychological services for children under the age of 18 in North County Dublin[26]. She gave evidence that "there is a gap for people who have mental health issues but who are not severe enough to be seen by CAMHS"[27].

Her submission further highlighted the benefit of a service that proactively treats children when they first present with symptoms:

> "We need a service for the less severe range of mental health issues in our children. Let us not wait until they have got to the point of attempting suicide. We need to nip it in the bud. Maybe that is not an issue for CAMHS but for the HSE to provide psychology services within the community. There are no psychology services for children younger than 18 in North County Dublin. We need more staff. Many of the staff in CAMHS who I have been involved with are temporary or locum staff. Recently, they lost a really good psychiatrist who was a locum for two years and who wanted a permanent contract but there was none. They are caught up in unnecessary paperwork and more children are then put at risk. That needs to change"[28].

24 *Mental Health Reform, Mental Health in Primary Care in Ireland: A Briefing Paper (2013) p. 2.*

25 *Doyle, Maeve, Consultant Child Psychiatrist in CAMHS, Day 2, Transcript, p. 17.*

26 *McGee, Sinead, Chairperson of the CAMHS Carer's Forum, Day 1, Transcript, p. 20.*

27 *Ibid.*

28 *Ibid.*

One parent told the Committee that her son, aged 13, diagnosed with autism and suicidal ideation and in need of psychological services was referred to CAMHS for psychological services and remained on the waiting for almost four years[29].

When primary care psychological services are in short supply, the situation for the child worsens and the child is then in need of more specialist services as their symptoms have advanced. Dr. Maeve Doyle, Consultant Child Psychiatrist, spoke to the Committee about the practical effect of delayed access to Tier 1 on a distressed child downstream:

> "Many children and adolescents are placed on waiting lists for CAMHS inappropriately due to the lack of development of primary care services and disability services. For example, in my own area the number of primary care psychologists has declined from four when I started up my practice 17 years ago to only one. Although it is outlined in their brief that they can deal with children with mild anxiety by providing a brief number of sessions, by virtue of the fact that the waiting list to see a primary care psychology is 18 months, the problems of these children and adolescents will have escalated to the extent that they then present with severe anxiety problems that need to be addressed by CAMHS"[30].

Dr. Glenda Kavanagh from the Lucena Clinic told the Committee that in the absence of care "underneath", children are admitted to Tier 2 CAMHS services in "crisis-bound states"[31].

The HSE gave evidence to the Committee that they have ring-fenced approximately €5 million for 114 assistant psychologist roles. It is unclear at the time of writing when the recruitment process will commence but the Committee reserves its view on the announcements of posts in the knowledge that at the end of 2016, 1,500 vacant posts exist in the HSE's mental health division operational plan[32]. Moreover, the Committee is aware of the distinction between the announcement of roles and the more difficult task of filling said roles. In the words of Dr. Shari McDaid's submission to the Committee, "it would be a first step if we could fill the posts to which there is already a commitment"[33].

Submissions were also received from Dr. Elisabetta Petitbon and Dr. Eddie Murphy. Their vision and input regarding issues concerning primary care were valid. Dr. Petitbon said that psychotherapy should have more of a role rather than focusing solely on clinical psychologists. Her point being that their current role cannot provide mental health diagnosis because it is carried out by a psychiatrist in the CAMHS Team. Therefore the remit of a clinical psychologist is similar to that which can be carried out by a psychotherapist – where there are many more available in the country for employment at half the cost.

Dr. Eddie Murphy spoke about a Needs Led Stepped Care Psychosocial Model which provides accessible and cost effective health services. This would provide a wide spectrum of interventions, ranging from low-intensity (self-care, primary care) to high intensity interventions (e.g. complex multidisciplinary interventions). He went onto talk about a Children's centre of excellence – a one stop/single point of entry where appropriate staff work from a psychosocial model rather than a medical one, which would deliver child and family centred care.

29 *Ms. Paula Dalton, Mother, Day 1, Transcript,p. 7 of 60.*

30 *Doyle, Maeve, Consultant Child Psychiatrist, Day 2, Transcript, p. 17.*

31 *Kavanagh, Glenda, Consultant Child & Adolescent Psychiatrist, Day 1, p. 54 of 60.*

32 *Health Service Executive, Mental Health Division Operational Plan (2017). The service plan allocated funding for the recruitment of 1,500 staff between 2015 and 2017. It does not appear that this has materialised.*

33 *McDaid, Shari, Director, Mental Health Reform, Day 1, Transcript, p. 54.*

The Committee heard how the benefit of fully resourced primary care also reduces stigma for children. One parent, Ms. Louise Walsh, told the Committee that attending primary care for services normalised the experience for children:

> "...I believe primary care is the way to go because as children attend primary care centres for dental and physiotherapy services and so on they would not be stepping out of their comfort zone and would see going to such a centre to see a counsellor as normal. They would not feel isolated or have the label of having mental health problems. They would just be seeing the counsellor with all the other kids from their school with appointments. It would be an easier way for a child to get help"[34].

In respect of her own son, Ms. Walsh told the Committee:

> "My son had very severe difficulty going to a counsellor. He would not go when we had appointments made and he just told me he was not able to speak to a counsellor. He was not at the stage he could do that. Perhaps if he had been, he would not have been in such a crisis. It is very hard even for adults to go to see a counsellor and it is a tough task. We do not even have to put a name like "counselling" on this. If we put a nice, happy name on it, the child could go to see someone in primary care in a safe environment beside a dentist, for example. This would happen in the community and the person would not go to a hospital or where he or she would be labelled as someone with mental health issues. It is a major fear kids have and they are afraid to say it because people will think they are mad or crazy. It would be something to bridge the gap, a little stepping stone between being a normal Joe Soap and someone who ends up in an acute psychiatric ward. Primary care is definitely the way to go"[35]

The Committee recommends as a matter of urgency that psychologists be actively recruited to primary care.

Key Recommendation 1.2 Clinical Assessments at Tier 2 should be delegated to Psychiatric Nurses to immediately reduce CAMHS waiting lists.

Key Recommendation 1.3 Initial Assessments ought to be considered as a means of triaging waiting lists and filtering referrals to appropriate services.

Between January and March 2017, 2,818 children awaited clinical assessment by a consultant child psychiatrist in Ireland. Some 218 of those children were on that waiting list for in excess of one year. The Committee heard that waiting list trends are co-dependent on the staffing levels in their CHO area. For example, Dr. Yvonne Begley reported very low waiting lists in Limerick CAMHS, while waiting lists for assessment in Cork and North Dublin remained considerably longer owing to incomplete CAMHS teams. In Dublin 15, for example, the ICGP told the Committee that there was a period where CAMHS had no child psychiatrist, followed by a further period of repeated changes of psychiatrists[36].

34 *Ms Louise Walsh, Parent, Day 1, Transcript, p. 26.*

35 *Ibid.*

36 *O'Brien, John, ICGP, Day 2, Transcript, p. 11.*

The submissions make clear that long waiting lists for clinical assessment are attributed to both insufficient levels of in-post consultant child psychiatrists and the requirement that consultant child psychiatrists must carry out the assessments under HSE operating procedure. The widely reported difficulty to recruit consultant child psychiatrists therefore frustrates the pace at which assessments take place.

The Committee heard recommendations that if the clinical assessments were delegated to other staff, waiting lists would be significantly reduced. Professor Joyce O'Connor, co-author of *A Vision for Change*, suggested delegation of the clinical assessments to other members of the multidisciplinary CAMHS team. Professor O'Connor told the Committee:

> "...more streamlined triage practices can significantly speed up triage and assessment, and reduce waiting times from a year to just a few weeks. As suggested earlier, triage can be undertaken by nurse practitioners and other experienced members of a multidisciplinary team. As we know, mental health issues cover a wide span and triage is a very good way to address the issues quickly"[37].

Professor O'Connor brought the Committee's attention to the joint research of Aisling Ní Shiothcháin and Michael Byrne authors of *Waiting List Management and Initiatives* published in 2009[38].

Both authors carried out a review on best practice and analysed waiting list management and initiatives in 2009. Their research recommends the benefit of triage clinics or "initial assessments" as means of determining the severity of cases and the nature of clinical needs prior to first appointments. This in turn can have an almost immediate impact on waiting lists. Their 14 step initiative referred to by Professor O'Connor is as follows:

1. Put in place clear referral guidelines, including eligibility criteria, in order to maximise optimum referrals and ensure early intervention for clients that fit the service inclusion criteria.
2. Keep a single service waiting list.
3. Offer clients an initial screening appointment (i.e., first step of triage) soon after referral in order to gather further information and redirect inappropriate referrals.
4. Offer a one-off brief therapeutic appointment (i.e., second step of triage) in order to supply the client with written information about treatment
5. Provide the client with evidence-based bibliotherapy material and temporary coping strategies.
6. The client can then decide whether he or she wants to "opt-in" to joining the waiting list in order to access further treatment.
7. Priority code the client according to transparent and consistent criteria surrounding perceived importance of treatment.
8. If possible offer clients a guaranteed waiting time after which the client has the right to be treated in another service.
9. Maintain regular contact with the clients on the waiting list and keep them informed of likely waiting time for appointment.
10. Prior to treatment, routinely address non-attendance policy.

37 *Professor Joyce O'Connor, p. 54 of 71.*

38 *Ni Shiothcháin, Aisling & Byrne, Michael "Waiting List Management and Initiatives", Irish Psychologist, Vol. 35, No. 8 (2009).*

11. Periodically review the waiting list and ask clients to "opt-in" to remaining on the waiting list.
12. Make a reasonable effort to contact the client when therapeutic appointments become available.
13. Make clear to the client the limited number of sessions provided, or offer treatment in a group format.
14. Remove from the active caseloads clients who disengage and inform referral source of same.

In Professor O'Connor's opinion, the issue of waiting lists could be resolved by Christmas 2017 with a focused approach:

> "I believe we can do it because there is a structure already in place, we have limited resources in the community, we have community care organisations that operate under the director of mental health services, we have evidence-based research in how to address the problem through referral, triage and interventions, and we have a 14-point plan."

Orla Gogarty, Director of Development at St. Patrick's Mental Health Facility, also gave evidence that the Independent Sector could meet the requirement of carrying out the clinical assessments at Tier 2, as the facility has done in the past. She told the Committee:

> "In my role as director of development over the past two years, I have had numerous approaches by local CAMHS services, very challenged and stressed business managers and executive clinical directors, who are struggling with critical gaps in resources, in particular the roles of consultant psychiatrists in CAMHS. I wish to cite one example where we worked towards a very functional arrangement that is still in place with CAMHS in the Sligo-Leitrim area where we provide a triage, which is often one of the first issues. If we can triage the services and get people to the right area, then we do not have them languishing on waiting lists that do not need to be there. They could be pointed to the appropriate primary and community services. We provided assessments in 2015, 2016 and 2017. We provide follow-up care through our consultant psychiatrist and psychotherapy services. We helped the service manage a waiting list that was causing it, families and communities incredible distress and concern"[39].

The Committee recommends that existing assessment structures be altered by which clinical assessments are carried out by Consultant Child Psychiatrists and that this function is delegated to Psychiatric Nurses.

The Committee recommends that the HSE ought to consider the benefit of initial assessments or screening processes as a speedier way of triaging waiting lists and directing children to appropriate services, rather than continuing the existing practice by which children remain on waiting lists for in-depth assessments and in turn, their symptoms are exacerbated.

39 *Gogarty, Orla, Director of ICT, St. Patrick's Mental Health Service, Day 2, Transcript, p. 4.*

Key Recommendation 1.4 Waiting Lists should be triaged in accordance with urgency and need.

It appears from the submissions that there is no triaging of urgent cases, or at the very least if there exists a priority list in CAMHS, the Committee heard from oral submissions that it does not perform at the desired pace for treatment[40] and in some cases can involve a child waiting between two to three weeks.

The following case study of one parent with a child on a waiting list is indicative of the mounting distress the situation creates. Lauren Keogh was invited to give evidence to the Committee in relation to her thirteen year-old daughter who has a dual diagnosis of autism spectrum disorder and hereditary neuropath with liability to pressure palsies.

40 *See comments of Sinead McGee, Chairperson of the CAMHS Carer's Forum, Day 1, Transcript, p. 14.*

Case Study A: Ms. Lauren Keogh

Lauren's daughter was referred by their GP to CAMHS and was waiting 18 months on a waiting list for her first appointment. Lauren told the Committee that her daughter regularly expressed "suicidal thoughts" during this time and required twenty-four hour monitoring. Lauren further told the Committee that her daughter stopped eating during this time and developed anorexia. Lauren attributed the manifestation of anorexia to the time spent on the waiting list. Lauren had to cease working and ceased mortgage repayments so that she could afford private treatment for her daughter. Despite these presenting conditions, Lauren's child was diagnosed on the autistic spectrum. Lauren was dissatisfied with this diagnosis and sought a further referral to CAMHS. This time, her child was assessed within three weeks and given a different diagnosis of anorexia nervosa. Lauren told the Committee that she was informed by CAMHS that this diagnosis brought her daughter outside the CAMHS services as they did not deal with disabilities and could not provide psychology to address the root cause of anorexia. Lauren told the Committee: "I did not care about the label but needed help with the challenged presented." CAMHS referred Lauren's daughter back to the disability team with her initial diagnosis of Autism Spectrum Disorder. However, Lauren's child had to wait a further period of 18 months to revisit the initial team that saw her child. The entire experience from presentation to diagnosis took 18 months[41].

41 *Keogh, Lauren, Parent, Day 1, Transcript, p. 21.*

The Committee also heard from Ms. Sinead McGee, Chairperson of the Dublin City County and CAMHS Carers Forum, who spoke about a parent who waited two weeks for an appointment with CAMHS after their child had attempted suicide and had to be admitted to the Emergency Department. The child sat vomiting into a bag while in the Emergency Department.[42]

The Committee heard oral testimony from Ms. Paula Dalton who addressed the Committee as a parent to a son with high functioning autism who later developed self-harming tendencies and suicidal ideation. He was referred to CAMHS and remained on the waiting list for 12 months. A further appointment was not forthcoming for six months[43]. She told the Committee that the HSE did not communicate with her in respect of the long waiting lists.

The Committee finds that access to treatment must be prompt in order to be effective. The existing waiting times represent a counter therapeutic and failed attempt at treatment when one considers that the services being accessed are specialist services for moderate to severely ill children. The Committee was reminded that there is no equivalent waiting list for physically ill children and accordingly the same parity of esteem for mentally ill children is not shown by the manner in which resources are applied to each area.

Key Recommendation 1.5 CAMHS referral criteria should be expanded to include children with intellectual disabilities.

The Irish College of General Practitioners guidelines note that "*referral of Children and Adolescents to local Child and Adolescent Mental Health Services (CAMHS)... is reserved for children and adolescents who have been diagnosed with a psychiatric (Axis 1) disorder*"[44]. This referral criterion excludes children and young people with autistic spectrum disorders, emotional difficulties, behavioural problems, developmental difficulties and intellectual disabilities unless there is a clear mental health component.

The Committee received a number of submissions which expressed confusion over referral pathways with the effect that certain children were not receiving treatment owing to their co-morbid diagnosis. Inclusion Ireland informed the Committee that where a child or adolescent has intellectual disability and mental illness there is often no clarity over responsibility[45]. The Committee heard how two teenage boys in HSE Dublin northeast both were excluded from CAMHS because their intellectual disability was "*more than mild*"[46].

This is not to say that those needs have not been considered before now. *A Vision for Change* recommended the creation of thirteen consultant-led multidisciplinary teams for children and adolescents with mental illness and intellectual disabilities. However the Committee heard that only half of these were in operation. Submissions from both parents and service providers suggest that the strict admission criteria for CAMHS operates to exclude a large proportion of children with dual diagnosis and causes confusion among practitioners and parents as regards referral pathways.

42 *McGee, Sinead, Chairperson of the CAMHS Carer's Forum, Transcript, Day 1, p. 13.*

43 *Dalton, Paula, Parent, Day 1, Transcript, p. 28.*

44 *ICGP, Child and Adolescent Mental Health: Diagnosis and Management (2013), p. 1.*

45 *Lennon, Sarah Inclusion Ireland, Day 1, Transcript, p. 35.*

46 *Helen, Julie Inclusion Ireland, Day 1, Transcript, p. 32.*

Inclusion Ireland informed the Committee in their submission that as recently as 2015, the HSE estimated that 25% of people with mild or moderate intellectual disabilities also experience mental health difficulties and if behavioural difficulties are included then up to 50% of people can experience that type of diagnosis[47]. Senator Collette Kelleher highlighted the plight of other child minorities excluded from consideration in existing services. Mr John Duffy from BeLong made clear that LGBT young people, travellers, asylum seekers and refugees were also overlooked in the model of service delivered.

According to the World Health Organisation (2005), an essential requirement for CAMHS is to be responsive to the needs of vulnerable and marginalised groups in society[48]. By contrast, submissions received from parents suggest that CAMHS apply the diagnosis criteria inflexibly to the extent that by reason of having a co-existing mental health illness with an intellectual disability, children are as a matter of course transferred to the disability service, or at worst excluded from the service with no clear referral path. One parent gave evidence that the existence of two separate teams; a disability team and a mental health service team working in two different ways was problematic as "*patients are moved from one waiting list to another*"[49].

The Committee finds that the existence of co-morbid presentation in children can lead to situations where children are unwittingly excluded from CAMHS. This difficulty is compounded by poorly staffed multidisciplinary teams, separate from the mainstream CAMHS model, who are tasked with catering for these children.

The Committee also finds that the existence of both the disability and mental health service operating mutually exclusive of the other ought to be harmonized so that irrespective of a child's co-morbid presentation, she or he will be treated by the CAMHS service. This would protect the multi-disciplinary approach to their treatment acknowledged by the HSE in their CAMHS Standard Operating Procedure:

> "Psychiatric disorders in these children are complex and best responded to by a biopsychosocial model for assessment and treatment. These children have multiple needs, and therefore assessment and diagnosis is multifaceted and multidisciplinary. There is also an increased risk of medical conditions due to the greater incidence of congenital abnormalities"[50].

The Committee takes the view that these children in particular represent our must vulnerable population and yet seem to fall outside the administration. The Committee recommends that CAMHS referral criteria be expanded to include children with intellectual disabilities.

47 *Gallagher, Arianna Inclusion Ireland, Day 1, Transcript, p. 34 of 60.*

48 *World Health Organisation Mental Health Policy and Service Guidance Package: CAMH policies and plans (2005) WHO, Geneva.*

49 *Keogh, Lauren Parent, Day 1, Transcript, p. 19 of 60.*

50 *Health Service Executive, Draft Child and Adolescent Mental Health Policy, Chapter 13, p. 26.*

Key Recommendation 1.6 CAMHS must be extended nationwide to children up to the age of 18.

Section 2 of the Mental Health Act 2001 defines a child as a person aged up to 18[51]. There is wholesale confusion between different CHO areas as to whether children aged between 16 and 18 can be accepted by CAMHS specialist services, despite the referral criteria to community CAMHS in HSE Standard Operating Procedure in 2015 suggesting that children can be accepted up to age 18. This reinforces the Committee's belief that there are significant geographic variances in provision.

The number of presentations to accident and emergency services with self-harm is high, with the highest occurrence among the 15 to 19 years age group. The Committee heard how number of referrals to children's services of young persons with self-harm and suicidal ideas has increased significantly[52]. The recent CAMHS annual report showed that those presenting with self-harm and suicidal ideas accounted for approximately 70% of referrals among children.[53] It appears to the Committee that between the ages of 16 to 18 when adolescents are most at risk that the least amount of services are available. Ironically, it appears to the Committee that the point at which CAMHS could have the most impact on young people's lives and have the best outcomes for their future is where the least provision is available.

The submissions received lead to the conclusion that services are particularly inadequate for 16 to 18 year-olds. The Committee heard, for example, that there are no services for those aged 17 in North Tipperary because the HSE has not been able to fill a clinician's post there. One parent, Ms Louise Walsh, told the Committee about her son's depression which set in after the sudden death of his father. The nurses on a 24-hour HSE suicide helpline said that her son, being 17, was not eligible for the service. On the other end of the spectrum, Sinead McGee, Chairperson of the Dublin City and County CAMHS Forum, gave evidence of children aged four and five presenting with suicidal thoughts yet excluded from the CAMHS qualifying criteria, being too young[54].

The Committee recommends as a matter of priority that CAMHS be extended consistently across the Country to include children up to the age of 18 in all cases.

51 *Section 2 the Mental Health Act, 2001.*

52 *Migone, Maria Consultant Psychiatrist at the Lucena Clinic, Day 1, Transcript,p. 37.*

53 *Health Service Executive, Fifth Annual Child and Adolescent Mental Health Service Report 2012-2013, p. 7. Notably, CAMHS have not published any report monitoring services since 2013.*

54 *McGee, Sinead Chairperson of the CAMHS Carer's Forum, Day 1, Transcript, p. 13 of 60.*

Key Recommendation 1.7 Admissions to Adult Psychiatric Units should be prohibited.

The Committee heard that in 2016, 68 out of 509 children were admitted to adult psychiatric units, which represents one in seven of all admissions of children. In 2016, there were 19 adult approved centres admitting children. The age range of children admitted to adult approved centres is between 13 and 17. Some 66% were 17, some 23% were 16 years of age and 12% were 15 or under. The average length of stay was six days. The Committee also heard that only 35% of children admitted to adult units were moved to a CAMHS unit.

The Committee heard from the Mental Health Commission that the number of preliminary notifications received by the Mental Health Commission of admissions of children to adult units from 1 January 2017 to 31 May 2017 was 44, an increase of eight compared with the same period in 2016, when there were 36 admissions of children to adult units.

The Committee heard that in 2016, 68 out of 509 children were admitted to adult psychiatric units, which represents one in seven of all admissions of children.

Given the trend of child admissions so far in 2017 and owing to the existing low number of child inpatient beds, a likely prediction might be that admissions to adult units will increase in 2017.

The inevitability of adult admissions was accepted given the continued absence of out-of-hours service:

> "Children who present to the emergency department out of hours with a mental health difficulty are assessed and treated by non-specialist non-consultant hospital doctors and consultant psychiatrists in the emergency department and it appears that they have no other option but to admit children because of their risk and due to the lack of appropriate services and beds"[55].

55 *Finnerty, Susan Mental Health Commission, Day 2, Transcript, p. 42.*

Professor Brendan Kelly told the Committee of the last resort nature of child admissions to adult units at night:

> "When a child might need to be admitted to an adult unit, we need to fill out a statutory Mental Health Commission form detailing the efforts we made to find a bed in an adolescent unit. We try to phone every single one in the country during the middle of the night. I might be in at 2 a.m. and spend three or four hours on the telephone trying to see if there is a bed but knowing in my heart that if I am in Dublin and I do identify a bed in Cork, it is very unlikely that it is the right move for the patient or the family. It can be very difficult at night to do that anyway, and it is under that kind of circumstance where there is no other alternative that a child is admitted to an adult unit."[56]

Professor Kelly went on to say that "it is a fact that most of the admissions do not meet the requirements in terms of educational provision for children or separate occupational therapy for children"[57].

The Committee also note that inpatient beds are available only in the major urban centres of Cork, Dublin and Galway, often placing treatment options far from the homes of patients in other areas of the country. For example, no inpatient beds exist in the country's north west, south east or midlands, nor are there inpatient beds in the country's third most populated city, Limerick. Where referrals are required for patients in these regions, they travel to Dublin, Cork or Galway, which puts additional strain on both patients and families.[58]

Louise Walsh gave evidence of her son, aged 17 being admitted to a padded Adult psychiatric unit in Waterford following his grief after the unexpected death of his father. She was informed that she would have to wait two weeks for an adolescent bed in that catchment area. Ms Walsh gave evidence that she was informed that her son could be accommodated after a period of two weeks in Waterford. She described his symptoms at that time as self-harming and suicidal ideation. She pointed out that this was not satisfactory as she was in essence a lone parent (recently widowed) at this point with two younger children based in Waterford. She told the Committee:

> "I was told there was nothing they could do but that I had the option of sending him to Cork or Galway. I could not believe it. They were telling me to send my son to Cork or Galway, that he could go to an adolescent care centre there for psychiatric problems. I asked them how they seriously expected me to be a parent in Waterford and a parent in Cork or Galway at the same time. I could not do it, financially, physically or in any other way. The option I had was to leave him in the hospital. I was told it would take about two weeks to get a place for him and that I could leave him in the acute psychiatric ward in Waterford until a place became available or I could take him home."[59]

56 *Kelly, Brendan, Professor of Psychiatry Trinity College Dublin, Day 2 of Hearings, pp. 29-30.*

57 *Ibid.*

58 *Sadlier, Matthew IMO, Day 2, Transcript, p. 44.*

59 *Walsh, Louise, Parent, Day 1, Transcript, p. 21.*

Ms. Walsh then told the Committee about the experience of her 17 year-old son in an adult ward:

> "My son spent the night in accident and emergency. On Saturday at 9 a.m. he was brought down to the adult psychiatric ward. He was told that he would not be allowed to leave his room because he would be in danger from other patients there. He said he was not staying locked up in that place. I begged him to stay. He got up and he ran out of the hospital. There was a big lock-down. All the alarms were put on in the psychiatric ward. He slammed his head off a concrete wall and he was brought into a padded room. He turned around and he said, "Do you believe it. It is like Bobby Sands' room in here." He was a 17-year old boy whose father had died and that was what we got. He was in that padded room. They asked me to leave so they could calm him down. I left. I came back an hour or two later and he had been given a room. There was no staff. They had nobody to mind him. He was in danger from other psychiatric patients. They had to get an agency nurse in to mind him and to sit with him 24/7. I had to bring him in pyjamas. I had to take the cord out in case he hanged himself. I had to take the cord out of the hoodie he got from Santa in case he hanged himself. He was not allowed his bag. It was locked away. He was not allowed anything. He went in on Saturday morning...I told the doctors that day that if I had known that this was what was going to happen I would have just hired a security man to come and sit in his bedroom because we would have been better off. We waited all day for a child psychologist. The child psychologist in Wexford hospital had to finish her rounds before she could come to Waterford. There was no one to see him. I asked where the doctor was and she was upstairs on another ward seeing another patient. I was raging. I asked how any other patient in the hospital was more important than my son who had been in there since Friday night in the acute area of an adult psychiatric ward on lock-down. I asked who in the hospital was more important than him that he or she was seen before him. We had waited all weekend. At about 7.15 p.m. the psychologist eventually came."

Ms. Walsh:

> "My son was around alcoholics and drug addicts etc. I do not mean to label anyone else in society but if a child feels at his or her lowest, feels worthless, useless and that society and their families are better without them, it is difficult if the child is placed in an adult ward. My son came out of there believing this was what he was. He believed his future was to be the same as the adults with all those mental health problems. The only thing he got from that was a firm belief that this was going to be him in ten years if he did not manage to commit suicide in the meantime. I firmly believe that putting him in there caused more damage. One would not put a child with a kidney infection, particularly a little girl, in a ward with old men. With due disrespect to men, children with mental health issues should not be put in a ward with old men? These children, whether physically or mentally ill, are sick children and they deserve to be treated in the same way as a child with gallstones or anything else would be treated. They deserve to be treated fairly. They have done nothing wrong. They are blameless. They did not ask for their illness and they need to be treated in the same way as every other child, namely, in a paediatric ward, where there are lovely paintings on the walls and balloons and toys in the corridors outside them. My son was surrounded by alcoholics and other people who were a danger to him and themselves. Under no circumstances would I say there is any excuse for doing that to a child"[60].

60 *Walsh, Louise Parent, Day 1, Transcript, p. 24.*

Peter Hughes, General Secretary of the Psychiatric Nurses Association spoke about the inappropriate admission of children to chairs in Kilkenny Adult Mental Health Unit:

> "We witnessed a stark example of this just last month with the admission of a 16 year old to the adult mental health unit in Waterford. Adding to the trauma already experienced, this child had to spend the night sitting on a chair. As recently as last night, a 17 year old was admitted to a chair in Kilkenny adult mental health unit. Just over a week ago, another 17 year old in Kilkenny was admitted and remains on the unit. Both Waterford and Kilkenny are operating above capacity with the result that children are being admitted to chairs. To say 11 years after the publication of A Vision for Change that this is unacceptable is an understatement. CAMHS are in crisis and, as outlined, the provision of services is deteriorating rather than improving. There were 74 operational beds two years ago but 26 fewer beds are operational now".

The Committee also addressed the Mental Health (Amendment) Bill 2016 which proposed to prohibit the admission of children to adult psychiatric units. Minister Jim Daly sought refinement of the Bill but in principle, support existed to legislate against this practice. Dr. Geoffrey Shannon, Dr. Niall Muldoon and various other representations were made which supported legislative reform to end the practice. The Committee also acknowledged the Mental Health Commission's code of practice which stated that the placement of children in adult wards was intended to be phased out by the end of 2011, but it is very clear this non-legally binding code has not been effective.

The Committee recommends that no child be admitted to an adult unit and that appropriate steps be taken to safeguard against this procedure in a way that is least harmful to the health of the child. The Committee does not find acceptable the absence of inpatient facilities and out-of-hours services an adequate excuse for the admissions.

Key Recommendation 1.8 CAMHS out-of-hours service must be extended across all Community Health Organisation (CHO) areas for acutely ill children and adolescents.

The Quality Framework for Mental Health Services in Ireland states that the "mental health service should be available on a 24-hour basis, seven days a week".[61] Despite this requirement, recent HSE data suggests that only 8 out of 17 weekend services are in operation around the country[62]. Parents report a consistent absence of emergency response services for crisis intervention. Dr. Geoffrey Shannon made the observations that families operate 24 hours a day, seven days a week[63]. They do not operate from 9 a.m. to 5 p.m. Despite this, the Committee finds that the majority of CAMHS facilities solely operate between those hours.

One parent reported despair at not having an appropriate phone number call during these times.[64] Another parent praised the involvement of An Garda Síochána as a last resort during the crisis symptoms presented by her son.[65]

61 *Mental Health Commission Quality Framework for Mental Health Services in Ireland (2007) MHC, Dublin.*

62 *See Parliamentary Question and response received by Deputy James Browne, TD: http://oireachtasdebates.oireachtas.ie/debates%20authoring/debateswebpack.nsf/takes/dail2017071300120.*

63 *Shannon, Geoffrey,Special Rapporteur on Child Protection, Day 1, Transcript, p. 46*

64 *Keogh, Lauren, Parent, Day 1, Transcript, p. 20.*

65 *Kelly, Marina, Parent, Day 1, Transcript, p. 13.*

Martina Kelly, parent, gave evidence that most of the crisis with her child "occurred on weekends and nights".[66]

Another mother gave evidence that her son aged 13 suffered from suicidal ideation. He had regular expressions of wanting to die. She described how her son was sent home from accident and emergency departments on multiple occasions without treatment[67].

The Committee was made aware of an out-of-hours 24/7 social work service in Northern Ireland which has a large contingent of mental health professionals within it. The Committee heard that this service costs £3.6 million a year to run. The Committee agreed with the view that this is not a large amount of money to provide 24-hour support for child protection and mental health[68].

The Committee also heard that there would be a benefit to attaching a 24/7 service to General Practices in CHO areas given that quite often, children's acute out-of-hours needs are met by GPs.

The Committee recommend as a priority that out-of-hours CAMHS be provided across all CHO areas on a 24/7 basis for acute presentations. In the absence of this service, children are required to rely on local Accident and Emergency Departments which do not have child-appropriate staff, let alone psychiatric staff to deal with the presentations.

Key Recommendation 1.9 CAMHS ought to measure geographic need for services and distribute services in accordance with need and not solely population size.

The Committee heard submissions that CAMHS data fails to address the variability in demand for service across multiple CHO areas.

This is problematic as services are distributed under the *A Vision for Change* model in accordance with population and not by reference to need. Undoubtedly, there are certain areas in which higher instances of mental health issues will be found in children. This is not measured by the HSE and is not used as a framework for distributing services.

The necessity to measure waiting lists and demand for mental health services in specific areas is crucial to delivering those services. Throughout the submissions received, there appears to be little engagement with areas in most need of services.

The Committee recommends that the need for mental health services be the deciding factor in the distribution of services and allocation of staff, and not solely population.

66 *Ibid, p. 27.*

67 *Dalton, Paula, Parent, Day 1, Transcript, p. 12.*

68 *Nicholson, Mary, ISPCC Day 1, Transcript, p. 58.*

6. Theme 2: Recruitment

Overview: *Understaffing in CAMHS is attributed directly to poor delivery of services in CHO areas in the submissions received by the Committee. While the HSE has allocated funding to increase staffing, the submissions suggest that working conditions are a deterrent factor.*

Key Recommendation 2.1 180 child and adolescent psychiatrists in post by 2020 applied by reference to need in each CHO area.

Key Recommendation 2.2 Two-tier remuneration for nurses and consultants qualified post-2012 should cease.

As of the end of December 2015, there was 51.6% of the staffing level recommended in *A Vision for Change* across child and adolescent mental health services in Ireland. Despite efforts by the HSE to improve staffing levels in CAMHS in the past couple of years, there has been very little increase in staff. This is borne out in the submission by Minister Jim Daly which records an increase in CAMHS staff from 622 in 2010 to 842 in 2015.

In the weeks prior to the Committee hearings, Linn Dara CAMHS inpatient unit for children and adolescents in Ballyfermot, Dublin closed 11 beds. This reduced the national bed compliment to 48 beds for acute mental illness in children and adolescents in Ireland. The closure of the beds was publically attributed to insufficient nursing staff for the units. There are 1.15 million people under the age of 18 years in Ireland in 2017. It is estimated that 115,000 have a mental health illness, causing some impairment, and 23,000 have severe and disabling mental health problems[69]. The proper delivery of child and adolescent mental health services is dependent on having the appropriate staff to deliver those services.

69 *O'Brien, John ICGP, Day 2, Transcript, p. 12.*

The unanimous view in submissions is that there are insufficient levels of psychiatric nurses, psychologists and consultant child psychiatrists to properly operate the CAMHS model. Dr. Matthew Sadlier from the Irish Medical Organisation told the Committee:

> "The IMO has identified deficiencies in service provision nationwide, with specific problems identified in the CAMHS teams in Mayo, Roscommon and Wexford. Pronounced staffing difficulties also severely hamper service provision. According to A National Model of Care for Paediatric Healthcare Services in Ireland, currently CAMHS teams in Ireland have approximately 50% of the staffing recommended by A Vision for Change. This limits severely the number and range of therapeutic interventions that each team can provide. Many CAMHS teams operate with as little as one third of the complement of staff required under A Vision for Change. Often teams nationwide share staff members, thereby rendering the full extent of under-staffing ambiguous as the same individual may be reported as being a member of more than one team. This is creating a virtual postcode lottery, whereby the range of services is dependent on a patient's address rather than on need.[70]

At the end of March 2017, some 51% of referrals to CAMHS were waiting over three months for an appointment, demonstrating the inability of existing staff to treat patients in a timely manner. The Committee heard that in Waterford, for example, which has funding for three child and adolescent consultant psychiatrists, has only been able to fill one and a half of these posts. In north Tipperary and west Limerick, the Committee received submissions to the effect that there are no non-consultant hospital doctors and no consultants in training on the CAMHS teams[71].

The issue of recruitment and retention of staff is directly linked to budget funding. There is much research to suggest that the allocation of budget funding to mental health services in Ireland as a proportion of the overall health spend is disproportionately small by comparison to other countries. In the HSE's service plan for 2017, funding for mental health services made up 6.1% of the HSE's total operational budget. The total health fund spending recommended in *A Vision for Change* was 8.24% in 2006. The Committee received submissions which suggest that the total health budget for mental health decreased from 13% in 1984 to 7.3% in 2004, to the current 6.1%. The Committee is also cognisant of external research which suggests that mental health services in Ireland have seen a proportionally greater reduction in the number of staff members than other areas of the health services[72].

The HSE have announced funding for the creation of 114 assistant psychologist posts and communicated this to the Committee. However, a fundamental observation made by the Mental Health Reform Group is that it would be more prudent to fill the existing vacant posts rather than creating and allocating funding to new posts. The HSE's mental health division's operational plan in 2016 shows that at the end of December, there was the equivalent of almost 1,500 vacant posts between development posts that had not been filled and posts that were being covered by agency staff and overtime. Moreover, the question remains unanswered as to whether the proposed *assistant* psychologists [author's emphasis] need 'supervision' from senior psychologists who, if not there, cannot operate to oversee their work.

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70 *Sadlier, Matthew, Consultant Psychiatrist, IMO, Day 2, p. 51.*

71 *Ibid.*

72 *Health Service Executive, Sixth Annual Report of the Independent Monitoring Group for A Vision for Change – the Report of the Expert Group on Mental Health Policy (2012).*

Working Conditions

The Committee heard evidence which suggested that working conditions also represent a barrier to recruitment. Dr. Migone, Consultant Psychiatrist in the Lucena Clinic, made the following submission:

> "...it is proving difficult to recruit and retain child psychiatrists to work here. Without a consultant, some of the inpatient units have been forced to reduce their numbers by half because other people have had to step in to try to fill the empty posts. The reason is that working conditions in Ireland have been compared unfavourably with those in other English speaking countries. As a result, we are unable to retain senior staff and trainees are moving abroad. In addition, many consultant colleagues in Dublin have left permanent posts in recent years. Others are on long-term sick leave or have chosen to emigrate. If staffing for CAMHS could be improved, we would be better able to retain some of these senior staff"[73].

The Committee heard that remuneration and working conditions lag significantly behind those available elsewhere in the English-speaking world. The Committee was directed to independent research on the emigration of health professionals from Ireland which suggests that recent emigration has been driven by dissatisfaction with working conditions in the health system and uncertain career progression opportunities, aggravated by austerity-related staff reductions, salary reductions and taxation increases[74].

The Psychiatric Nurses Association and Royal College of Surgeons of Ireland jointly published *An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A National Descriptive Evaluation Project* in 2016. This report evaluates the progress that has been made in implementing *A Vision for Change* since it was put into place in 2006. The evaluation shows that in implementing *A Vision for Change* the Government has been cutting investments and removing services without executing the replacement procedures as planned[75].

The findings indicate that the failure to properly implement *A Vision for Change* has had a very significant impact on the quality of mental health services and care that is made available to the Irish public. The report compares this to the UK/Australia which devotes between 12% and 14% of its overall health budget to mental health services.

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73 *Migone, Maria Consultant Psychiatrist at the Lucena Clinic, Day 1, Transcript, p. 37.*

74 *Sadlier, Matthew, Consultant Psychiatrist, IMO, Day 2, Transcript, p. 53.*

75 *PNA & RCSI, An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A National Descriptive Evaluation Project (2016).*

Poor and unequal remuneration were also highlighted in the submissions received by the Committee. Mr. Peter Hughes of the Psychiatric Nurses Association gave his opinion on the issue of nurse immigration:

> "Most of the staff in Linn Dara are relatively newly qualified and they are going abroad. Even within Ireland private services give them incentives and will pay a certain amount up front if the nurse will stay two years. They go to the UK and Australia, where their education is supported, they get time off to do it, it is paid for and they have subsidised accommodation. The NHS is building 20,000 units for staff accommodation because it knows this is a problem. The high rents in Dublin were mentioned. That needs to be addressed, whether through subsidised accommodation or a rent allowance. Nobody is listening but we are losing the nurses year on year. A graduate scheme was brought in to pay 85% of the staff nurse salary for the first two years to those people who qualified and then 90%. The majority of them emigrated and it would be very difficult to get them back. That was one of the biggest insults to any profession, not to pay the salary after people had done a four-year honours degree. Those people have left with a seriously bad taste in their mouths. We need to keep the people we have here and to keep those who will be trained in the next few years"[76].

The reduction in salaries experienced by both nursing and consultant psychiatrists was also highlighted to the Committee by referring the members to the Strategic Review of Medical Training and Career Structure ("the MacCraith Report") published in 2014. In July 2013, a Strategic Review Working Group chaired by the President of Dublin City University Professor Brian MacCraith was established to carry out a review of medical training and career structures. The group was tasked with examining and making recommendations relating to training and career pathways for doctors. Its aim was to improve graduate retention in the public health system and plan for future service needs.

The MacCraith Report points out that there are strong concerns as to the negative impact the reduction in consultant salary for new entrants may have on recruitment. The report also recognizes concerns regarding the quality, duration, supports and flexibility options in training experiences. The Interim Report in April 2014 recommended as follows:

> "The Working Group recommends that the relevant parties commence, as a matter of urgency, a focused, timetabled IR engagement of short duration to address the barrier caused by the variation in rates of remuneration between new entrant Consultants and their established peers that have emerged since 2012."[77].

At the time of writing, this does not appear to have occurred by reference to the Fifth Progress Report published in May 2017[78].

76 *Hughes, Peter General Secretary, PNA, Day 1, Transcript, p. 53*

77 *Health Service Executive, The Strategic Review of Medical Training and Career Structure ("the MacCraith Report") (2014)*

78 *Health Service Executive, The Strategic Review of Medical Training and Career Structure Fifth Progress Report August 2016 – January 2017 (2017) Para 2.1, p.22.*

The Committee also heard that working conditions were made difficult by the limited services clinical staff are aware they can provide. Dr. Blánaid Gavin told the Committee:

> "One of the fundamental issues that arises regularly, and has a direct impact in terms of the retention issues which have been mentioned already, is the fact it is a very harrowing experience to be placed in a position where children are presenting with acute mental health conditions where there are treatable evidence-based interventions yet the practitioners are not in a position to provide those interventions in a timely way. It is an incredibly helpless and harrowing position"[79].

In light of the foregoing, the Committee adopts the recommendations of the Irish College of Psychiatrists that 180 child and adolescent psychiatrists in post by 2020 applied by reference to need in each CHO area. The Committee further recommends that consultant and nurse pay be restored. Health staff ought to be remunerated at an international competitive level so they are retained.

79 *Dr. Blánaid Gavin, Consultant Child Psychiatrist in CAMHS, p. 6 of 71.*

7. Theme 3: Outcome Monitoring by CAMHS

Overview: *CAMHS do not collect data which monitors the outcome of treatment for children and adolescents. This is viewed in the submissions as a fundamental omission in progressing the service by providing comprehensive treatment for children.*

Key Recommendation 3.1 Outcome indicators should be measured by those embarking on CAMHS and reported annually with the CAMHS Report.

The Mental Health Reform report on the progress of implementation of *A Vision for Change* outlines that there are no CAMHS-specific quality standards and guidelines and no quality and outcome monitoring system for CAMHS in Ireland. This concern is reflected in the submissions received by the Committee. The effect of this is described by Dr. Blánaid Gavin, Consultant Child Psychiatrist:

> "Unfortunately, there is no data available in regard to what is happening in CAMHS. To speak the truth we must have information and data that tell us what are the quality outcomes and what are the differences that the services make, so we can look at how good a service we are providing, where we need to input efficiencies and where we need to become more effective. This has a dual purpose. It has the purpose of recognising and rightfully commending the excellent work that is on-going in CAMHS, and the effectiveness of the multiple evidence based treatments that are available and from which children benefit. If the message is consistently about the negatives, it disempowers people in terms of access and makes people more helpless in terms of the conditions with which they are dealing and struggling daily. In addition, in the absence of data that specifically seeks to find out what the services are doing we run the risk of continuing to provide a lottery both in access to services and in the nature and quality of the service that is provided. In many cases, people liken service provision currently to the roll of a dice. While there are known effective treatments available in line with any standard medical interventions, it is not clear where and how they are accessible and how many children benefit from their input. It is a cornerstone of any quality service internationally or nationally that there is a drive to establish the practice exactly. There is no oversight of any of that."

It is also noted by the Committee that, in so far as child admissions to adult psychiatric units are concerned, no data is available as to aftercare for those children.

The Committee recommends that outcome indicators should be measured by those embarking on CAMHS and reported annually with the CAMHS Report.

8. Conclusions and Recommendations

The Committee finds that there is a chronic lack of standardised services and a lack of clarity surrounding the operation of CAMHS in Ireland, particularly from the perspective of service users. In order that the equity and accessibility of mental health services for children be enhanced, the Committee recommends that the findings in this Report be discussed by the Seanad and given appropriate consideration in the upcoming review of *A Vision for Change*.

Dr. Geoffrey Shannon, Special Rapporteur on Child Protection, told the Committee that when the State takes a child into its care, it is saying it can do a "better job". He hastened to add that when the State fails that child, it fails them "a second time". The submissions received from parents reflect the traumatic consequences this can have. We have raised expectations only for those expectations to be dashed in the context of poor communication between agencies and the failure to deliver on services.

Every child under the age of 18 years in Ireland has the right to life, survival and development. Every child should have a fair chance in life. Unfortunately, the submissions made to this Committee suggest that the restricted allocation of resources to mental health services for children and adolescents do not appear to prioritise needs based, timely services, nor does the allocation of resources takes account of the greater need for mental health services in areas of deprivation.

This Report not only reflects the serious flaws in Children's mental health services but also the solutions to these issues. The Committee wish to have a Review in one year's time by the Seanad on the implementation of the recommendations contained herein, this will ensure that the Minister for Mental Health will report on the progress of same.

Theme 1: Recommendations on Access to Services

Key Recommendation 1.1	Primary Care should be urgently staffed with the level of psychologists recommended in *A Vision for Change* and updated in accordance with child population data in 2017
Key Recommendation 1.2	Clinical Assessments at Tier 2 should be delegated to Psychiatric Nurses to immediately reduce CAMHS waiting lists
Key Recommendation 1.3	Initial Assessments ought to be considered as a means of triaging waiting lists and filtering referrals to appropriate services
Key Recommendation 1.4	Waiting Lists should be triaged in accordance with urgency and need
Key Recommendation 1.5	CAMHS referral criteria should be expanded to include children with intellectual disabilities
Key Recommendation 1.6	CAMHS must be extended nationwide to children up to the age of 18
Key Recommendation 1.7	Admissions to Adult Psychiatric Units should be prohibited
Key Recommendation 1.8	CAMHS out-of-hours service must be extended across all Community Health Organisation (CHO) areas for acutely ill children and adolescents
Key Recommendation 1.9	CAMHS ought to measure geographic need for services and distribute services in accordance with need and not solely population size

Theme 2: Recommendations on Recruitment

Key Recommendation 2.1	180 child and adolescent psychiatrists in post by 2020 applied by reference to need in each CHO area
Key Recommendation 2.2	The two-tier remuneration for nurses and consultants qualified post-2012 should cease

Theme 3: Recommendation on Outcome Monitoring by CAMHS

Key Recommendation 3.1	Outcome indicators should be measured by those embarking on CAMHS and reported annually with the CAMHS Report

9. Appendix 1: Orders of Reference of the Seanad Public Consultation Committee

That, in accordance with the recommendation of the Committee on Procedure and Privileges pursuant to Standing Order 98(1)(a) –

1. A select committee, which shall be called the Seanad Public Consultation Committee ("the Committee"), shall be appointed to facilitate direct engagement and consultation between members of the public and Seanad Éireann on specific issues related to the legislative powers of the Seanad or an issue of public policy.
2. The Committee shall consist of 11 members including the Leas-Chathaoirleach who, ex officio, shall be Chairman of the Committee and the quorum of the Committee shall be five.
3. The Committee –
    a. shall identify for examination specific issues related to the legislative powers of the Seanad or an issue of public policy;
    b. shall, for the purposes of sub-paragraph (a), have the powers defined in Standing Order 72(1) and (2);
    c. shall, in respect of any issue it identifies for examination in accordance with sub-paragraph (a), exercise its power under Standing Order 72(2) by public notice which shall specify the issue on which written submissions are invited and the date by which they must be received by the Committee: provided that the Committee may also invite written submissions directly from interested persons or bodies;
    d. shall review submissions received by it, determine whether or not such submissions are admissible in accordance with the criteria set out in paragraph (8) of this Standing Order, reject any submissions which it rules to be inadmissible and consider what action, if any, to take in relation to submissions which it judges to be admissible; and
    e. shall, for the purposes of sub-paragraphs (a) and (d) of this paragraph, meet in private.
4. The Committee may meet in public in the Seanad Chamber for the purpose of taking oral evidence.
5. Paragraphs (2) to (6) inclusive of Standing Order 76 shall not apply to the Committee.
6. In addition to its obligation under Standing Order 77(1) to lay every report made by it before the Seanad, the Committee may refer any report made by it to the relevant joint committee.
7. Written submissions to the Committee shall clearly indicate the name of the person or body making the submission and a postal or e-mail address.
8. A submission is admissible unless it –
    a. requests the Seanad to do anything other than the Seanad has power to do;
    b. does not comply with Standing Orders or is otherwise not in proper form;
    c. it contains any matter which is *sub judice* within the meaning of Standing Order 47;
    d. comments on, criticises or makes charges against a person outside the House or an official, either by name or in such a way as to make him or her identifiable;
    e. contains language which is offensive or defamatory;
    f. is the same as, or in substantially similar terms to, a submission made by or on behalf of the same person or body during the lifetime of the Committee.

10. Appendix 2: List of witnesses who presented to the Committee

On June 29, 2017 and July 6, 2017 Senator Joan Freeman, along with the other members of the Seanad Public Consultation Committee held the Public Consultation for Children's Mental Health Services in the Seanad. Members of the Seanad Public Consultation Committee include Senator Paul Coghlan, Chairman, Senator Catherine Ardagh, Senator Jerry Buttimer, Senator Maria Byrne, Senator Martin Conway, Senator Mark Daly, Senator Máire Devine, Senator Colette Kelleher, Senator Denis Landy and Senator Pádraig Ó Céidigh.

On June 29, 2017 there were five service users who spoke during the Public Consultation as witnesses. These witnesses include Paula Dalton, Martina Kelly, Lauren Keogh, Sinead McGee (Chairman of the CAMHS carer's forum) and Louise Walsh. John Duffy, Arianna Gallagher, (BelonG To), Sarah Lennon, Julie Helen (Inclusion Ireland), Dr. Maria Migone, Dr. Glenda Kavanagh (Lucena Clinic), Julie Ahern, Saoirse Brady from the Children's Rights Alliance, Mary Nicholson, Andrew Jackson (ISPCC), Kate Mitchell, Dr. Shari McDaid (Mental Health Reform), Peter Hughes (Psychiatric Nurses Association) and Dr. Geoffey Shannon (Special Rapporteur on Child Protection) spoke as advocacy and service provider.

On July 6, 2017 clinicians spoke as witnesses including Dr. Elisabeth Petitbon, Professor Brendan Kelly, Professor Fiona McNicholas, Dr. Blánaid Gavin, Dr. Brendan Doody, Dr. Yvonne Begley and Dr. Eddie Murphy. Professional bodies also had witness representatives including Dr. Brendan O'Shea and Dr. John O'Brien from the Irish College of General Practitioners, Mr. Paul Gilligan and Ms. Orla Gogarty from St. Patrick's Mental Health Services, John Hillery and Dr. Maeve Doyle from the College of Psychiatrists of Ireland and Mr. Gareth Noble as a Children's Law Specialist.

Witnesses from State and official bodies also spoke during the Public Consultation on July 6, 2017. These witnesses include Dr. Niall Muldoon and Mrs. Naomi Kennan from Ombudsman for Children's Office, Mr. Jim Ryan and Mr. Philip Dodd from Health Service Executive Mental Health Division, Ms. Patricia Gilheaney and Dr. Susan Finnerty from the Mental Health Commission, Dr, Matthew Sadlier and Mr. Cian O'Dowd from the Irish Medical Organization, Mr. Jim Gibson and Ms. Patricia Finlay from TUSLA, Minister Jim Daly as the Minister of State at the Department of Health with special responsibility for Mental Health and Older People, and Professor Joyce O'Connor, Chair of *A Vision for Change* Expert Group on Mental Health Policy.

User Experiences quoted in text:

- Lauren Keogh
- Paula Dalton
- Louise Walsh
- Martina Kelly