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Submission to the Seanad Public Consultation Committee on Children's Mental Health in Ireland

1) **The name, postal address, e-mail address and telephone number of the organisation or person making the submission**

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Our submission is made in a private capacity as clinicians.

2. A brief introduction indicating any experience, expertise or background you may have in this area.

My name is Fiona McNicholas. I am a qualified, registered medical doctor. I hold a Bachelors degree in medicine (MB BCh BAO) and a Doctorate in medicine (MD). I am a fellow of the Royal College of Psychiatrists and a member of the College of Psychiatrists of Ireland. My name is included on the Register of Medical Specialists maintained by the Medical Council of Ireland (registration number 012772).
I am Professor of Child and Adolescent Psychiatry at University College Dublin and Consultant Psychiatrist at Our Lady's Hospital, Crumlin and Lucena Clinic, Rathgar.
I have worked in my current consultant role since Oct 2001, and previously have worked in the UK and USA. Over that time, I have experienced first-hand the coal face of acute mental health service provision in Ireland. Like most of my colleagues, I am passionate about ensuring that children and families receive early and appropriate evidenced base mental health care and that they, their families, teachers and the public are provided with the necessary information about mental illness, and that clinicians receive the necessary training in mental illness, from transient self-limiting presentations, to severe and enduring mental illness. It is in that spirit that I offer this submission.

My name is Blánaid Gavin. I am a qualified, registered medical doctor. I hold a Bachelors degree in medicine (MB BCh BAO) and a MSc in Cognitive Behavioural therapy. I am a

member of the Royal College of Psychiatrists and the College of Psychiatrists of Ireland. My name is included on the Register of Medical Specialists maintained by the Medical Council of Ireland (registration number 22418). I am Associate Professor of Child and Adolescent Psychiatry at University College Dublin and a Consultant Child and Adolescent Psychiatrist.

I have worked as a consultant psychiatrist since 2008 and in that capacity have gained extensive experience of the challenges for children and families in accessing timely, effective mental health treatment in addition to experiencing the barriers that exist within the current service framework for clinicians attempting to optimise service provision and therapeutic outcomes. I have collaborated extensively with my colleague Professor Fiona McNicholas to research and develop 'real world' solutions to enhance care for children with mental health difficulties in Ireland. I make this submission in the hope that it will be a meaningful contribution to the ultimate goal of providing children in Ireland with a world-class mental health service.

3. Factual information, observations or opinions that you believe will assist the Committee in drawing conclusions.

Specialist Mental Health care for children in Ireland is provided in 3 separate services: (i) Consultant child psychiatry led outpatient teams or CAMHS OPD, (ii) Consultant child psychiatry led in-patient services, CAMHS in-patient, and (iii) acute psychiatry provision in paediatric hospitals. It is a matter of record that effective specialist mental health services play a vital role in the remediation of mental illness in children. It is accepted that Early Intervention in child psychiatry is key to optimising outcomes and that well-resourced services are essential to provide the specialised treatment necessary for children presenting with severe and impairing illnesses in both acute and non-acute settings. Previous HSE reports document the huge number of children accessing specialised services currently, the complexity and range of illnesses being treated and the wealth of initiatives being undertaken by specialised services. Despite this, mental health services for children and adolescents in Ireland are often experienced by children, adolescents and families as challenging to navigate and unavailable at times of crisis. Service providers, too, experience the system as chaotic, non-transparent and without adequate expert opinion informing service design; non-standardisation in services nationally effectively equates to a 'postcode lottery'. At a time when rates of mental health problems and self-harm in children and teenagers are recognised as being at an all-time high and when demand far outstrips available services, inefficient resource allocation and ineffective service design has grave implications.

The lack of expertise and evidenced base data driving service design is in contrast to the various strategies employed in other areas of healthcare and appears to reflect a stigmatising attitude to mental health. The unchallenged perception that 'little things' are adequate to treat

complex, enduring mental illness in children further reflects the lack of understanding that pertains and facilitates a habit of utilising the limited resources that do exist in a non-evidenced based and ad hoc manner. This is best summed up by a teenage participant in one of our research studies which sought to explore adolescents' experience of attending mental health services who expressed the view that the current focus on minor, self-limiting mental health symptoms at the expense of severe mental illness was 'like comparing having a cold to having cancer'. This point elegantly highlights the need for mental health services to mirror traditional service design in other healthcare areas i.e. that there are clear, timely, access points and standards of care expected and provided depending on the severity of the illness experienced and that expert treatment is as available and accessible at times of acute crisis as it is for routine care. Clearly, given that psychiatric services deal with the severe end of the mental illness spectrum, this must be reflected in resource allocation and service design.

4**. Changes that you believe need to be made to legislation or public policy.**

Specialist Mental Health:

- Prioritise services that are in fact offering immediate access to Mental Health assessment and stabilisation. Resource these services centrally. Coordinate and manage resources through the HSE Mental Health division, with shared governance, funding, operational protocols and staffing. Currently a significant amount is conducted in Emergency Departments of acute hospitals via Liaison psychiatry but probably unrecognised and are funded separately.
- Set up a strategy group akin to the National Cancer Strategy headed by an International Expert to oversee the overhaul of service provision with an overarching goal that all children and teenagers in the country can be assured of the same access to and provision of care no matter where they live.
- Ensure that the voice of the children and families using services is being heard through standardised quality assurance mechanisms.
- Provide 'out of hours' CAMHS nationally.
- Ensure urgent access to in-patient child beds
- Money should follow the patient
- Resource paediatric and adolescent (16-18) Paediatric Consultant Liaison Services
- Ensure co-ordinated planning and adequate resources for mental health provision in the National Children's Hospital.
- Develop appropriate out-of-hours community Social Work services
- Continue to extend primary care counselling services in a co-ordinated fashion.
- Establish key quality indicators for services and routinely monitor outcome data.
- Develop Public Health Campaign to help children, teenagers and parents/carers know how and where to access appropriate services, what to expect and what their rights are in this regard.
- It is important to note that making it illegal to admit a child under 18 to an adult ward will certainly sharpen the focus on the need for urgent access to in-patient beds.

Although not best practice, and against the MH commission principles, in the absence of access to beds, a less than appropriate admission may be safer for an adolescent at high risk waiting in the community for a bed to become available. The issue is, how in the absence of more appropriate placement, can this be made as safe as possible for the young person. How can child psychiatry teams support the therapeutic milieu of the adult ward, what additional safe guards need to be considered and put in place, which areas of the ward are most appropriate, and which hospital may be best placed; some settings might be better than others. From my experience (FMcN) of trying to safely care for some acutely unwell 16/17 year old children in OLCHC over the years, as a clinician, I believe that their interests may have been better served by a carefully planned admission to an adult psychiatry ward. This will always need to be done on a case by case basis, and in the knowledge that a law making it illegal to admit an under 18 year old to an adult ward, in the absence of alternative, should not cause even more risk to the young person, given the current difficulties we experience in CAMHS emergency bed access and the lack of mental health designated beds in many medical/paediatric hospitals. Where should an acutely unwell 17 year old go, if there are no available CAMHS beds nationally and there is a law preventing them access an adult ward? Until appropriate resources are in place allowing constant protection of an immediate urgent bed in CAMHS, this seems to be clinically unsafe.

This public consultation offers a unique opportunity to consider the mental health wellbeing of all children in Ireland. In Ireland, more than one third of our population are children, but all are our future. Investing in them is investing in our future.