DÁIL ÉIREANN

AN COMHCHOISTE UM LEANAÍ AGUS GNÓTHAÍ ÓIGE

JOINT COMMITTEE ON CHILDREN AND YOUTH AFFAIRS

Dé Céadaoin, 25 Meán Fómhair 2019

Wednesday, 25 September 2019

The Joint Committee met at 10 a.m.

Comhaltaí a bhí i láthair/Members present:

Lisa Chambers,	Fintan Warfield.
Denise Mitchell,	
Tom Neville,	
Anne Rabbitte,	
Sean Sherlock.	

I láthair/In attendance: Deputies Pat Buckley and Dessie Ellis.

Teachta/Deputy Alan Farrell sa Chathaoir/in the Chair.

Business of Joint Committee

Chairman: Apologies have been received from Deputy Kathleen Funchion and Senators Joan Freeman and Catherine Noone. I propose that we go into private session to deal with some housekeeping matters. Is that agreed? Agreed.

The joint committee went into private session at 10.10 a.m. and resumed in public session at 10.35 a.m.

Youth Mental Health: Discussion

Chairman: Before the commencement of this meeting, I would like to note that during the private session, Deputies Rabbitte and Neville, Senator Warfield and I raised the issue of a lack of response from Tusla, the Child and Family Agency, to questions posed during the course of a public debate on this matter during the recess on the subject of Hyde & Seek and specifically the issues raised in the airing of that RTÉ programme. During the course of our private session, the committee asked that this be raised in public session for the purpose of highlighting that we are disappointed we have not had a response from Tusla and following this meeting the secretariat will contact Tusla in order for it to provide us with a reasonable response to the matters raised during that public session up to and including the number of crèches under investigation, the 37 that have been mentioned on several occasions. It is appropriate we mention that in public session rather than behind closed doors.

I welcome the members back to the joint committee and also our guests who are joining us this morning. The purpose of this meeting is to discuss with representatives of the child and adolescent mental health services, CAMHS and Jigsaw, the national centre for youth mental health, youth mental health. On behalf of the committee, I welcome Mr. Jim Ryan, assistant national director and head of operations, mental health services, HSE; Professor Brendan Doody, consultant child psychiatrist and clinical director of Linn Dara Child and Adolescent Mental Health services, HSE; Dr. Joseph Duffy, chief executive officer, Jigsaw; and Ms Sarah Cullinan, director of services, Jigsaw.

Before we commence, in accordance with procedure, I am required to draw the attention of our guests to the fact that by virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to the committee. They are directed that only evidence connected to the subject matter of these proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing parliamentary practice to the effect that they should not comment on, criticise or make 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.

I remind our guests, as I have already reminded the members, to switch off their mobile phones or put them on flight mode as they can interfere with the sound system and make it difficult for those following these proceedings to pick up what they are saying, and we would not want that. I also advise them that any submission or opening statement they have made to the joint committee will be published on the committee's website following this meeting. Follow-

ing our guests' presentations there will be an exchange and members will pose questions. I note Deputies Buckley and Ellis have joined us this morning in addition to the membership of the committee and I thank them for doing so.

I call Professor Doody and Mr. Ryan to make their opening statements.

Mr. Jim Ryan: Good morning, Chairman and members of the committee. I am the head of operations in mental health in the HSE. I thank the committee for the invitation to attend this joint committee meeting to discuss youth mental health. I am joined today by my colleague, Professor Brendan Doody, child and adolescent psychiatrist and clinical director in Linn Dara Child and Adolescent Mental Health Services.

I am pleased to be here today to speak to the committee about mental health. We submitted a briefing paper in advance of today's meeting so I will confine my remarks in this statement to giving members an overview of HSE youth mental health services.

Since 2012, €208 million additional funding has been allocated under programme for Government to HSE mental health services, including youth mental health. The HSE provides and funds services for young people in community, child and adolescent mental health teams and in inpatient facilities up to the age of 18. The fact that the Mental Health Act defines a child as being under 18 impacts on the legal and organisational responses to youth mental health. The main priority of HSE mental health services is providing care for young people with secondary care mental health needs.

Members will be aware of a number of national policies and strategies which inform the direction of mental health services for young people, including A Vision for Change, our national mental health policy, which is currently being updated by the Department of Health; Connecting for Life, Ireland's National Strategy to Reduce Suicide 2015-2020; and Sláintecare. We have also been involved in and informed by the recent National Youth Mental Health Task Force Report 2017 and the 2018 report of the Joint Committee on the Future of Mental Health Care.

Youth mental health services in Ireland are integrated with primary care, acute hospitals, disability services and a wide range of community partners. Services are provided in a number of different settings, including health centres, day centres, inpatient units and sometimes in the service user's own home.

Regionally, the nine community healthcare organisations, CHOs, have responsibility for the delivery of community healthcare services within their respective programme areas. While the chief officer of the CHO has overall responsibility, the head of service for mental health in each CHO area, in conjunction with the executive clinical director, is responsible for the delivery of mental health services across the CHO area.

In terms of a tiered level of services, the HSE reaches the wider population in a number of ways, including our Little Things campaign and, more recently, our digital mental health service improvements. Interventions at primary care level are important to support young people when they first start to struggle with mental health issues. Many young people can be treated at primary care level and make progress without needing to access specialist mental health services. Primary care services include GPs, Jigsaw and other NGO service providers, primary care psychology services and counselling in primary care, CIPC, which is available to those over 18. Jigsaw services are fully funded by the HSE and they see young people up to the age

of 25. There are 13 Jigsaw services in communities across Ireland providing mental health support to young people and work continues to develop two new Jigsaw services in Wicklow and Tipperary.

CAMHS provide specialist mental health service to those aged up to 18 years who have reached the threshold for a diagnosis of moderate to severe mental health disorder that requires the input of a consultant led multidisciplinary mental health team. CAMHS inpatient units offer assessment and treatment to children and adolescents up to the age of 18, with severe and often complex mental health difficulties. For those aged over 18, these services are provided by general adult community teams and inpatient units. Approximately 2% of the under 18 population will require a CAMHS intervention at any given time.

Mental health services for young people have improved significantly in recent years, with an emphasis on early intervention but also on services for those with severe mental illness using models of care supported by the clinical evidence base. Notwithstanding the improvements, we are very aware of the continued need to further develop services and deal with challenges, including consultant vacancies, and we will continue to work with all stakeholders, including the Department of Health, in this regard.

Chairman: I invite Dr. Duffy to make his opening statement.

Dr. Joseph Duffy: Jigsaw warmly welcomes this opportunity to contribute to the vital work of the Joint Oireachtas Committee on Children and Youth Affairs. We all know that adolescence is a time of huge change and upheaval. The journey from childhood to adulthood is complex and challenging and for many young people this journey can be particularly tough to handle. Jigsaw's vision is an Ireland where every young person's mental health is valued and supported. Jigsaw was established in 2006, as Headstrong, to meet an identified gap in service provision for young people struggling with their mental health, possibly with emerging mental health issues, who did not require the support of specialist mental health services.

Previous research by Jigsaw has shown that a third of Ireland's young people have experienced mental health difficulties. Our evidence and our experience of working with young people tell us that many across Ireland struggle daily with anxiety, low mood, stress and isolation. The cost of this mental health crisis to Ireland's economy is a staggering €8.3 billion a year, not to mention the devastating personal cost to an individual's quality of life and physical well-being. We know social inequalities are associated with higher rates of mental health difficulties. The more unequal the society, the greater the rate of distress. In Ireland, this is particularly relevant given that the gap between rich and poor is growing and the numbers of young people finding themselves homeless is on the rise.

The young people we see tell us about how they feel under tremendous pressure to succeed and excel at school, at home, on the sports ground and in social groups. Jigsaw supports thousands of young people across Ireland every year through our community based youth mental health services, our work educating parents, teachers and young people, and our information and guidance at

www.jigsawonline.ie.

Since Jigsaw was founded, young people have been involved in helping us to develop and design our services. We now have a youth advisory panel in each of our services and the national office. These panels are made up of young people aged between 16 and 25 years who

may or may not have experience of the mental health system but who all are passionate about this area. Our youth advisers asked me to emphasise the following to the committee today. A holistic approach is needed to address the causes of mental health difficulties. Young people are worried about big issues in society, such as inaction over climate change, increased homelessness, academic pressure and the pressure on minority groups. More specifically, they are concerned about wait times for mental health support, gaps between child and adolescent and adult mental health services and the cost of private therapeutic support. Awareness campaigns are not enough; young people respond better to information from their peers.

In Jigsaw, we believe in intervening early with mental health difficulties, offering a therapeutic service to young people at primary care level. We also believe in listening to each young person's judgment of his or her own needs, hence we have a service with no lower threshold. We aim to construct an understanding of what is happening in a young person's life with him or her, rather than solely through the objective assessment of the clinician as the mental health expert.

We know that there is no easy fix or miracle solution for mental health problems because these are complex and challenging, but there is much that Government and policymakers can do to better support young people who are experiencing mental health difficulties. For this reason, we are calling for an increased focus on mental health services that are proactive, community based, integrated and early interventionist in nature. Investment in keeping people well, rather than waiting until they are very unwell, has the potential to save lives and save significant financial resourcing. Investing in early intervention, implementing the recommendations of the National Youth Mental Health Task Force Report 2017, will contribute to making a real meaningful difference to the mental health of Ireland's young people and give them the best possible chance for a full and healthy future.

Jigsaw very much welcomes this opportunity to discuss the issues that we have raised further during this meeting. I thank the committee for the invitation to participate in this process.

Chairman: I thank Mr. Ryan and Dr. Duffy for their opening statements in this important discussion.

Deputy Tom Neville: I thank our guests for appearing. My first question is to Mr. Ryan who spoke about A Vision for Change being updated. When will the full document be updated? Has a date been provided? What is the position regarding the implementation of a 24-7 telephone service? The Minister spoke previously about introducing such a service.

I am working on the path finder service behind the scenes with various Departments. I would like an update on that but that is more for the Government side.

Two weeks ago, I joined a Limerick Suicide Watch patrol for four or five hours. It was an extremely humbling experience. I cannot find another description for it. One intervention was made during that time but I did not witness it as it occurred on the other side of the city where a second team was on patrol. We met people who felt low and wanted to speak to somebody and did so before going about their business. These groups operate across the country and are doing unbelievable work. My experience was that there was a jovial atmosphere among the volunteers patrolling the bridges because that is how people deal with these types of issues. However, there is also a sense of nervousness at all times. For want of a better description, people have butterflies in their stomach for the four hours that they are on patrol. I was shadowing others as I am not a qualified patroller.

Does the HSE interact with these patrol groups to discuss their findings, the data they gather, the types of interventions they make and the tangible recommendations they may make on deterrence? They are doing all they can but is the HSE and the other agencies doing all they can to communicate with these groups. Anecdotally, I heard from the Limerick group that further interventions sometimes occur after people have been brought to hospital by the emergency services. They recommended having a qualified person on site immediately because the gap between the intervention and the involvement of the emergency services is where they believe the system needs to be improved.

Dr. Duffy spoke about being proactive in reaching out to these people as opposed to being reactive. I accept that this is difficult. From speaking to people, those who experience a mental health difficulty often find it difficult to make the call and seek help. They need somebody to help them make that call and reach out, as opposed to reacting. It is all very fine to say to somebody that he or she should get help, but sometimes that person would need somebody else to take the lead and ask whether to make that call for help. I am trying to consider the system, particularly at this acute emergency level, when there are people in such distress and there is a link between the emergency service and where the cases are. This is an example but I am coming from an area where I do not have a huge amount of knowledge. I only spent four hours with these people.

Was all the new money coming from the Government to the Health Service Executive, HSE, spent in 2018 or was some of it handed back? We know there have been recruitment challenges in mental health services but has anything been done to overcome those recruitment challenges since the mental health committee sat? We identified a number of roadblocks in the recruitment process but have any changes or improvements been made? If there have been, what are those improvements?

I visited the Jigsaw service in Limerick and it is fantastic. It was mentioned that Jigsaw is seeking proactive community early intervention. What type of work, from the experience of the witnesses, has been done on stigma? Is there a push or move against stigma? I take comfort that in some people of the younger generation, stigma is not as prevalent as it would have been in the older generations, but we should not take our eye off the ball. Stigma is still there. What is Jigsaw's experience of this and what would be its advice for any future campaigns trying to combat stigma?

Mr. Jim Ryan: We understand the refresh of A Vision for Change is in the final stages. It is a Department of Health document but it is in the final stages of completion. It is likely to be published before the end of the year, but it is with the Department. We expect that the Minister of State, Deputy Daly, will make an announcement on the 24-7 call number on World Mental Health Day in early October, as he outlined earlier. As the Deputy said, the Pathfinder initiative is challenging because it is across government. We are waiting for that to happen as it will have an impact on a number of the recommendations from the original youth mental health task force report. I do not have the details on the patrols on the Shannon in Limerick, but I can get details on that.

Deputy Tom Neville: My question was general because I know these patrols are happening in other parts of the country. Is there a relationship with these organisations?

Mr. Jim Ryan: In some parts of the country there is but it has not come to me.

Deputy Tom Neville: It is not a formalised relationship.

Mr. Jim Ryan: No, it is not. I can get more information, especially from my colleague, Mr. John Meehan, from our National Office for Suicide Prevention. I can report to the committee on that. That office would have a day-to-day relationship with those organisations. The country has responded in a wide variety of ways to suicide and the threat of suicide. We try to support that within our resources and also in ensuring that the models being used are appropriate and evidence-based.

Deputy Tom Neville: I can back that up. The figure in Limerick has gone from 23 per 100,000 to 15 per 100,000 in the past three or four years. I do not have any evidence of why that is happening but I assume there have been a number of initiatives, including those patrols.

Mr. Jim Ryan: It can be difficult, internationally, to see what one initiative can make a difference. It can be a combination or matrix response rather than a single initiative. The Deputy asked about the money spent in the HSE. I assure the Deputy that all the money allocated for mental health is being spent within mental health services. The Deputy mentioned recruitment challenges and the work of a previous committee, and those challenges remain. We have invested HSE funding in additional undergraduate and postgraduate nursing, and by September 2020, there should be an additional approximately 60 nurses per year. The number will go from 295 this year to 350 next year. That is because we have invested HSE mental health money in paying colleges to put through more undergraduate nurses as well as postgraduate students. We hope that will make a difference because we have many challenges in that regard.

Deputy Tom Neville: Has the recruitment process changed in any way since? We identified the 26 to 29 steps to hire psychiatric nurses, but has any of that process changed? Have any of the recruitment process changed with respect to mental health services?

Mr. Jim Ryan: As a result of much unrest around the process, the Minister of State, Deputy Daly, raised this as a significant issue with us and Health Business Services, HBS, which is our recruitment partner. There has not been enormous change. We have been affected by some of the recruitment issues from the point of view of staying in budget etc. We have tried to streamline the system to the best of our ability while ensuring we remain within the licence we have as a recruitment agency. It is one of the challenges.

Deputy Tom Neville: Could the witness provide a breakdown of those improvements in the process? I am not asking for it today.

Mr. Jim Ryan: Absolutely. I will come back to the Deputy on that.

Deputy Tom Neville: No problem.

Mr. Jim Ryan: There was a question on stigma.

Deputy Tom Neville: From the HSE perspective, what has been done to overcome the challenge with consultant psychiatrists?

Mr. Jim Ryan: Dr. Doody might speak on that. We have had some success recently in recruiting consultants in parts of the country where we previously found it difficult, including the north west and the south east. It can sometimes take six months for people to change life circumstances etc. The committee is aware that the Minister for Health has spoken about the need to look at the differential between the new recruits and existing consultants. The mood music may be changing a little on that. We are also looking at putting in higher support training posts so we can grow consultants over a number of years. It is a little like nursing in that sometimes

we have new developments that essentially denude existing services. We move people around as distinct from increasing a pool.

Deputy Tom Neville: Was there a key factor in recruiting those consultant psychiatrists? Is the issue unique to each candidate? We are trying to find a trend.

Mr. Jim Ryan: Absolutely. We are trying to find a trend. We often say that if one understands one area, one understands one area. For example, if somebody wants to work in the north west, we know the south west is very different.

Deputy Tom Neville: Is it a case of going back to the panels?

Mr. Jim Ryan: Yes.

Dr. Brendan Doody: I echo what Mr. Ryan has said. There has been a major expansion in child and adolescent mental health services, CAMHS, over the past eight to ten years and there has been a significant increase in the number of consultant child and adolescent psychiatrists. On the one hand we are developing new services and creating new posts while at the same time there is a turnover of existing posts with retirements. A number of years ago, many higher trainees left the country to take up employment opportunities abroad. The reality is there is a worldwide shortage of child and adolescent psychiatrists. They are mobile and there are worldwide opportunities. Those who would have been eligible for consultant posts would have most frequently gone to either Australia or Canada. On a positive note, the demand with intake into higher training places in child and adolescent psychiatry is now exceeding the number of places. It will take a number of years before these higher trainees complete training. Basic training takes three to four years and higher training is a further three years. There is going to be a lag with the new consultant posts coming on stream. It is one factor.

Another factor may be geographical and it is across the various disciplines. For recruitment, as can be seen in other countries, there may be geographical as well as service factors. One needs to consider many factors. What may apply in one area may not necessarily be at issue in another.

We are becoming more attractive for external consultants to come and work here. Some consultants who work in the UK may now consider coming to Ireland and taking up posts here. Even in the case of recruitment from recruitment agencies to fill posts on a temporary basis, the agencies suggest that consultants in the UK in locum positions, or European consultants who may have chosen to go to the UK, now consider Ireland to be an option. It will take a number of years before we fill all the posts permanently and it will depend on the demand as we create new services. As we have created more specialist services, we have experienced that the posts are taken up by existing consultants. We fill one post but it creates a vacancy somewhere else.

Deputy Tom Neville: Has there been any change to the panel structures? People are put on panels and the system is quite rigid. Has there been any movement or flexibility in that respect? If somebody has a consultant psychiatry background in treating adults, is he or she able to move to treating adolescents, or is there a blockage in that regard?

Dr. Brendan Doody: To take up a consultant post, the requirement is to be on the specialist register, which is either for the treatment of adults, or children and adolescents. For consultants coming from certain European countries, there can sometimes be an issue with their eligibility to be on the child specialist register. The major divide is between adults, and children and adolescents.

Deputy Tom Neville: To clarify for my lack of medical knowledge, what is the rationale behind that? Is it because the difference between children and adolescent, and adults is such that one must specialise in one or the other?

Dr. Brendan Doody: The training diverges. It is broken down into basic and higher training. The former is generic and for everyone, and at the end of the training one will specialise. The training bifurcates into that for adults and children.

Deputy Tom Neville: How long does it take to specialise?

Dr. Brendan Doody: There are three years of higher training.

Deputy Tom Neville: If somebody was a consultant in adult psychiatry, it would take him or her three years to specialise in child and adolescent. Is that the case?

Dr. Brendan Doody: There are a small number of dual-trained consultants. Such training is done with the psychiatrist's college, which will have specific requirements to achieve the necessary training and expertise in order that the psychiatrist will be eligible to register on the child-specialist register too.

Deputy Tom Neville: I also asked questions about panels and stigma.

Mr. Jim Ryan: Panels are not an issue for child psychiatrists because they are used for specific posts for which one must go through the Consultant Applications Advisory Committee. Nursing panels remain generic. At various times we have tried both local and generic recruitment. The benefit of a national panel is that there is only one panel, while the disadvantage is that somebody might say he or she wants to work only in Limerick or Dublin and may wait until such time as a vacancy arises. Meanwhile, the panel is paused and there are challenges in that regard. We have put in place a structure whereby if a recruiter cannot hire someone from a national panel, recruitment can be made through a bespoke local panel.

Dr. Joseph Duffy: Stigma is very much a live issue in our experience of services. The way we respond to it is by examining the stigma and level of knowledge within different groups. In particular, we work with young people in schools on peer education. Our experience, supported by the evidence, is that peer education is very effective in creating a knowledge base and to encourage young people to connect with other young people. There is a strong peer influence.

There is also a strong influence in the awareness and training provided to adults, whether they are specialists already working with young people or parents working with young people. We do much work with campaigns. A current campaign with one of our sponsors, Lidl, is called One Good Adult and is about promoting the wider initiative. Where we can target, there is good evidence and experience that it is highly effective. The difficulty is in generational shifts and changes.

While young people who are involved, educated and aware have much more knowledge, and their parents are beginning to have it, there are also groups within the wider community where, at times, there may be difficulties. As an anecdote, when we were establishing another office for a Jigsaw service, we encountered a difficulty with a landlord who did not want there to be a mental service, although we tried, brought the tenants to another service and did everything we could. In many ways, we can address stigma where it is clear or obvious with a wider group, which is successful, but pockets of it remain. It is a continuing issue but we invest many resources. Much of the work we do with any of the fundraising sponsors is on awareness raising.

Chairman: As is the custom in committee meetings, I will call members first before calling Deputies Ellis and Buckley, who are in attendance.

Deputy Anne Rabbitte: I thank our guests for their presentations. I will break up my questions into three sections. What constitutes a team for youth mental health and how many teams are there?

Mr. Jim Ryan: There are 71 child and adolescent mental health teams. A Vision for Change states there should be 13 members on a team. Approximately 60% of the 71 teams have 13 members and, therefore, we are not at full membership.

Adult teams comprise approximately seven individuals. The professionals who are represented on the teams are consultant psychiatrists, non-consultant hospital doctors, nurses, social care workers, occupational therapists, speech and language therapists and psychologists. There is a broad range of therapeutic, medical and nursing staff.

Deputy Anne Rabbitte: The report to which I referred earlier states the HSE quarterly performance report for January to March 2019 shows that all but two of the nine community healthcare organisations, CHOs, fall below the target of a 100% response rate to acute CAMHS referrals, with the service in Connacht and Ulster especially well below target, at 54.6% and 29.6%, respectively, for the CHOs covering the region. Does that relate to the teams? Will Mr. Ryan explain that commentary?

Mr. Jim Ryan: The Deputy may recall that the Minister of State, Deputy Daly, sought to explain an emergency response. If a young person is referred to CAMHS and his or her condition is deemed an emergency by the team, there is a target of 72 hours by which the young person will be seen. The target arose as a result of a particular development a number of years ago. While we provided the figures the Deputy quoted, I have some concerns about their validity and will have to revert to the committee on them. We expect 100% of young people in an emergency to be seen within the period outlined.

Deputy Anne Rabbitte: It is clear that geography plays a part. A child in an emergency in Connacht or Ulster will not receive the same response or support that he or she would in another part of the country. Is that a fair reading?

Mr. Jim Ryan: It is a fair reading but, unfortunately, it does not do justice to the people working there, especially in Galway, as the Deputy will know. That is why I have a difficulty with the veracity of the figures and have challenged them in recent days. I will need to revert to the committee on the matter. I need to come back to everybody on that because it might be a little bit about how people have defined what an emergency is. For example, a person might be referred in an emergency but when he or she is assessed by the team, his or her case might not be regarded as an emergency. Something else might be going on.

Deputy Anne Rabbitte: I suppose that brings me back to the first question I asked. We have been told that 60% of teams are fully and adequately staffed with the complete cohort of 13 people. How many of the teams in the Connacht-Ulster region are fully staffed?

Mr. Jim Ryan: I am not sure offhand. I can get that information for the Deputy.

Deputy Anne Rabbitte: Would Mr. Ryan mind sending that information into us? It is important.

Mr. Jim Ryan: I will of course.

Deputy Anne Rabbitte: I would also like to ask about the disability side of the mental health issue. How is the integration going on, particularly for young people who present with issues relating to CAMHS, ADHD and Asperger's syndrome? As the witnesses are probably aware, approximately 200 young people were on the CAMHS waiting list in Galway. There was a complete overhaul 12 months ago. Now there is a disability element. They were put over to the other side. Have the 200 people who were moved to disability from CAMHS, which they had been on to begin with, been seen? What is the update on that?

Mr. Jim Ryan: Dr. Doody might comment on this matter as well. CAMHS is a secondary care mental health service for young people with a moderate to severe mental illness, as distinct from somebody who might have a disability and a mild mental illness. We have to be very clear about how we manage our services. Primary care services deliver for people who have mild mental health issues and may have some disability issues. Our CAMHS teams deliver for people who have moderate to severe mental health difficulties. That is how we try to differentiate between the two cohorts. As Dr. Doody said earlier, approximately 2% of the young population will require CAMHS at any stage. We have to ensure the teams we have are available and able to meet the demand from that 2% - not from those who may have a mental difficulty but do not meet the CAMHS criteria. We have invested in other interventions like primary care psychology and in Jigsaw and many other non-governmental organisations to make sure there is a primary care response and a more universal response to those who may need to be seen in a secondary care situation. Dr. Doody might like to comment on mental health intellectual disabilities.

Dr. Brendan Doody: I will speak about the teams and the staffing. A Vision for Change recommended that areas with a population of 50,000 should be supported by 11 clinicians and by two support administrative staff. As an average of 25% of people are under the age of 18, there are 12,500 young people in each of these areas. As Mr. Ryan has said, the number of teams has increased to 71. Although not all of the teams would have the full 11 staff members, all of the disciplines would be recommended on them. It was recommended in A Vision for Change that there should be two psychology posts, two nursing posts and two social work posts within each team. I think there is an average of between six and eight people on each team. I do not have the exact figure. However, most teams have close to the full multidisciplinary complement, if not necessarily to the level recommended in A Vision for Change. The priority has been to fill the multidisciplinary complement. Not all teams have the full multidisciplinary complement. There are two issues at stake here: first, whether a team has the full multidisciplinary complement, and approximately 70% of them are at the level recommended in A Vision for Change; and second, whether a team has two psychologists, two nurses and two social workers. That is what was recommended. We have approximately 80% of the number of teams recommended in A Vision for Change, which was 90. Approximately 70% of the teams which are in place have the staffing levels recommended in A Vision for Change. That brings the figure down to under 60%, if that makes sense.

Deputy Anne Rabbitte: All right.

Dr. Brendan Doody: That is the staffing-----

Deputy Anne Rabbitte: With the height of respect, a team cannot function unless everybody is part of the team. That is the definition of a team.

Dr. Brendan Doody: Yes.

Deputy Anne Rabbitte: Everybody must be there and everybody must have a function. Surely everybody has a role to play within the team. There are different levels of sign-off. How can there be sign-off at different levels if there is not a full complement on the team?

Dr. Brendan Doody: I would like to make a point about the way teams have been filled. As I have said, the first priority is to provide a full multidisciplinary complement. Given that A Vision for Change recommended that there should be a multidisciplinary complement, it is clear that certain key disciplines need to have two members present on the team. They are in place in some teams, but they are not in place in many teams. In those cases, there is just one representative of the discipline in question. Therefore, not all services are at the level recommended in A Vision for Change. In all cases, the team has the fully multidisciplinary complement necessary to provide a multidisciplinary response. The needs of children and families who come to specialist mental health services are quite complex. Access to the full multidisciplinary skill mix is necessary to provide an appropriate package of intervention and care. As I have said, the resourcing of services is not of the level that would have been recommended in A Vision for Change.

Mr. Jim Ryan: The Deputy has asked about sign-off. Not all young people who will be accepted for CAMHS will require speech and language services, for example. When they are being assessed initially as part of an overall multidisciplinary assessment, there is a need to ascertain what element of our service they will need. In that situation, ideally the psychologist will be there in addition to everybody else. If we do not have a speech and language service, as is occasionally the case, we might be able to buy it in on an agency basis or we might be able to go to primary care to say we need speech and language assistance. Our teams develop from consultants to NCHDs to nursing staff to AHPs. A consultant is needed to start a team because he or she is the team leader. We are very conscious of the need to have a full multidisciplinary team approach because that is what CAMHS does best, but there are occasions when that is not in place.

Deputy Anne Rabbitte: According to the report I mentioned earlier, in 2017 CAMHS made progress on reducing the number of young people waiting more than 12 months for an appointment. By March of this year, however, increasing demand for services had led to a combined national waiting list of 2,738 young people. This represents both a year-on-year increase and a higher figure than had been anticipated by the HSE. It indicates that the service, in the round, is under continuous strain. When the witnesses speak about buying in support for the services, we must remember that they are talking about emergencies. Anything that is going into CAMHS is acute. It is an emergency. Why are we not buying in support? Could we not have used some of the new funds to buy in support services for whatever part of the team was under pressure?

Mr. Jim Ryan: I would like to make a number of points. The demand for services is continuing to increase. The number of teams has increased from 40 to 70 in recent years. We are attempting to increase the capacity while meeting demand. Part of the challenge relates to the recruitment issue that was mentioned earlier. A consultant child psychiatrist is needed at the beginning in order to get a team. For all sorts of reasons, for example relating to medication, a medical doctor is needed initially. The AHPs work have a significant and important role to play in working with these teams. The Deputy has said that all CAMHS cases are emergencies, but some of them are more urgent than others and we have to try to respond to those initially.

Deputy Anne Rabbitte: I will put a final question to Mr. Ryan before I ask some questions about Jigsaw. How many of the teams do not have a consultant child psychiatrist?

Mr. Jim Ryan: I think each of the teams has a child psychiatrist, either through permanent placements, locums or agency staff.

Deputy Anne Rabbitte: Does that mean that all 71 teams have a head lead?

Mr. Jim Ryan: I do not want to mislead anybody. I will come back to the committee with the details. If somebody is sick or if we are in the process of recruiting, there may be rare occasions when we ask a consultant from outside the catchment area to provide cover.

Deputy Anne Rabbitte: That is okay.

Mr. Jim Ryan: I will come back with specifics, but that is our general principle.

Dr. Brendan Doody: I would like to comment on the waiting lists. As the committee will have seen, the waiting lists are not evenly distributed around the country. The areas that have the most consistent resource available are those which have the shortest waiting lists. As one would expect, it is a question of the availability of teams and of consultants. The key is having the multidisciplinary team in place on a consistent basis, with consistent availability. Issues can arise within teams where there is a lot of turnover of personnel or where there are agency or locum staff in position on a sustained basis. There may be a number of factors involved. In general waiting lists are a resource issue but there may be specific issues relating to a particular area that can explain the variations in waiting times and waiting lists.

Again, to echo what Mr. Ryan said, when a referral comes in it is triaged. A decision is made as to what response is needed and the timeliness of that response. As is clear from the various reports, 50% of referrals are seen within four weeks and 75% are seen within the 12-week framework. Often the issue is that less urgent cases are left on waiting lists. They are being displaced by new, more urgent referrals which are superseding them. I can speak for the Linn Dara service and I know how this happens but I am not saying that young people who are on waiting lists do not have an identified need that requires a response. In the context of fewer resources, such that exist will be taken up by the more urgent referrals which means that those with a less acute need are pushed back and their needs are not met in as timely a manner as they should be.

Deputy Anne Rabbitte: My last question relates to Jigsaw's new projects. Has the project in Tipperary started yet?

Dr. Joseph Duffy: No. The plan is to begin in Tipperary by the end of quarter one next year.

Deputy Anne Rabbitte: Has that deadline not been extended several times? We have been talking about Tipperary for at least the last 18 months.

Dr. Joseph Duffy: There was confirmation earlier this year that Tipperary would be the location for one of the new services and the agreement with the HSE is that it will be in place by the end of the first quarter next year. We agreed that we would focus on the service in Wicklow first. One of the big issues in providing a service, now that the resources are available, is finding premises. That is a big issue for us right across the country. In a number of areas we are finding it difficult to find premises of an appropriate size for an acceptable rent.

Deputy Anne Rabbitte: Does the HSE not have any buildings that could be used?

Mr. Jim Ryan: The Jigsaw service is youth friendly and we want to stay away from HSE buildings, to be honest. The Essex Street service, for example, which is one of the Dublin city centre services, is based in premises belonging to Dublin City Council. It is bang in the heart of Temple Bar, where it is all happening. Young people are reluctant to attend services identified with the HSE but when it is Jigsaw, it has different connotations. We have looked at premises in Tipperary and Wicklow but have not found appropriate buildings.

Chairman: Deputy Chambers is next.

Deputy Lisa Chambers: I have read the opening statements and accept the point that mental health funding has increased. However, there are cases that I have dealt with in my office that are deeply upsetting and which have stayed with me. A number of mental health cases involving young people have shone a light on the lack of services in the community. I refer to the west of Ireland in particular. I am from County Mayo and we do not really have youth mental health services. There are voluntary organisations like Pieta House and other charitable bodies trying to bridge the gaps and provide some level of service. The biggest issue is that if young people are sick after 5 p.m., the only place they can go is the emergency department. If they have mental health issues, are suffering from severe depression or anxiety and are having an episode or a difficult time, the last place they want to go is the emergency department of a hospital. As most people know, most emergency departments in this country are overcrowded, manic and chaotic. That is not the right kind of environment for young people who are ill but that all that is available.

A young girl came to my office who had spent three weeks in an adult mental health unit in Castlebar Hospital. She was there involuntarily. There were no activities and no structure to the day. There was a list of activities on the wall so that if the unit was inspected, it looked as if things were happening every day but none of the listed activities ever took place, apart from a weekly one-hour music lesson and mass on Sunday. That is all that was available. She was not able to leave the facility. It has a small courtyard or garden, no bigger than this room, which is a glorified smoking area. That was all of the outdoor space that she had in the three weeks that she was there. She got out of there only because her parents could afford to put her into private care. She fundamentally believes that she is better now and doing well only because she got private mental health care in St. Patrick's. She felt that if she had been left in Castlebar, she would be in a very different space today. Thankfully, she is doing well and is in college. She is determined now to help others in that situation who cannot get out. She spoke about a culture of sleeping tablets and medication, with no psychological services. If the first sleeping tablet did not work, patients were given a second one two hours later. She said people were left sobbing and crying in the middle of the night with nobody there to show any compassion or to check on them. She described people of all ages with all types of illness in the same small facility with no way out. In a wealthy, first-world country, that is disgusting and unacceptable. This is a HSE facility. A few months ago I was told that everything was fine in that facility, that services were good and resources and staff were plentiful but the girl who came to me spoke about bedclothes not being changed and elderly patients being left untended. She talked about the place having a smell and being unhygienic. This is unacceptable. I am sure that conditions in that facility are replicated right across the country. I have no doubt that Castlebar is not an outlier. It is a fine hospital and provides great services. As Mr. Ryan pointed out, it is not the fault of staff, who can only work with what they have.

I received a reply to a parliamentary question recently on staff vacancies in the mental health unit in that hospital which runs to two pages. A basic-grade psychologist post has been vacant

since 2015 but there is no date or deadline for the filling of that vacancy. There are several vacancies in CAMHS itself, most of which are six months to a year old, if not longer with no final date for those posts to be filled. Clearly the staff that are working there are doing the job of two or three people. I cannot see how that is not the case. How can there be no psychological services within a mental health unit that is treating people who have been involuntarily committed for a number of weeks? How is that even possible? There are no gym facilities, no structure and no place to exercise. If any of us were in such facilities for three days, not to mention three weeks, we would be climbing the walls. The girl who came to me spoke about not being able to sleep at night because of the noise and because there was no way to burn off energy during the day. Patients were wide awake in bed at night. One can imagine the noises in a facility of that nature, where people are stressed and upset and suffering from severe mental health episodes. I do not think I will ever forget the day that lady called into my office. I am still in contact with her but she is one of the lucky ones. She sent me a poem that she wrote but I will not go through it today. She is an exceptionally talented young person. She went on to speak to me about her experience in St. Patrick's, the private hospital that she went to afterwards. She talked of the wrap-around care that she received. There were basic things like the fact that every service user or resident had to get up for breakfast every morning; that was part of being there. There was structure to the day. Bedclothes were changed and patients were made take showers. There were activities during the day like yoga, dance or art. There was positivity during the day. She felt that she was being cared for and given the opportunity to get better. What really upsets her is the fact that people are being readmitted all the time to mental health units. The same people are going back into these units because they have not been given the opportunity to get better. When are we going to change how we deal with this? If one robs children or young people of the opportunity to get better at a young age, what hope do they have in later life? That is not all on Mr. Ryan's shoulders, he is merely the HSE representative today and it is an opportunity for us to ask questions and put those things across, but we need to change how we do things. Perhaps the HSE needs to look to the private facilities and ask how they do it. Of course it will be expensive but the proportion of our health budget allocated to mental health is far too small. We all know this. It is not enough to tell us that the budget has increased since 2012 to over €200 million. That is buttons. It is not working and is not enough. I am sure that Jigsaw will agree. It is on the coalface dealing with it daily. A nice office in Temple Bar is great and it caters for some young people. It is great that it is in the community but we are failing young people in this country and committing them to lifelong mental health issues, as they will not be able to recover. Could we have a bit of honesty from the HSE to the Government about the vacant posts and why they cannot be filled, that it requires more money for mental health services and that this has to be a priority? This is far more important than the next motorway, or extension to the Luas or DART. The most basic thing that a country can do for its citizens is make sure that they are healthy. The saying is "your health is your wealth". If one does not have one's health, one has nothing. Our health service has to be the top priority and at present, the mental health service is the poor relation. We need more honesty, rather than being told that things are great and we are progressing in the right direction. Things are far from good and the Government needs to hear that from those on the front line as when it comes from politicians, it just slides off and does not have the same weight. I do not know what the HSE can tell Hannah. She is not the first individual I have met in those circumstances but she has left a mark on me and by having the bravery to come out and tell her story, she will help others. She is a young woman who is very determined to ensure that the services improve.

Mr. Jim Ryan: I also receive a great deal of feedback from patients who contact my office telling me of their experiences of some of our services. In 1960 there were 20,000 people in

psychiatric hospitals in Ireland. There are now 1,000 acute inpatient beds. We have one of the lower uses of beds across Europe. We have changed the model of care from institutional care to community care. That is challenging as we must ensure that our community services are in place to ensure that the beds that we do have are for those who need them most. I cannot condone the experience of that young woman. I understand that. I have responsibility for the Central Mental Hospital. There are people on the waiting list to come into the hospital from prisons. I understand issues like that on a day-to-day basis.

We have tried to do various things. In Galway last week, for instance, we opened a new 50-bed unit. It is a state-of-the-art unit that had been open for 12 months before being formally opened last week. We have opened units in Drogheda and Cork and have renovated Limerick and Sligo. We are trying to change the way in which mental health services are delivered but it is taking longer than any of us would hope.

I agree about budget and staffing. I am head of operations and obviously, I would prefer that we had more resources. The submissions we make are based on the need, particularly that outlined in our policy document, A Vision for Change. We must also recognise our ability to staff the units we have, and there is a constant issue with the recruitment and retention of staff in the psychiatric and mental health services.

There was a question about what to do during the day when one comes out of hospital. In Mayo in particular, we have a very strong recovery college based in Castlebar. Service users have been involved in setting up recovery colleges, including wellness recovery action plans, WRAPs, and other programmes that they have implemented. That is because we have a relatively small number of inpatient beds and we want people to be in there for the least time possible and we want something for them to plug into immediately when they do come out. We have employed peer support workers and service user leads who have a lived experience of mental illness and who are changing the way in which we are delivering services. I will not sit here and say that the experience that a person has had is anything other than unsatisfactory - I am not just saying that, I believe it personally and professionally - but I must try to work with what we have and to try to change things. I spoke about the budget and the increase in funding. I acknowledge that the budget increase is going from a low base. Mental health has about 6.7% of the overall health budget, whereas the equivalent figure in other countries is 8% or 9% but that is an issue which is above my pay grade. These are points we have made time and again.

I acknowledge what the Deputy said. We are always disappointed to hear when people have had bad experiences of our services. I know the unit in Castlebar and have visited it many times. I often ask myself what would I want if I was in that situation. We are trying to achieve a much better service so that when people are in there - for the shortest time possible - they are helped when they come out and have something else to do. Today, for example, as we speak the Minister of State, Deputy Jim Daly, is launching 30 specialist rehabilitation unit beds we have purchased from outside the HSE in two services in Dublin. We recognise there are those who have been in inpatient units in the long term, who have become institutionalised and who are unable to come out and get into a more meaningful life. We expect that within 12 or 18 months, those 30 beds in those two areas will make a significant impact and a difference. We hope to extend that across the country in coming years. We are making efforts but there are still deficits.

Deputy Sean Sherlock: I thank the representatives for coming before the committee. I do not doubt but that they seek to make a genuine effort to tackle these sensitive issues. A common theme which is emerging here is that of resources. I acknowledge the role played by the former Minister of State, Deputy Kathleen Lynch, in seeking to progress matters, particularly in mental

health, and the challenges she faced in trying to get a greater slice of the health budget assigned to mental health. I understand the constraints.

I will speak specifically on Cork. How many inpatient beds are there in Cork at present?

Mr. Jim Ryan: The Éist Linn unit in Cork is being refurbished at the moment as a high-dependency area is being put in. That unit was built for a capacity of 20. One of the rooms was a double room. This was before my time. There was no high-dependency area, which meant the unit was unable to admit a young person who needed such an area. As a result, they have used two of the rooms to create a space that is suitable for a young person who needs time out and who may need particular treatment for a period. The operational number will be 16.

Deputy Sean Sherlock: That will be the operational number. How many are there now?

Mr. Jim Ryan: I think it is 12.

Deputy Sean Sherlock: Are they at capacity every night of the week?

Mr. Jim Ryan: That is a difficult question, as it is a clinical question. I am not trying to avoid the question.

Deputy Sean Sherlock: I know.

Mr. Jim Ryan: For example, a young person, as part of his or her treatment programme, might be out. It might be better if Professor Brendan Doody, who manages the Linn Dara unit, explains. The previous Minister of State, Deputy Kathleen Lynch, visited Éist Linn and looked at how many young people were there compared with the number it was stated were there. There may be young people out on leave or back home as part of their care plan and so they may not be in the unit on a particular day.

Deputy Sean Sherlock: My motivation in asking is, whether or not there is full occupancy, in an effort to understand the culture that exists within the acute inpatient facilities. I am trying to have some degree of knowledge about the decision-making process whereby a person finds himself or herself in one of the these units. Due to the culture or decision making process, there are situations from time to time when some of those beds are left vacant for prolonged periods when there is clear evidence of a demand for them. I do not have sight of that and Mr. Ryan might not be able to give an answer on it today, but I would be happy to revisit it with him and the HSE at a future meeting. If there is such a demand for services and if it is the case that there are empty beds, there is a disparity that must be addressed.

Mr. Jim Ryan: I will ask Professor Doody to speak on this but for the benefit of members there is a teleconference every Monday morning, chaired by a member of my staff, with the four inpatient units looking at the number of referrals made, their current occupancy and if there are beds available. We examine what referrals have been made across the fours units and then talk to the paediatric hospitals if they have young people in the hospitals who require admission. Every Monday morning, a list is prepared. I know every day, and each Monday in particular, how many young people are in, how many vacancies there may be and what young people will be admitted during that week. Professor Doody might speak about the experience of running a unit.

Dr. Brendan Doody: It is important to bear in mind that the unit in Cork is in a refurbished building. It was not a bespoke build. We had the advantage in Linn Dara of having a bespoke

build on a greenfield site. We configured it based on best evidence and experience from units elsewhere, particularly in the United Kingdom and Northern Ireland. There are two 11-bedded units plus a two-bed high-dependency unit. Our capacity to respond to admissions depends on the acuity of the case mix. It also depends on the availability of our high-dependency unit. For a period last year when it was not available, it severely reduced our capacity.

As a CAMHS unit, we must manage young people with a diverse range of presentations and ages. There are admissions down to the age of 12 years with severe anxiety or depressive disorders. A significant proportion of our admissions to inpatient facilities have quite severe eating disorders. It is about trying to manage, in that open facility, a young person who may be in a very distressed and agitated presentation as a result of the person's mental health and how to provide a safe environment for not only managing and treating that young person but also being mindful of the other young people on the ward and providing a safe and therapeutic environment. That is much easier to do in a unit with facilities such as access to a high-dependency suite, where the young person can be managed for a period until he or she is ready to join the open ward.

Deputy Sean Sherlock: I do not wish to extrapolate too much from what Dr. Doody said or to put words in his mouth, but he referred to Linn Dara versus the Cork facility, Eist Linn. Eist Linn is a refurbished facility.

Dr. Brendan Doody: That is correct.

Deputy Sean Sherlock: Would that come up to the mark as a fit-for-purpose or appropriate setting post-refurbishment for the type of structures he just spoke about?

Dr. Brendan Doody: Again, it depends on the acuity of the cases one can admit at a time. In other words, if one looks at the full range of young people who can be admitted, when we get a referral to Linn Dara we must make a determination as to whether we are in a position to provide safe, therapeutic care to the young person. Obviously, one is looking at staffing resources and the skills of the staff, but one is also looking at the physical environment. That will be a major factor that will have to be taken into consideration. Then one is looking at the acuity of the mix of the other cases on the ward. This is seen across all units. Even though the capacity of a CAMHS unit might be 11 or 12 beds, the ability to admit a young person at a particular point will depend on the acuity because there may be young people who may require additional nursing or one-to-one nursing. A number of factors must be considered when one is looking at being able to admit a young person. Again, it is important that the young person can be managed safely in that environment.

Deputy Alan Farrell resumed the Chair.

Deputy Sean Sherlock: My time is brief and I will refer back to Dr. Doody on the Cork facility at a future date as there are further questions to be asked about it to shed light on, and understand better, the dynamics that inform the running of the facility. There have been legitimate questions in the past about the culture that exists there.

There are 130 individuals waiting more than 18 months for CAMHS assessments in my neck of the woods. If I am reading information relating to interventions correctly, and without putting words in anybody's mouth, the term "resources" is the key. It is preventing children and families in my area from receiving proper assessments. I understand there is a multidisciplinary team and that there are constraints with regard to recruitment and so forth. Has the HSE

examined the multidisciplinary team model with regard to reducing the numbers on the waiting lists in such a way as to redeploy resources from other areas or through outside recruitment on short-term contracts or by ensuring that with proper supervision it might not necessarily have to be a psychiatrist who would make the initial assessment and it could be somebody else under the supervision of a psychiatrist?

The bottom line is that the families I know must be able to get assessments. If we are talking about staving off problems down the line, as Deputy Lisa Chambers mentioned, intervention at the earliest stage is required. That is self-evident, and I am not a physician. It can prevent many problems down the line. Are more imaginative solutions being considered at present to ensure we can get the waiting list down in spite of the capacity and resource constraints?

Mr. Jim Ryan: The short answer is "Yes", and particularly in Cork as a result of three or four years of a number of waiting list initiatives which we have examined. Obviously, staffing is an issue. We have looked at whether a consultant from another area can cover if a consultant is not available. We have also looked at bringing in consultants on agency on locum. The model we have is that a young person is triaged, as Dr. Doody said earlier, but each team will need to-----

Deputy Sean Sherlock: I apologise for cutting across Mr. Ryan but Dr. Doody is saying that 50% are seen within four weeks. I have 130 families waiting 18 months. That is based on a reply to a parliamentary question, which was Mr. Ryan's reply.

Mr. Jim Ryan: Absolutely.

Deputy Sean Sherlock: There is a big gap there.

Mr. Jim Ryan: What tends to happen is that the young person with the greatest need is seen earliest. That sometimes means people who are not the most urgent are waiting longest. I am from Cork and I have spent the most time at home trying to ensure we address those waiting lists. I will be down there again on Friday. We have another way of trying to look at this. There are some things we must address with the current staff regarding trying to do things differently because if one does not have a child psychiatrist, it can impact on one's ability to do the initial assessment.

Deputy Sean Sherlock: What is best international practice *vis-à-vis* the multidisciplinary teams? Is it a flat structure or is it a hierarchical structure whereby the psychiatrist is the head honcho, as it were? Is that best international practice or does it differ in other countries?

Dr. Brendan Doody: Clearly, the teams require a clinical lead. Abroad, there is always a clinical lead on the team. The way the consultant contract is configured is that this role is defined as being that of the consultant. It is also stated in A Vision for Change that the clinical leadership of the team is provided by the consultant psychiatrist. That is the model. The model envisioned and reflected in the consultant contract calls for the consultant to be the lead clinical role.

Deputy Sean Sherlock: I will follow up with Mr. Ryan. We might have a meeting in Cork in respect of services there.

Chairman: On Friday, absolutely.

Deputy Denise Mitchell: I thank the witnesses for their opening statements. I wish to

touch on what Deputy Sherlock was talking about with regard to waiting lists. What is the average waiting time for a young person to access services?

Mr. Jim Ryan: I do not have that information with me. I can tell the Deputy what the waiting list is across every one of the 70 teams, but I do not have an average. I will come back with that information, if that is all right.

Deputy Denise Mitchell: Would it be possible to forward information on the average waiting time and the longest waiting time? I would appreciate that. Mr. Ryan's opening statement mentioned e-well. Could he tell us a little bit more about that?

Mr. Jim Ryan: It is a six-week cognitive behavioural therapy, CBT, programme that our psychological primary care side is looking at. It is an add-on to our current face-to-face service. If a young person or an adult is on a waiting list, it may be possible in advance of his or her appointment to offer e-mental health initiatives, in other words, e-well or e-CBT. Jigsaw is working on this in its services. We are doing that in our own services and through Turn2me and BeLonG To. We are piloting this with several external organisations to monitor the uptake. This will take some time because not everyone is comfortable doing this online. However our experience is that young people access their information online much more than my generation did. We have to address that. Social media is seen as one of the difficulties we face but it may also be a solution to some of the issues we face. As members will know, the Minister of State, Deputy Daly, has been leading that agenda. I will send the Deputy specific information, but that is the general gist.

Deputy Denise Mitchell: When do we expect it to be rolled out? Is there a timeframe?

Mr. Jim Ryan: We are looking at early 2020. We have to go through a pilot process. All of the concerns that arise in a one-to-one appointment with a counsellor must be built into any online service.

Deputy Denise Mitchell: Is this replicating Jigsaw's-----

Mr. Jim Ryan: I do not think so, but the Deputy is correct in that we have to be careful about funding a variety of different online initiatives. Our experience is that young people access resources in a way over which we have no control anyway. They will go online and look at *SpunOut.ie*, Turn2me or something else. They could access an American or Australian service or any one of a variety of different options. We are trying to ensure that what we are delivering is evidence-based and backed up by proper clinical governance.

Chairman: Presumably it is a unique product in Ireland.

Mr. Jim Ryan: It is, but with the way the world is now, we find that people access online counselling from a variety of different sources. It is a very fractured market. We are also working with videoDoc, which provides online counselling through video link. That consultancy is doing that anyway. Aviva and VHI are looking at this because it is a way of delivering services to people in their own homes at a time that suits them and without placing them on a waiting list.

Deputy Denise Mitchell: I would like to ask Jigsaw's representatives two questions. Dr. Duffy's opening statement referred to the supports needed to upskill those who work directly with children. One bit that stuck out for me was his assertion that only 1% of primary school teachers thought they were adequately trained. What sort of supports do we need and what

upskilling do these teachers need to be able to support children?

Dr. Joseph Duffy: We have been working with teachers for several years. We connected with them through schools that contacted the Jigsaw service to mention a particular pupil or concern. We realised several things. The teachers themselves would say they were trained to teach a subject but found they were teaching the whole person. They are teaching young people, and a young person's ability to learn and participate in class is very influenced by his or her well-being and mental health. In working with teachers and the teachers' education centres, we have been upskilling teachers on awareness of mental health. We have done a lot of work around a concept called "one good teacher". This means a teacher does not freeze on hearing a young person's concerns and knows how to connect with services in the community. We have built skills as well. We have worked with the National Educational Psychological Service, NEPS, and local primary care. We have particularly worked in Meath and we are now spreading that out through a model called one good school, which looks to support teachers, parents and young people. We have had a series of smaller initiatives for a long time. We offer peer education in which young people can participate. They are trained to talk about mental health and they deliver that message to their peers, the other pupils in the school. We have educated parents on how they can support young people. We have looked at this in a very holistic way.

Deputy Denise Mitchell: What are the outcomes for young people who go through Jigsaw?

Ms Sarah Cullinan: We evaluate outcomes for each individual by looking at his or her level of distress when they first come through our door and at the end of our intervention. Our outcomes are really positive and show that our early intervention service really does work. A large majority of the young people coming through the door have greatly decreased levels of psychological distress when they leave the Jigsaw service.

We also seek to help them build capacity to support them when they encounter challenges again in the future. Jigsaw does not set out to eradicate mental health difficulties, which are part of the human condition. Young people will encounter challenges again, in relationships, school or transitions. Part of Jigsaw's intervention is intended to help them so that when they walk out the door, they take some tools and tips with them that will help when another challenge presents itself. Last week we heard from a panel of service users who came to give us some feedback about their experience. One of them spoke about a folder she had built up with the clinician she worked with that included some hints and tips. She talked about knowing her own triggers and being able to remember the things she worked on in sessions with that clinician when things became a bit more challenging and her mental health slipped a little bit. The idea is that service users bring something away with them for when something else presents itself, as it inevitably does in all of our lives. The important thing for us is that the data on outcomes, not just for Jigsaw but internationally, show that an early intervention service really does work in alleviating that stress.

Deputy Denise Mitchell: I wish to touch on the topic of community service and early intervention. In my own area of Coolock, two young lads have committed suicide in the past two weeks. The community is on its knees. Knowing the lads and their families, it is so difficult to hear the cries when sitting in church. Young men are carrying their friends out on their shoulders. When there is a spike like that in a certain area, can resources be put into the area so that these young men and women can talk about things? For parents who are concerned, is there an avenue for services to be opened up in an area when there is a spike in suicide?

Mr. Jim Ryan: Yes. As the Deputy may be aware, we have a service level agreement with

Pieta House, which provides services in local areas. We also have suicide resource officers in each of our areas. When a spike happens in an area, they will know about it straight away and will put services in place. If the Deputy could speak to me afterwards, we can look at that particular area.

Deputy Denise Mitchell: I appreciate that. I thank Mr. Ryan.

Deputy Dessie Ellis: I thank both of the witnesses for their presentations. I represent Dublin North-West, an area with a very high suicide rate. People know about that. It includes Ballymun and Finglas. It is quite a serious issue. I am curious about several things. I refer to the primary care centres that are utilised throughout the country. They help in looking after mental health issues among the youth. The centres are places people can go to engage. The HSE plans to put one on the Church of the Annunciation site in Finglas. I hope that is at a far more advanced stage now. It is badly needed in the Finglas area. What sort of mental health services will be available for young people there and how will the centre work? The primary care centre in Ballymun is working very well. Responses to parliamentary questions indicated that people in Ballymun are waiting between 18 months and two years for psychiatric service for young people, which is a hell of a long time.

We all know the importance of early identification and intervention. What engagements take place with schools? How does that work? The biggest problem is identifying the people involved and the nature of the problem. Are schools the primary source? Is there any other way we can look at it? Within the schools, there are serious problems with cyberbullying that are leading to mental health issues among young people. Is that a primary engagement that the mental health services have?

According to the statistics Mr. Ryan provided, one third of young people are struggling with mental health issues on an ongoing basis, which is a very high figure. Obviously, we need to have the resources there. Dr. Shari McDaid of Mental Health Reform has said that the mental health services are seriously underfunded. We have heard what Mr. Ryan said and we accept they are badly underfunded. I am also very concerned about dual diagnosis in the context of young children in particular. It is an area that seems to cause problems. It does not matter whether it is a young child or someone else who reports to a hospital or otherwise, there seems to be a particular attitude when alcohol and drugs are involved. Many young children now are smoking hash, which is a big problem. I would like to hear how we are dealing with the issue of dual diagnosis.

There are many groups offering help and Jigsaw is one of them. I am concerned at the amount of private funding they have to get. Companies such as Lidl are contributing and fair play to them. However, it shows the deficit of funding from Government for Jigsaw and other groups. We need regular funding so that they do not need to rely on private donations. Obviously, education is the big issue. We need to get to people early and tackle it at an early stage.

In the past, suicides among young people had a ripple effect with one after another. A few years ago in Dunsoghly in Finglas there were three or four suicides of young people one after another. I am glad to hear Mr. Ryan say that the mental health services put in a team and try to focus on getting to those young people. How do they identify and reach out to those young people to try to stop something snowballing the way it did at one stage in my experience?

Mr. Jim Ryan: The Deputy mentioned the primary care services. Child and adolescent mental health services are delivered to primary care services around the country. We are try-

ing to provide services for young people in locations they will actually attend. Young men in particular do not tend to go into HSE-delivered services. We struggle with that. It is a phenomenon all over the world and certainly in this country. I was a youth worker in Tallaght for ten years and there was a group called "the non-joiners". We needed to have a very particular way of working with some young men because they had significant difficulty attending GP practices or anywhere else. That is one of the reasons we partner with NGOs to be able to provide services in a more appropriate youth-friendly way. We do not want a big sign on the road saying "HSE this" or "HSE that" because for some people that is a turn-off.

The HSE provides 94% of funding to Jigsaw. The other funding it has received recently is for very specific purposes, but all the counselling and the 13 sites are funded by the HSE. That has been a significant development in recent years.

We will certainly have a secondary-care mental health service. The waiting list for primary-care psychology is very long in some areas. We have employed over 100 assistant psychologists across the nine CHOs to try to address that issue. We recognise that if we have waiting lists at primary care, sometimes GPs and others will refer to the next available service which will tend to be CAMHS. That means we end up with young people who should not be on our waiting list and who could be dealt with at a lower level.

Dual diagnosis has been an issue for many years. It goes back to the drug task forces of the late 1970s. Is addiction a mental illness or where does it fit? In the drug task force policy and the mental health policy, addiction is not seen as a mental illness. In this city, we have Trinity Court, which deals with people who have both an addiction and a mental illness. We are trying to get to a point where we have a "no wrong door" policy which means that nobody looking for help is turned away because they have an addiction or a mental illness. We try to treat both. That is taking much longer than I expected. Internationally it is also an issue. In most other parts of the world addiction and mental illness are treated the same. In some parts of the country that is the case here. We still have considerable work to do to integrate our services so that the person who asks for help is not turned away because they do not meet particular criteria.

We fund hundreds of groups across the country in the context of both early intervention and suicide. We have to try to manage that because we need to ensure the quality of the services being delivered and the clinical governance behind them is appropriate. That is one of the reasons that in some respects we need a smaller number of larger organisations. When an issue happens in the community, many people will come together, as is the Irish way, and form a group which is very well meaning. However, unfortunately in today's world we need to ensure that is done in an appropriate manner.

The Deputy mentioned schools. While our care is secondary care, some of the stuff we have done includes the Mind Monster campaign, which is aimed at second level school students. We provide posters and people go into schools to support it. It focuses on examination stress, sleep, digital issues and feelings because the feedback we have got from young people, similar to what Jigsaw would have found, is that those are the areas that cause the most stress. Studies show that our inpatient units tend to have less demand in summer when young people are out of school. School is a stressor. I am not suggesting it is stressor for all students, but for some young people it is a serious stressor in their lives. We also have a recharge programme for third level students. We fund interventions in the Union of Students in Ireland, USI. Members may be aware of its report earlier this week that examinations, sleep and alcohol are the three key issues that we have addressed in our programme for third level. We are conscious of the need to do this in schools, but there are many young people who are not in school and we have to try

to help them remain connected as well.

On suicide clusters, this has been a feature of the past. We work with community groups to ensure that the way in which a young person's life is celebrated when there is a suicide is appropriate and does not create a circus of issues that some other young people buy into. We have tried to analyse that and to ensure that the support provided is done through Pieta and in an evidence way that does not create a drama, which sometimes can happen. Priests officiating at funerals have been trying to ensure that they are not another drama for young people to buy into.

Dr. Joseph Duffy: The Deputy mentioned funding for Jigsaw. As stated by Mr. Ryan, the HSE is supportive of the Jigsaw services. From the beginning, we have worked with philanthropy and private fundraising, particularly around innovation. We are innovating around schools and online services. In terms of the research and work we do in the community, we use the funding to develop a proof of concept. There is no evidence base in regard to how we might work with young people and provide information, so we develop that over time. This is how Jigsaw developed. There is real benefit in the community side and the corporate side coming together. They complement each other in terms of managing the work.

Deputy Dessie Ellis: Secondary schools were mentioned. There is also a problem in our primary schools. How do we identify the young people at risk and where is the first port of call for them? It was mentioned that they do not want to go into a HSE service. We have to develop placements and identify those at risk at an early age. We need a continuous programme within our schools, primary and secondary, with perhaps a particular day or week set aside for engagement with the principals, teachers and the pupils on problem areas.

Previously, when a pupil was frequently absent from school there would be follow-up by an educational welfare officer. As far as I am aware, this post no longer exists. This oversight helped to identify children who had problems and needed to be directed towards engagement with services. Consideration should be given to the reintroduction of that service.

In my earlier contribution I mentioned cyberbullying. This matter can only be addressed through engagement with the schools and those affected. There are a few areas on which I think we need to do a bit more work.

Mr. Jim Ryan: The education sector is an important part of the overall work of the group. From a HSE point of view, we work with schools but we have to be conscious of our role and the limits of it. At primary school level, we have to be conscious that they are the experts in the area and they also have the relationship with the young people. What goes on in school will impact in the community and at home. We would be supportive of it, but we need to recognise the role that the education system also has in this area.

Chairman: I thank Mr. Ryan.

Deputy Pat Buckley: I thank the witnesses for being here today and I acknowledge the fantastic work that is being done. The purpose of the committee's work is to identify the gaps that need to be filled. I will be frank, as always. Do the witnesses believe that we have made progress in this area in the past ten years?

Mr. Ryan mentioned consultant-led multidisciplinary teams. I have received information that indicates that no lead has yet been appointed to the HSE clinical programme announced in December 2015. As of September 2019, this clinical programme does not appear on the HSE

website. I have been told that it is now a matter for the HSE service improvement board. In the four years from 2015 to 2019, nothing has been done in terms of dual diagnosis. In regard to the Kiwi model, the New Zealand Government established an inquiry into dual diagnosis, in respect of which six panel members surveyed people about what was needed. Following this, they produced a report and the Government accepted the majority of the recommendations made and agreed with the budget allocations. All of this was completed in 15 months. Are we plodding along here? I have only been a Member for a short time but my background has been in the mental health area for the past 15 or 16 years. It is like Groundhog Day in terms of what is being said and promised, including in regard to recruitment and retention. I have raised in the House with the Taoiseach and the Tánaiste the issue of nurses being trained but not being given a contract by the HSE. We are shovelling snow while it is still snowing. Why are we engaging locums and agency staff at huge expense rather than giving nurses contracts?

There are 700 vacancies within the mental health services. We are training people in mental health but we are not employing them. This does not make sense. A Vision for Change was produced almost 14 years ago and the review of it took almost as long. The Joint Committee on the Future of Mental Health Care also carried out a review of mental health services. Yet, we have not moved forward. There is much talk of a worldwide crisis in terms of mental health. Why is there no plan in place to train, recruit and retain mental health services staff? In the past ten years, only 68 posts in the mental health services have been filled. We face 500 possible vacancies within the next two to three years owing to retirements, which will mean a massive shortage of staff. Capacity was mentioned. We will not be able to do it. In a reply to a parliamentary question, I learned that we have a €19 million underspend on recruitment in the mental health budget. This is ludicrous.

My cousin recently emigrated to the UK because she was not offered a contract here. Many of our emigrants would have liked to have remained in Ireland. They want to work here and to pay their tax in Ireland, where they can remain close to their families. There is no positive news for them. This is not a personal attack on the witnesses. I need to put my views on the record in order that their managers will be made aware of the lack of drive in terms of recruitment. It seems to be a tick-box exercise. We have all heard about fake news. We do not need to go the USA or the UK for it. We sometimes have it in committees. An additional allocation of €55 million was not provided last year to the mental health service. The HSE report launched in the audiovisual room showed a €35 million allocation. Somebody is being spun lies. The witnesses are trying to do their bit but they do not seem to have the proper information, which I find frustrating. I have said that to bake a cake one needs the correct ingredients. There is no point using half the ingredients and expecting the cake to taste the same. It will not happen.

Returning to my original question and following on from my remarks, do the witnesses believe they are restricted? They have spoken about models of care changing and I accept that service demand has increased, not only in the youth sector but also in the disability sector. There is a large ageing population and rural isolation and we are losing general practitioners. Everything seems to be centralised in accident and emergency services and the delegates' services are being overcrowded. We are listening to this time and again, yet nobody in the Government or at the top of the HSE is addressing it. The Government and the HSE should sit down and state they need to come up with a plan rapidly, whatever it takes, and acknowledge that whoever is trained within the service needs to be retained. Staff are retained by offering them a contract. I cannot understand what is happening.

Recently I asked a parliamentary question about CAMHS. I will put it to the delegates. Are

they genuinely satisfied or dissatisfied with the direction CAMHS is taking? There is misinformation circulated on it. The delegates spoke about members of CAMHS teams. Let us say a premier league of ten teams was set up and each had 11 staff. We would not be able to run the league at present because team A has 11 staff, team B has five and team C has nine. Therefore, it would not work in the system.

The demographic issues are known about. Cork is a black spot and there are many others. I will use Cork as an example because I am from there. The demographic data imply that the rate of suicide and self-harm is high. Let us have a pilot project and resource and staff it fully, thus facilitating all those concerned because they all have to work as a team and start to reduce the figures, thus showing that this model works. When one invests in a model that works, it can be replicated throughout the country, thus improving everything. At present, however, the strategy is to try to do everything together, with no plan A. Plan A has been shelved for the past four years and is to be transferred to somebody else's department to talk about it. In the meantime, we are losing nurses and people to suicide, unfortunately. The information we have shows that there are 76 beds and that 23 or 27 were vacant in July. I received that information in the response to a parliamentary question. While the number of beds has increased, the number is only at 75% of the level recommended in A Vision for Change 13 years ago. In reality, if one removes the 23 beds, or the 27, we are only at a rate of 50% under the CAMHS plan. If one stops putting out all of these figures, it makes no difference to those who are trying to gain access to the service. It is a matter of access, as I know from experience.

I was late yesterday because I had to meet an individual in my office about a crisis case during the so-called break. Four times I had to have a young man arrested for his own safety. I will give credit where credit is due in that when I contacted the crisis team in Cork, its response was above and beyond the call of duty and absolutely brilliant. However, it is just one section.

I need an honest answer that management and the Government can hear to the question of what the delegates genuinely believe, 13 years on and having had a children's committee, a health committee, a committee on the future of mental health care and the Sláintecare report which in fairness was produced in very short time. CAMHS is only at a figure of 50% of what is needed. There are 700 vacancies in the mental health service and we face losing another 500 staff in the next two to three years. There is under-expenditure of €19 million on recruitment because we cannot pay, yet we have money available. There is misinformation every year. The original figure was €84 million, of which some €29 million was spent the year before. There was a total of €55 million and the HSE's report refers to €35 million. We are trying to do our best, yet we are back again to phase 1. What is planned for next year? That is my spiel. I am not saying this to pick on the delegates, but I need their management and top brass to ask the Government to stop trying to fix everything in one go and try to proceed properly, giving each service the maximum resources, be they for Linn Dara, Éist Linn or the Jigsaw project in Galway. Squashy Couch was in Galway when I started 12 or 14 years ago. Do the delegates believe services are under-resourced? Is the plan plodding along? Is there genuine drive, bearing in mind that in New Zealand something could be done in 15 months? It came up with a ten-point plan. There is a video which shows what is being done in New Zealand. It is patient centred.

I am here three and a half years. I am sitting in front of some of the same delegates hearing the same thing time and again. We flagged the issue of recruitment three years ago. If the nurses who were trained in the past three years had been retained, we could have 400 vacancies in the mental health service, rather than 700. There have been 700 vacancies for the past three

and a half years and nothing has happened. As an old lady said to me one time, it is like a penance where one gets a bucket with no arse in it and is told to empty the Red Sea with it. One will have a bucket, but one will not be able to do anything with it. We seem to have budgets and nothing seems to be done with them.

What is happening is being misconstrued. This is not to reflect on the delegates. They will take responsibility, but it is their managers with whom I want to deal. I would love to sit down with them to ask them to tell us the truth and whether mistakes are being made. There are mistakes being made, but this is not the platform for addressing them. It will emerge that there are many parts of the mental health service that are not fit for purpose. Deputy Sherlock touched on this issue. Staff are not being disciplined for X, Y and Z, but that is a different story. My priority is to implement a preventive measure. There does not seem to be any joined-up thinking. There is misinformation and we are hearing the same stories. We are hearing them today and will do so again tomorrow. We are told that services are short a few bob. If the delegates outline their position in black and white, we will tell the Government on their behalf. I have no doubt that they would not be in their current positions if they were not passionate about their work. They want to make changes, but they cannot be managers of football teams if there are six on one team and 11 on the next. This puts one team at a disadvantage straightaway. If the disadvantaged team does not receive funding, it will be relegated. Once it is gone, it is gone. It feels the same with mental health services. Even with the best will in the world and everything that takes place, there is no access and people are being turned away. The services are oversubscribed and understaffed and those who require them are told by the staff that they are sorry. This is not a reflection on the delegates. The front-line staff do their best, but my point is that this should go back to head management. The Minister for Health, the Minister of State responsible for mental health services and all of the others should be told the truth, even by text, and that the time for talking is long gone. There is now a different class of politicians who actually give a damn. We are not talking about statistics and percentages but people. The delegates are saying - we have heard from other delegates - that when one person dies, 42 to 45 others are affected directly, fluttering out to 220 odd people. That could be a rural community devastated in just one go and it is happening every day. The WHO's report states somebody dies by or contemplates suicide every 40 seconds in the world. There is a crisis and something is going wrong. Do the delegates genuinely believe we have moved forward in the past ten years?

Mr. Jim Ryan: I have worked in mental health services for over 15 years amd genuinely believe circumstances are getting better. Where is the evidence for this? There were six beds in 2006 for CAMHS and now we have 74. I accept that there are only 48 open. We have 70 teams. While I could trot out any of those statistics, it is much more about how much the way we look at mental health has changed in the past 15 years. We now have a regulator in charge in the Mental Health Commission; we have the Mental Health Act that was implemented in 2006 and reviewed in 2011, and we have A Vision for Change, a policy document that is recognised as one of the most far-seeing in the western world. There are a lot of basic building blocks, but the mental health service was at a very low ebb. Anyone who saw the television programme "Behind the Walls" will have seen what was happening in this country. While things have changed dramatically, we are obviously still on a journey. I am in contact with people elsewhere in Europe who look at what we are doing with service users and cannot believe it. We have a service user on my management team whose sole responsibility is to represent the role and views of service users at national level. No other division has this. We have nine area leads for mental health who are service users, carers and family members. No other division has this. We have forums and peer support workers, while a lot of the things which are needed from a carer's perspective or the point of view of recovery are in place.

On the issues raised by the Deputy, I will try to give some context on the figure of €55 million. Last year there was a figure of €35 million. One will receive €15 million of it in the year and €20 million the following year. That is the reason the figure of €55 million can be confusing at times. I assure the Deputy that it confuses me at times too because I am saying "I thought we got this." The other figure is €89 million which ones gets when one adds items like consultant back pay and annual increases. It is not money that is going into a service. The sum of €35 million is to go into the service. I told Deputy Neville that all of that money was spent on mental health services. I acknowlege that it may not all be spent in the areas for which it was given.

Issues were raised about nursing contracts. In virtually every area of the country there are nursing deficits. We have a process whereby if someone leaves, the head of area informs me and it goes to the national director to be signed off on. If a nurse leaves, we have never prevented that nurse from being replaced. We try to provide contracts for nurses who are graduating. We will have an extra 60 graduating in 2020 with mental health service money that we have spent, not education money. That gives a figure of 350 which will go up to 420 in the following year. We hope it will address some of the gaps. I am conscious that we have new developments every year and we try to fill them. They can sometimes create gaps in the services in which they arise. It is a churn and can be a question of catch-up, but I assure the committee that that is the rationale behind the figure of €55 million. I am involved with the Central Mental Hospital and we are offering permanent contracts to graduates as we will need them to open the new hospital in 2020. If a person wants a nursing contract, he or she will get one.

Our difficulty at times is with allied health professionals, AHPs. When we try to balance our budget and activities, we have to be cognisant of the resources allocated to us. While the Deputy is right about it being above my pay grade, it is to be open about it. I have to be straight and say each year we advocate on behalf of mental health services. We put together a business case for additional funding which has been allocated. At times, we have struggled to spend the money in the areas for which it has been allocated. Dual diagnosis is one such area, while early intervention, psychosis, perinatal, mental health and intellectual disability are other niche areas where it can be difficult at times to recruit specialist staff. Sometimes the staff who take on those posts come from our core services, which means that a deficit is created back at base. It becomes one of the circular difficulties.

There are a lot of things about which we do not talk in circumstances like this and it can become demoralising for people who work within the system because they hear a great deal of negativity. However, when we speaks to many service users, they will tell us that things are improving. While, as Deputy Lisa Chambers said, facilities nationally are still not as good as they should be, we have made some progress. In order to keep going one must believe things are improving. For example, over €10 million has been invested with our NGO colleagues in Jigsaw each year from HSE funds. We do not make a big deal out of it because that is how it is, but sometimes people say we are not doing anything. The fact is we fund organisations without having our name hugely up in lights. People can then become confused, but they do not need to. It is about delivering the service. It may be our service on which we are working with our partners, but it does not matter as long as people benefit from it.

Ms Sarah Cullinan: The question the Deputy posed was whether anything had moved on in ten years. If Jigsaw has one message for the committee, it is about early intervention. As Mr. Ryan said, ten years ago there was no such thing as early intervention use of the mental health service. As such, we have come a long way. I will not borrow the old phrase about-----

Deputy Pat Buckley: I acknowledge it totally. I respect the delegates' honesty which is what I want as I need people outside the realm to know that they are not being fully supported either. They want to do it. The Chairman will laugh and my wife will kill me for using this line, but "prevention is better than cure". We are a reactive society and have to change to become a preventive one. That is why I acknowledge all the work being done by the delegates. I asked the specific question in order that the delegates could make an appeal for more to do what they have set out to do.

Ms Sarah Cullinan: Absolutely. The discussion and questions have been reflective of the focus we, as a nation, have had on the more acute end of the spectrum which is important and needs to be resourced. As has come though in the discussion, acute services are overstretched. As a nation, we need to move our thinking and resourcing upstream. That is the key message Jigsaw has. I am always loath to make parallels with physical health because mental health is different and there are complexities to it. However, as a country, we would not countenance a system which did not have a comprehensive primary care structure for physical health. We would not countenance a system that did not have a vaccination programme across the board. While we have made lots of progress and are delighted to have Jigsaw services with HSE support, for which we are very grateful, we are only operating in 13 communities. We want to operate across the board. We need to do more than just offer the services we now offer.

The Deputy asked whether the systrem was under-resourced. As was pointed out, the mental health service remains the poor relation in the overall health budget. While the early intervention service is coming along, it is still the poor relation in the overall mental health budget. The figure referred to of approximately 33% of young people could seem to be overwhelming. One might wonder how we would ever meet the needs of those young people. However, we know from our work in Jigsaw that many of them will never need to attend a specialist service if we put adopt a comprehensive prevention and early intervention approach. Some of it can be online and some of it can be in their own community. They might never need to cross the door at Jigsaw if we were to empower and equipp parents, teachers, sports coaches and scout leaders, for example. Some people will I hope have their needs met through online supports, with information and guidance, group chat and one-to-one services. While some will need to come through Jigsaw's doors and some will obviously need specialist services, the key message is about getting in as early as possible. If we have a comprehensive approach to early intervention, it will best support the overstreteched acute end of the system.

Dr. Brendan Doody: As clinical director of services for over 13 years, I can speak about what is happening on the ground. On the one hand, one looks at the positives. We have invested in a new purpose-built community service based in Cherry Orchard. In that building we officially launched last month our specialist community eating disorder service. It was the first such team and a second is to start in Cork as part of the clinical programme for eating disorders. We have established a specific ADHD pathway team within our service. In the west Wicklow-Kildare area we cover the service has four teams, where once there was one and we hope to develop a fifth. We had an inpatient unit in 2006 with six operational beds. In 2015, we opened our brand new bespoke inpatient unit, which has won architectural design awards. Visitors from abroad have been very impressed by it. What means more to me is the feedback from young people and families. The Deputy has visited the unit, and seen that it is all single en suite bedrooms. We have a sports hall and a gym, attached school and parent accommodation. All of these are important.

They are the positives. The frustrations, however, are that our teams are not at the full

complement. Some teams have the complement of disciplines but not the numbers. Other teams are not at the full multidisciplinary complement. Some of this is due to lack of funding for new posts, some to staff going on maternity leave or leaving to take up posts elsewhere, and to delays in refilling an approved post when somebody leaves. There can be a significant gap. It is frustrating that we cannot provide the right level of service. There are much pride in the progress that has been made and frustration that we cannot deliver the service. Families are very appreciative of the service but it is important for that response to be timely.

On the inpatient side, we strive for maximum capacity in our unit. The way it has been designed has facilitated our capacity. Since we opened, we have averaged 80% to 90% occupancy but there have been times when we have not reached that level. That may have been for case mix reasons. At one point we had to close half of the unit because of staff shortages and we are running with significant vacancies within the inpatient setting. We require additional funding to fund new posts to build the teams up to the recommended level. The other frustration is that we are running vacancies where the issue is not funding but difficulty recruiting particular specialties.

We are involved in the planning of the inpatient unit in the new children's hospital, which will be under our governance. It will have an eight-bed specialist eating disorder unit and a 12-bed unit. That is another 20 beds. Ten beds will come on-stream in a low secure adolescent unit which is part of the redevelopment of the national forensic services. We are compromised because we do not have access to a low secure facility for those who have a high level of acuity and need that kind of environment for their care. If we have to manage such young people in open hour units, that will affect our ability to leverage services for others. The frustration on the ground is that, although there has been progress, it has not been at the level or speed we would like. Some of that is a funding issue, some not. Some time ago we were apologising to families for the facility; now we are proud of showing them the unit and the physical environment. The environment, however, is only one part. We need the staff to deliver the service. We need all those levels. Staff also feel the frustration at not being able to provide the level of service that we would wish to.

Chairman: On behalf of the committee, I thank the witnesses for their presentations and for so forthrightly answering the questions. This meeting is adjourned until Wednesday, 9 October when we will continue to discuss this subject.

The joint committee adjourned at 12.45 p.m. until 10 a.m. on Wednesday, 9 October 2019.