DÁIL ÉIREANN

AN COMHCHOISTE UM CHÚRAM MEABHAIRSHLÁINTE SA TODHCHAÍ

JOINT COMMITTEE ON FUTURE OF MENTAL HEALTH CARE

Dé Céadaoin, 18 Aibreán 2018

Wednesday, 18 April 2018

Tháinig an Comhchoiste le chéile ag 1.30 p.m.

The Joint Committee met at 1.30 p.m.

Comhaltaí a bhí i láthair / Members present:

Teachtaí Dála / Deputies	Seanadóirí / Senators
John Brassil,	Máire Devine,
James Browne,	Frank Feighan,
Pat Buckley,	Colette Kelleher,
Marcella Corcoran Kennedy,	Gabrielle McFadden,
Seán Crowe,	Jennifer Murnane O'Connor.
Michael Harty,	
Gino Kenny,	
Tony McLoughlin,	
Tom Neville,	
Fiona O'Loughlin,	
Anne Rabbitte.	

I láthair / In attendance: Deputy Eugene Murphy.

Seanadóir / Senator Joan Freeman sa Chathaoir / in the Chair.

Business of Joint Committee

Chairman: As we have a quorum, we shall begin our meeting in public session. Apologies have been received from Deputy Catherine Martin. Members are requested to ensure that for the duration of the meeting their mobile phones are off as they interfere with the sound system. I propose that we go into private session to deal with housekeeping matters. Is that agreed? Agreed.

The joint committee went into private session at 1.39 p.m. and resumed in public session at 1.43 p.m.

Mental Health Services: Discussion (Resumed)

Chairman: I welcome Dr. Aileen Murtagh, who is a child and adolescent consultant psychiatrist with St. Patrick's Mental Health Services. She is accompanied by Ms Carol McCormack, who is a clinical nurse manager with St. Patrick's Mental Health Services. Mr. Michael Walsh and Ms Sonia Magaharan, both of whom are clinical nurse specialists working in child and adolescent mental health services, are also in attendance. I am delighted they are here today. I thank them for taking the time to come to this meeting of the joint committee. I thank Mr. Walsh and Ms Magaharan, in particular, for travelling to Dublin from Cork and Wexford, respectively. The witnesses will be invited to make a brief opening statement, which will be followed by a question-and-answer session.

Before we begin, I would like to draw the attention of witnesses to the situation in relation to privilege. I ask them to note that they are protected by absolute privilege in respect of the evidence they are to give to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to a qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given. They are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person or entity by name or in such a way as to make him, her or it identifiable. I remind members and witnesses to turn off their mobile phones because such devices cause havoc here. Mobile phones interfere with the sound system and make it difficult for the parliamentary reporters to report the meeting. They can also have an adverse effect on television coverage and web streaming. I wish to advise the witnesses that any submissions or opening statements they have provided to the committee will be published on the committee's website after this meeting. I invite each of the witnesses to make an opening statement, beginning with a representative of St. Patrick's Mental Health Services.

Dr. Aileen Murtagh: I am a consultant child and adolescent psychiatrist with St. Patrick's Mental Health Services. I formerly worked as a consultant with the HSE's child and adolescent mental health services, CAMHS. I am accompanied by Ms Carol McCormack, who is a clinical nurse manager in Willow Grove adolescent inpatient unit. We welcome the opportunity to respond to the committee's invitation to provide information on the operation of adolescent mental health services at St. Patrick's Mental Health Services, which consists of three approved centres with a total inpatient capacity of 293 adult and 14 adolescent beds. Community mental health services are provided by a network of Dean Clinics in Dublin, Galway and Cork. The service works to provide the highest quality of mental health care, promote mentally healthy

living, develop mental health awareness, advocate for the rights of people who are experiencing mental health difficulties and enhance evidence-based knowledge.

The 14-bed Willow Grove adolescent inpatient unit provides specialist multidisciplinary evidence-based care to young people between the ages of 12 and 17. It accepts referrals nationally and offers intensive inpatient management for a range of severe mental health difficulties, including mood, anxiety and psychotic disorders, often with associated suicidality and self-harming behaviour. There are specific eating disorder recovery programmes for anorexia and bulimia. Young people may have associated neurodevelopmental difficulties, including attention deficit hyperactivity disorder or autistic spectrum disorder. Each young person has an individual care plan which is reviewed weekly by the multidisciplinary team and discussed with the young person. This ensures there is an individualised and person-centred package of care. Service quality is assessed through annual inspections by the Mental Health Commission and the quality network for inpatient CAMHS. In September 2017, electronic health records were introduced to the adolescent service. In the national context, the 2016 annual report of the Mental Health Commission highlighted 68 admissions of children to adult units in 2016. The shortage of operational beds in dedicated child units was a contributory factor in this regard. There were 76 registered beds in HSE child units, 66 of which were operational. The recommendation in A Vision for Change, based on population data from the 2011 census, is that there should be 118 child and adolescent inpatient beds. Each year, a small number of children are sent by the HSE to the UK for highly specialised inpatient treatment which is currently not available in this country.

A part-time adolescent community service in the Dean Clinic in Lucan offers outpatient care to young people between the ages of 12 and 17 who have mild or moderate mental health difficulties. This services offers assessment and a range of evidence-based therapeutic interventions, including cognitive behavioural therapy, supportive psychotherapy, psychiatric review, pharmacotherapy, family support, dietician advice, occupational therapy and a psychology skills group based on dialectical behavioural therapy concepts. There is also a subspecialist outpatient service offering assessment of gender identity. In addition, there is an adolescent Dean Clinic in Cork offering psychiatric input and individual cognitive behavioural therapy. All referrals are reviewed by a consultant psychiatrist on the day of receipt. The inclusion and exclusion criteria that are in operation are based on expertise and available resources to ensure our service meets the needs of young people. Due to the demand for our service, there is usually a waiting list in operation and it can vary in length in accordance with service demand. The current waiting list for the Dean Clinic in Lucan is three to four months.

A new system of nurse-led prompt assessment of need by means of telephone triage was introduced earlier this year to signpost the most appropriate service for adolescents. We have observed a number of recent trends. Some GPs are concurrently referring to local HSE CAMHS and St. Patrick's Mental Health Services outpatient services to request a service from the organisation that can offer the most rapid appointment to an adolescent. As a result of this increased number of referrals, young people who are admitted to paediatric medical beds can remain there for extended periods of time - sometimes weeks - while a suitable inpatient mental health bed is awaited. When public inpatient units are at capacity, CAMHS outpatient services may refer concurrently to public and independent inpatient units in the absence of private health insurance, with the HSE indicating a willingness to fund admission to St. Patrick's Mental Health Services. We have noticed an increase in HSE-funded inpatient admissions to Willow Grove, particularly in the last year and a half. In St. Patrick's, the Changing Minds Changing Lives Strategy 2018-2022 envisages an expansion of the Willow Grove adolescent service to 20 inpa-

tient beds, development of a comprehensive day programme and enhancement of the work of the adolescent Dean Clinics. We hope this information is helpful and we are happy to answer any questions.

Chairman: Thank you, Dr. Murtagh. I ask Ms Sonia Magaharan to make her presentation. Is Ms Carol McCormack going to speak?

Ms Carol McCormack: No.

Ms Sonia Magaharan: Good afternoon Chairperson and members of the committee. I thank the committee for the invitation to attend this meeting. I work as a clinical nurse specialist in the north Cork child and adolescent mental health services, CAMHS, area. For anyone who does not know that catchment area, it includes from Charleville at the border with Limerick to Mitchelstown at the border with Tipperary to Millstreet at the border with Kerry to our border with Waterford. I have been working in the field of child and adolescent mental health for the past 34 years. During that time I have worked 18 years in the United Kingdom, two years in Australia and the past 14 years in Ireland. During that time I worked within three inpatient adolescent units and in five CAMHS teams in Ireland, England and Australia. I have been working for the past four years in the north Cork CAMHS area, which has a population of 94,000. I am the chairperson for the Forum in Ireland for Nurses in Child and Adolescent Mental Health, FINCAMH. We are a group of specialist nurses who meet a number of times a year to discuss issues of practice, education and development in child and adolescent mental health. Our mission statement is to promote the knowledge and interests of nurses in child and adolescent mental health services and to increase their profile and self-awareness for the benefit of the nurses and the service users. As a clinical nurse specialist in CAMHS, I work directly with children, young people and their families. I am responsible for managing a caseload. I carry out assessments, provide evidenced-based therapeutic interventions and work as part of a multidisciplinary team.

I came today to talk about the strengths of the team and the gaps that I see in the services. Those are the issues I would like to cover. Regarding the strengths of the CAMHS team in which I work, we work as a multidisciplinary team, which, for anybody who does not know that term, means we have a range of disciplines available to work with our clients. We carry out joint assessments. We provide a range of individual interventions and also group activities such as behavioural management parenting groups, dialectical behaviour therapy, emotional regulation groups, mind and mood groups and adolescent parenting groups. These groups all run on a regular basis throughout the year. As part of our work, we liaise and network with other agencies such as the autistic spectrum disorder, ASD, team; the adult mental health service; Tusla, which is our child protection service; national and secondary schools within and outside the region; educational welfare officers; the National Educational Psychological Service; special educational needs co-ordinators; and the regional and national hospitals.

I will outline some of the challenges we currently face in the CAMHS team in which I work. As I explained, there is the vastness of the geographical area we cover, given the population size. A Vision for Change recommends there should be two CAHMS teams to a population of 100,000. At present we have one incomplete team for a population of 94,000. Children who present with a possible attention deficit hyperactivity disorder, ADHD, are most likely placed on a routine waiting list as older adolescents are often presenting as emergencies with deliberate self-harm, eating disorders and psychosis. As a result of this, children sit on a waiting list which risks their difficulties becoming more entrenched and, therefore, they are not reaching their social, emotional and academic potential. Medical paediatric consultations are frequently

required to clarify the physical health status of some children with mental health disorders. Lack of resources and waiting lists in those services have a knock-on effect on our diagnosis, intervention and can also impede discharge. Currently, children who have ADHD and are on medication are unable to be discharged due to a lack of a care pathway that meets their needs appropriately.

We have an absence of a hospital-based liaison team. During the 14.5 years I have been in posts in this area, there has been no liaison team. A Vision for Change recommends one team per catchment area of 300,000. A liaison team would provide cover to paediatric, general and maternity hospitals. National recruitment is unhelpful due to a lack of communication between the local level need and the national level recruitment drive. There is a time lag due to the processing of candidates and a mismatch between candidate's skill and the needs of the team. There is a lack of transparency for candidates about which team they will be placed in. Currently, the recruitment process gives neither the team nor the candidate an opportunity to prior information or knowledge. Currently in the CAMHS team in which I work, we have insufficient physical space for clinical intervention, waiting areas and staff offices. We have four clinical rooms available to a staff team of 10.5 clinicians. Rooms have to be booked or we are unable to see the clients. All staff should have appropriate experience, apart from college placements, prior to commencing in CAMHS, or if staff come in as a basic grade, they need to be under the direction of a senior clinician of their discipline that is based on-site.

Opportunities for training and continuous professional development are inequitable between disciplines placed on teams. Again, these do not always take into account the skills needs of the wider team. Children with both an ADHD and ASD query tend to sit on both a local CAMHS and an ASD team waiting list, despite both conditions being neurodevelopmental conditions. There is a high comorbidity between these conditions. We have no computerised system for collecting data, which prevents us from planning effectively for our client groups. We have insufficient administration support. This leads to clinicians using valuable clinical time to perform administrative duties such as sending out letters, reports and appointments. For the past four years in the north Cork CAMHS area we have had one full-time administrative officer. We were recently granted another administrative officer in November but on a temporary basis.

In terms of possible solutions, there is a need for two complete CAMHS teams to cover the catchment area that could be geographically located to best meet the needs of the client group and make more efficient use of clinician time. Currently, we are travelling across the region to provide satellite clinics. Access to the service by children with ADHD needs to maximised through the provision of a specialist neurodevelopmental team, which could consist of a paediatrician, CAMHS and ASD clinicians, as is the case and is working successfully in the UK. This could incorporate a nurse-led service with an advanced nurse practitioner, which would allow for children with ADHD on medication who have completed all other CAMHS intervention to be discharged to this nurse-led team. Discharging children is important for both the psychological well-being of both the child and his or her family. This also improves capacity for intake, improves staff morale and job satisfaction. In the UK, teams have a primary mental health worker, or workers, who is not discipline-specific, but is a senior clinician. Their role is to offer consultation to general practitioners, schools, on adult mental health, and to Tusla, our child protection service. They also take on the role of interfacing with all of the agencies that refer to CAMHS to ensure referrals are appropriate and engage in preventive work and consultations with referring agencies. These clinicians do not carry a caseload. Preventive and early intervention work is essential to build resilience in young people and parents. It needs to be done at community level in order that referrals to CAMHS will be reduced in the long term.

This can be addressed by supporting community teams, recognising the importance of infant mental health and psycho-educational groups for the parents of children who have commenced school. The service we offer should aim to improve the child's or young person's life chances by reducing and preventing comorbid acute mental health problems such as anxiety, depression and self-harm, thereby reducing the risk of family, social and educational breakdown and allowing a child to reach his or her full potential.

There is no national strategic plan for CAMHS. We need a five to ten year vision for the service. We also need to use technology in assisting with the diagnosis of attention deficit hyperactivity disorder, ADHD. The computer based QbTest is used successfully in the United Kingdom and within other CAMHS teams in Ireland and has improved the efficiency of the services. We do not have access to it within the Cork CAMHS team.

Chairman: I thank Ms Magaharan. That was very informative.

Mr. Michael Walsh: I thank the Chairman and committee members for giving me the opportunity to give an account of what it is like to work on the front line of child psychiatry and to highlight the issues that will face us in the future. I am not representing the Health Service Executive, HSE, and my address to the committee is without prejudice. I am a clinical nurse specialist in south Wexford CAMHS. I have spent the past 25 years working in CAMHS, the first 15 in the north east, serving counties Cavan, Meath, Monaghan and Louth, and the last ten in Wexford. In that time I have watched CAMHS teams develop throughout the country , from seven nurses nationally in 1993 to approximately 120 working in community CAMHS teams today. The number of CAMHS teams has grown from zero outside Dublin in 1993 to 69. When I speak about teams, I mean the teams recommended in A Vision for Change in 2006 - one team per 50,000 head of population, consisting of one child and adolescent consultant psychiatrist and, under the direction of this consultant, one junior medical staff member, two psychologists, two social workers, two clinical nurse specialists, one speech and language therapist, one occupational therapist and one social care worker. That gives a multidisciplinary team of 11 staff, which also requires one secretary and one administrator. This skill mix is a must to adequately address the clinical needs of the varied and very complex clinical presentation of the children we are asked to see.

There is a population of approximately 80,000 in my area of Wexford south. We do not meet and have never met the standards in A Vision for Change. We have one child and adolescent consultant psychiatrist, although we should have two for a population of 80,000; two clinical nurse specialists where we should have three; one psychologist instead of four; one basic grade social worker instead of a principal social worker, plus two basic grade social workers; one occupational therapist and 0.5 of a speech and language therapist where we should have one operating full time; 0.5 of a social care worker where we should have two.

We operate on a clinical need basis; urgent referrals are seen as a priority. Routine referrals are placed on a waiting list to be seen. Ours is a very hard working and committed creative team, like all CAMHS teams across the country. We get involved in projects in the community, set up groups to enhance treatments such as parenting groups for ADHD, activity groups and dog walking groups, to mention just a few.

The role of the child and adolescent health team is to assess and treat children at the severe end of the scale such as those with early onset schizophrenia, depression, anorexia nervosa, ADHD and severe anxiety. During the years many children and families have benefited from our input.

As a team, we struggle every day to overcome many obstacles, including being under-resourced; having poor accommodation which is not fit for purpose; having no consultant cover for consultant leave; difficulties in recruitment and the retention of staff and having no ability to facilitate the training of student nurses. The accommodation at Slaney House is substandard and not fit for purpose. A review of the building in 2006 pointed to 25 issues that needed to be addressed to bring the building up to standard. Some of these issues were first addressed in 2015 when it received its first coat of paint in 14 years. The building was a residential house and it is neither clinical nor child friendly. Five staff members share one room measuring approximately 6 m by 4 m. There are no facilities to carry out physical examinations which are necessary to start clients on medication. Accommodation was to have been secured in 2017. October 2017 was the move-in date. We were all very excited at the prospect of having more rooms to provide therapy, engage in group work and the possibility of developing a full child and adolescent mental health service. There was also the possibility of developing a day programme to support clients who could not be given an urgent hospital bed or clients who were not attending school owing to illness and those in need of a greater therapeutic input. We were informed by management that the proposed building was to have another tenant, but it could not inform us who. That was the last we heard about being given suitable accommodation.

The second problem I experience as a front-line worker is that of having no consultant cover. Our consultant child and adolescent psychiatrist is entitled to his leave, like the rest of us, but he is the clinical lead for the team and takes full responsibility for all of the patients who attend the service and their treatment. When he is on leave, there is no replacement; hence no new referrals are examined and no new clients are seen. As per An Bord Altrainis and the standard operating procedure, I, as a nurse, cannot see clients without a clinical lead, nor can the junior doctors. To work safely within my scope of practice, planned reviews must be cancelled during this time. For seven years I have been bringing this issue to the attention of management at all levels, including sending the reason children needed to be seen to them via email. Some children have been admitted to Wexford General Hospital for a week or more as a result of there being no consultant cover where they spent their time without any therapeutic input. However, that problem has changed in the past six months as an out-of-hours adult psychiatrist provides an assessment and treatment for the children admitted in the absence of a proper hospital liaison child and adolescent team as per A Vision for Change in 2006, that is, one team per 300,000 people.

My direction from management in the absence of a consultant child and adolescent psychiatrist is to work within my scope of practice and contact management should a child require a consultant assessment. It took two weeks the last time I needed this facility for a child who needed an urgent assessment. It required several requests by me before it was followed up. As a nurse, it is very frustrating to listen to distressed parents who are seeking help for their sick child when I cannot offer the service I offered the previous week. We lose the trust and credibility we work so hard to earn by not being able to offer a service. The parents tell us that there is no consistency in the service. As research has shown, consistency is the basis of all therapeutic interventions. This is not to mention the frustration of general practitioners who telephone CAMHS seeking a service during the consultant's absence. As a nurse on the front line, I should be able to go about my work without having to look for a consultant. I have received numerous calls from upset parents owing to cancelled appointments.

Most of the consultant child and adolescent positions in the country are filled. There are 69 teams, but, to the best of my knowledge, 35% of the consultants are locums, posts filled by agencies. As the committee heard from previous speakers at this forum, it is difficult to find

child and adolescent consultant psychiatrists owing to the two-tier salary scale. However, consultants on agency rates receive the same salary as, if not more than, the permanent consultant. Therefore, it does not make sense to have a two-tier system. My reason for bringing this to members' attention is that nurses who wish to progress and become acting nurse practitioners or wish to take the nurse prescribing course cannot do so in 35% of CAMHS services as the consultant is required to work with the nurse in taking the said course. Hence, a failure to provide a permanent child and adolescent consultant psychiatrist is preventing nurses in CAMHS from progressing on their career pathways.

On the recruitment of nurses to CAMHS, in Wexford south CAMHS we cannot take student nurses as there is not enough room in the building. We cannot offer consistency in that we may not have consultant cover for the period of the student placement. The knock-on effect of taking no students is no exposure to child psychiatry; hence nobody trains in the access module to child psychiatry. One nurse took the course two years ago and there has been none since from the south east. Some of the students who in the past sought placement in CAMHS are now working in London. They have informed me that they are well remunerated for their work, with accommodation packages and access to training courses such as nurse prescribing and family therapy. When asked whether they would return to work in Ireland, their answer was a very clear "no". They said they had already been treated badly following their qualification when they were given 85% of staff nurse wages.

Following discussion with my colleagues from around the country, many are reconsidering the positions they hold in CAMHS. Some have already left and are going to Canada, Australia and Britain. Given the deals nurses are being offered elsewhere, it would be hard to refuse, considering that we treat our newly qualified as "yellow packs" by offering them substandard wages. Even if we were to provide 500 more places in nurse training each year for the next three years, how many would remain in the country? Given the poor working conditions, poor pay and the fact that they are totally undervalued, there is no incentive to stay. In 1999 the commission on nursing made provision for nurses like me to stay in a clinical role and not to move into management. My colleagues and I endeavoured to educate more nurses in CAMHS, but owing to our working conditions, this was not possible.

Children seen by GPs are referred to CAMHS in the absence of a properly resourced primary care psychology, autism or disability service. Wexford autism and disability services have a two-year waiting list, while Wexford primary care psychology services have a two-year waiting list. These services do not work on clinical need, but CAMHS ends up receiving more referrals as a result. Our nearest inpatient hospital is over 200 km away in Éist Linn in Cork. It is not the case that when a child presents with a significant suicidal risk we can send him or her directly to Cork. It is often the case that the child is kept at home by the parents and monitored on a daily basis by CAMHS. Access to a bed may take three to four weeks. Sometimes, if the child's condition deteriorates and he or she cannot be managed at home, he or she, as has happened in a number of cases, is admitted to the department of psychiatry in Waterford. It is an adult psychiatry facility and no place for a child. While there, a child is confined to a room on his or her own, accompanied by a psychiatric nurse and not allowed out of it during the hours the adult patients are moving around the facility. It is my opinion that this simply contradicts what is in "the best interests of a child".

We are all here to look at how best we can provide a service for those less fortunate than ourselves. In my case, these are the children between the ages of six and 18 years who suffer from a mental illness. Children commit suicide. There were 70 children of schoolgoing age

who took their own lives last year. This does not account for the children between 16 and 18 years who were not at school. We have a long history of not looking after the most vulnerable in society, from the Tuam mother and baby home, to Artane, the Magdalen laundries, Letterfrack industrial school and Wexford, where we had the Ferns and Monageer reports, to mention just a few. We are again letting down the most vulnerable children in society.

We need A Vision for Change to be completed. We need nurses to be paid at therapeutic grade level to keep them in the country. We need a hospital liaison service and consultant cover. We must realise that if we treat children with psychiatric problems when young, the vast majority will not need treatment as adults. We need to stop embargoes on the recruitment of front-line staff. Perhaps the embargoes should be placed elsewhere. Those who manage the services should be held to account. In a therapeutic role, if we are doing something that is not working for a child, we must stop and come back with a different idea. The management system where I work seems to be doing more of the same when it is not working. CAMHS should have an input at management level. We also need access to emergency beds for children. The Constitution states children should be cherished. It is our duty to implement this right and look after children.

I thank the committee for listening to my submission and welcome its work in forming a direction for mental health services in looking after children in the future.

Chairman: Did Mr. Walsh say there were 70 suicides last year of schoolgoing children?

Mr. Michael Walsh: That is the report from the National Educational Psychological Service.

Chairman: That is just absolutely shocking. I thank all of the delegates for looking after children. I know that they are doing the best they possibly can in the circumstances. There are four members offering who will have seven minutes each in which to ask questions. They are renowned for keeping to that limit and I am renowned for being very cross if they go over it. As all members are anxious to ask questions, I ask the first four to keep to that limit.

Deputy Tom Neville: I express my gratitude to the delegates for coming before us to share their experiences of working on the front line. Their presentations have been educational. I have had a number of questions for management in the past few weeks and months but have found it very difficult to get answers to them. The testimony has filled in some of the grey areas. I appreciate the contributions of the delegates as a member of the committee but also personally. Everybody has different expertise and mine is in the clinical area and on the business or management side. Will the delegates tease out the recruitment matters? It was indicated that the national recruitment process was not connecting with the local process. If I remember correctly, candidates being screened were not being informed or matched specifically with teams. Will the delegates flesh it out? We are finding the big anomaly is in recruitment and that there has been a push-back by management, which states it cannot find certain staff. I worked in recruitment for eight years. Mr. Walsh correctly referred to innovation within management and having to change things if they were not working. We know the definition of doing the same thing again and again while expecting a different result. Recruitment is fluid.

Mr. Walsh also referred to the commission on nursing and how it discouraged people from going into management. Will he explain this a little more in order that we might be able to draw some correlations? I was unaware of it. He spoke about escalating to management proposals on how to improve matters, as have the others who presented. What type of engagement was

forthcoming from management when the delegates took the time and made the effort to use their expertise to propose efficiencies or improvements? What was the process and was there any feedback? Was anything put in place?

Chairman: There are a good few questions. Perhaps the delegates might give us answers that are as succinct as possible?

Ms Sonia Magaharan: I will answer on recruitment based on my experience. I worked in the UK where recruitment is all done at local level. Here we have panels where someone may be interviewed for a panel and may sit on that panel for year. They will not know where a job will arise or when and they will never see the place in which they are to work prior to starting. I interviewed in the UK as part of my role. One would not be called for interview if one had not made an informal visit. The interviews are done at local level by a local CAMHS team so a candidate will get to see the place and the people prior to working there. How can we send people in to do jobs when they do not know where they are going to work? They will not know if they are to work in a cupboard under the stairs, or the people with whom one will work. One needs to know the people with whom one will work. An interview is a two-way process and in Ireland we have a problem in that we think it is only one-way, that the employer has all the rights. It should be 50:50 with the person who is coming for the job. We are talking about transparency. If we want people to commit to being in a post long term we need to treat them respectfully. Recruitment needs to be done at local level. Candidates need to get to see where the vacancies are and the teams with which they will work.

Mr. Michael Walsh: The Deputy asked what kind of response I got on escalating the difficulties I was experiencing up to senior management. Senior management came down to the office and asked why I was escalating it up to them. There have been several times when a child was in difficulty and in need of an assessment by a consultant. I can think of one such case when a child needed to be seen by a consultant on a Friday evening; it was late, and I escalated it. To my knowledge, it had been escalated to senior management three days earlier. That Friday evening, I received a phone call asking why I had escalated the case and on Monday morning a manager arrived in my office asking the same thing. I was asked who I thought I was to contact senior management and that I should cease that practice. It is difficult when one is on the front line and can sometimes be left holding the can.

Deputy Tom Neville: Was Mr. Walsh given a reason he should cease that practice?

Mr. Michael Walsh: It was because the person I contacted on that occasion had been at an executive meeting and he informed the rest of the executive that there was a difficulty in CAMHS. It came back down the line and they asked me what the difficulty was and I told them. When that person arrived, thankfully it was recorded in the notes that it had been reported on earlier in the week but had not been acted upon.

Deputy Tom Neville: Were there any consequences as a result of this? Was there any accountability?

Mr. Michael Walsh: No, but that is only one incident. I have constantly emailed and phoned. These are the kids in Wexford who need to be looked after.

The commission on nursing was in 1999. Nurses were leaving the country in droves then. Ms Justice Mella Carroll put forward the commission on nursing. That looked at different routes for nurses to take within the profession. Some people went out to management, the clini-

cal nurse manager grades CNM 1, CNM 2 and CNM 3 were developed, there was the clinical nurse specialist and then there were acting nurse practitioners. Acting nurse practitioners are only coming on stream now in psychiatry. I did not wish to be in management and wanted to stay in clinical practice. Becoming a clinical nurse specialist allowed me to stay in clinical practice.

Chairman: We are way over time. We will come back to Deputy Neville at the end.

Senator Jennifer Murnane O'Connor: I welcome the witnesses here today. These are the conversations we need to have. I firmly believe in talking and awareness. The World Health Organization identified mental health as one of the most important public health issues to promote, protect and invest in. We are not doing enough. I agree with the witnesses. I constantly hear about waiting lists, lack of resources and the barriers to access. Funding and recruitment are the biggest issues.

Last November, 2,223 children were on the HSE waiting list for child and adolescent mental health services. There are families who are living in a nightmare, they are doing their best but they are also affected. In situations where children and adolescents are left waiting, how can we help the wider family cope? Can we put something like a virtual waiting room in place where families can receive support from CAMHS? There is such a waiting list that there needs to be something available in the interim. Providers have told me that the first port of call for families in distress needs to be strengthened. Families are often referred to psychiatric services when there might be an alternative. That is another issue on which the witnesses might respond to me.

Should GPs be given tools to deal with less urgent cases? Often people are left on waiting lists for lengthy periods when other avenues could be examined rather than compel them to be referred by their GP.

On the age limit for CAMHS, does the service continue until the 18th birthday when an adult service kicks in or is it at 17 and a half years, when an adolescent can fall between two stools? I have seen some cases recently where that has happened.

My other question relates to my area of Carlow and Kilkenny. I have been asked this and I do not know the answer. When a child or adolescent displays disturbing behaviour, is there a facility in my area for them to be taken into? Information has been circulating but I want to clarify this. There are not many places nationally but can the witnesses tell me if there are any places in the Carlow Kilkenny area?

I am familiar with a case where a doctor has made four referrals to CAMHS, but the person in question did not meet the threshold. When a doctor refers a patient to CAMHS and they are refused four times because they do not meet the criteria, can the witnesses explain this? I think thresholds should be examined. Can the witnesses tell me more about that?

Is it the case that there are only 69 beds for minors in the whole country?

I am aware of four minors in the south east who are in adult wards because there are no suitable beds. I am very concerned about this.

Chairman: The Senator has asked a lot of questions.

Senator Jennifer Murnane O'Connor: I have one more.

Chairman: The Senator only has seven minutes.

Senator Jennifer Murnane O'Connor: Are the witnesses aware of the self harm intervention project, SHIP, programme for the south east?

I thank the witnesses for their time. I know the hard work they do. Mental health is such a massive issue. Most families are affected by it. The services and funding will be crucial. We are all trying to help everybody as best we can.

Chairman: I thank the Senator. Before I ask the witnesses to respond, there are questions that they cannot answer.

Senator Jennifer Murnane O'Connor: That is fair enough. That is okay.

Chairman: They are from Wexford and Cork and they will not be able to answer about services in Kilkenny or in Carlow.

Senator Jennifer Murnane O'Connor: They can answer as best they can.

Chairman: I also want to remind members that this session is about the witnesses' lived experience as members of CAMHS. I am sure they have great ideas about how we can improve things but today we need to focus on their experience.

Mr. Michael Walsh: Nationally, we have a standard operating procedure, SOPs, manual which guides us in what we see, where we go and what we do. As part of that, every child in the country is supposed to be seen up to his or her 18th birthday. From that point, it is recommended that they are referred on and there should be a six month lead in to being referred on to adult psychiatry. That does not happen because many adult psychiatrists will not accept referrals from CAMHS.

On Carlow-Kilkenny and someone struggling emotionally, unless that child has a working diagnosis of a mental condition they cannot be contained in any particular psychiatric unit. To my knowledge there is no psychiatric unit in Carlow-Kilkenny that looks after children. The only one is Cork.

As I said in my submission, sometimes a child who has received a diagnosis and is acting out and is difficult to maintain can be sent to the department of psychiatry which is an adult facility. That is fundamentally wrong.

The question of referral by a GP and what meets a threshold is one that arises every day of the week. We have a problem insofar as we do not have a primary care psychology service. There is a two year waiting list, and in some cases it is a four year waiting list across the country. The psychology service has been under-resourced for years. They do not have the psychologists. I know there is talk of perhaps 200 assistant psychologists coming on line, but that is a long line. We will be a long time waiting. We have heard of buildings and staff coming, but that will not happen. When there are no primary care psychology services, we end up as the gatekeepers, taking all the referrals from GPs. The GPs are very frustrated, they do 90% of all the referrals for every condition across the country, working on 4% of the budget. It is difficult.

What meets criteria? We are the end of the line as regards mental health. We are looking at early onset schizophrenia, depression, anorexia nervosa and severe anxiety. We are not talking about what some people would refer to as "soft psychiatry" where somebody needs to discuss things and would benefit from counselling. If a child had a substance misuse, they would go to

somebody dealing with substance abuse. In doing a referral, the GP would have to do a mental state assessment and see how big a risk the child was. If that is the risk, one makes a phone call and there is a discussion on it.

Chairman: I thank Senator Murnane O'Connor for excellent timekeeping as well.

Ms Sonia Magaharan: It does happen sometimes that referrals do come back in again. We would have an average of 40 to 50 referrals per month to our CAMHS team. That is what we have had for the past five months. Some of those referrals will be inappropriate referrals as they do not meet the threshold. We would contact the GP and have a conversation. We have a standardised referral form that the details come in on, sometimes there are gaps, where the section of the form has not been completed, but we will pick up the phone and explain that in order for the client to be screened, we need more information. We also send out what we call forms to the parent and to the child, if the child is an adolescent. We get their details as well before a decision is made whether it is appropriate or not. The screening process is quite detailed, but if we had somebody coming back two or three times, we would be on to the GP and asking what is actually going on. There is something that is not right, if the person is coming in four times and feeling he or she is falling through the drains.

Senator Jennifer Murnane O'Connor: Between the drains.

Ms Sonia Magaharan: I spoke about the importance of working alongside GPs and the people on the front line. We need workers to do that.

Chairman: I call Deputy Harty.

Deputy Michael Harty: I thank the witnesses for coming before the committee to give their evidence. I am a GP as well as a TD, so I have an understanding of the difficulties in the child and adolescent mental health services.

Are many referrals inappropriate to CAMHS? It seems to be the default referral option because there are a lack of counselling and psychological services in the community. The default position is to refer a child or an adolescent to CAMHS, even though we may feel it might not be the most appropriate referral to make. There is a lack of talk therapy and counselling in general practice and in the community.

Second, is there a lack of integration in services because we have GPs, CAMHS, NEPS, Tusla and voluntary organisations? It would be ideal if there was a one stop shop, where one could have a filtering mechanism to decide which is the most appropriate place to send a child. I do not think the psychiatric services are necessarily the appropriate services for many children. Will the witnesses comment on that?

Is there a computerised system where one could have integrated services where one could identify the most appropriate location for people to go to? In the programme for Government there is a proposal to introduce mental health well-being into the junior certificate. Are the witnesses aware of that proposal? Will it happen?

Are the front-line staff in CAMHS involved in HSE management structures to guide them on the best pathway? Quite often decisions are made which make no sense to those who are on the front line.

Chairman: Who will answer that? I invite Dr. Murtagh to respond.

Dr. Aileen Murtagh: I worked in CAMHS for years prior to my current post. Certainly my experience was that CAMHS was very much the default position. I was lucky enough to work in one CAMHS area, which was at one stage,relatively well resourced in terms of other community services. This is in contrast to the UK, where there is a tiered approach and often young people would have been to one, two or sometimes three services before being referred to CAMHS and many intervention assessments would have already been carried out. Let me give an example of what is happening in CAMHS. I worked in another area, where there was no primary care psychology, so that cases which probably would have been much better served by primary care psychology services were referred directly to CAMHS. I never worked in an area where there was a local autism spectrum disorder, ASD, team so it led to a great many referrals for ASD assessments for young people without comorbid mental health difficulties. It is quite stigmatising for young people if they are referred to a service which is envisaged to provide a service for severe mental health difficulties when an ASD assessment is the primary need.

In terms of the lack of integration of services, currently we would work with a number of young people who are involved in a number of different services, it might be CAMHS, Tusla, inpatient services and I think there are more meetings of professionals being held to try to integrate these services. It is like the two Luas lines joining up. It is about integrating service, collaboration and working together in the best interests of young people.

Chairman: We will probably get back to Dr. Murtagh. Dr. Murtagh said she worked with the HSE, and she is working with St. Patrick's Mental Health Service. She must see a very wide disparity between the two services. I will call Dr. Murtagh later, if that is okay.

Ms Sonia Magaharan: In response to the question on the integration of services, we have actually set up a system where we meet every six weeks with our ASD service to discuss our joint cases. As I said in my submission, there is a high comorbidity for ADHD and ASD and I think we need to look at integration. The Chairman makes a valid point on integration. I actually think some of these services should be joined up. We have a paediatrician from the North who is coming on Friday to speak to our team. In the United Kingdom, some 50% of ADHD cases are seen by the paediatrics service. They are treated, diagnosed, and managed by paediatrics, whereas in the Republic of Ireland, it is all managed by the child and adolescent mental health service. We need to look at other ways of providing services, such as neurodevelopmental teams, where we can deal with ASD and CAMHS. We need paediatric staff on those teams, because these children often have other conditions as well. We need a wraparound service. Currently what is happening is that children may be coming to CAMHS for ADHD, they are sent down the road for ASD and then in the meantime they may be referred on to the paediatric service for certain screeners. I have a child who has been waiting 18 months currently for an endocrine screener before we can actually treat the child. Our hands are tied. We cannot do an intervention because we do not know what else is going on for him. We need to do things differently and integration is really important.

Mr. Michael Walsh: I thank Deputy Harty for his question on the involvement of CAMHS in the management structure of the executive. From the point of view of CAMHS in the south east, the answer is no. We do not have any input into the executive meetings, the vast majority of the people who sit at the table on the executive are adult psychiatrists but the adult manager, child psychiatry does not have a seat at that table. I think we should have because how is one supposed to develop a service if nobody knows what one is trying to do? We do not get a budget from year to year. We do not know what the budget is for child psychiatry from one end of the

year to the other. If I were running a business I would like to know what my budget for the year is and how I could plan and develop that budget.

Ms Magaharan talked about the QbTest. I could have a QbTest taken and reduce the number of children waiting because I could have it done ASAP in order that I would provide a better service.

Deputy Michael Harty: Is there a view among the delegates that, because there is not an adequate service provided, medication is overprescribed at the expense of talk therapy and psychological services?

Mr. Michael Walsh: That is a very relevant question because that is the debate in child psychiatry all the time. We deal with illness. As Ms Magaharan said, sometimes GPs must treat illness as it presents. A child I saw last week was so far down she needed something else to get her out of the hole. Talk therapy would not have taken her out of it; she needed something in the nature of a medication to bring her up. Sometimes that happens. When someone is brought back up, it is easier to provide talk therapy. The gold standard in the treatment of ADHD is behavioural therapy and medication. We argue and discuss among ourselves, with patients and parents what will work. The patients and parents have the final say. We do not make that call. It is between the parents and the child.

Senator Frank Feighan: I thank the delegates for their submissions. I will come at the matter from probably a different angle, that is, staffing and capital development.

The delegates said they needed A Vision for Change to be completed. What are the outstanding aspects that need to be completed?

We talked about nurses. The issues they face constitute a huge challenge across all sectors. We see members of the Army and the Air Corps signing up as pilots. We are losing nurses to other areas. What can we do that will be effective? It is very frustrating that people are trained to a certain level and then, because of market forces, they move away. What exactly is therapeutic grade?

We face a huge difficulty in the appointment of consultants. Most come from the United Kingdom. There was a pay cap. Do the delegates know how it affected the the appointment of consultants? I know that it had an effect in some places and there was no way around it. It was something for which everyone was calling when the country was effectively broke, but it was introduced without any flexibility. Is it having an effect? Capital projects and providing new buildings are the least of our problems; it is how one staffs them. I found that if one employed people locally in other professions - let us say, for one facility - their career prospects would be somewhat limited. I refer to a local hospital, Roscommon University Hospital. In the Saolta group we could not find nurses, doctors or, especially, consultants. We brought them in under the Saolta group. The group employs everyone in counties Galway, Mayo, Roscommon, Donegal and Sligo and it seems to have worked a lot better, but the delegates are probably saying there is also a need for flexibility.

I must again raise a legacy issue in County Roscommon. If the delegates know it, they will know that the mental health services are not fit for purpose. Five years ago there was a €20 million investment and the provision of an endoscopy unit which cost €7 million or €8 million. We have the rehab unit for the west and an eight-bed palliative care unit. We wanted to go straight back out and effectively build a brand new mental health service. We were waiting

six months, but they came back and said no and told us that it would inconvenience staff and patients. However, five years later, after all of the various developments, people are calling for a new building. As a politician, I am really frustrated that we could not receive the co-operation of the HSE, as it has cost us millions. We have built the endoscopy unit and are now trying to build around it. When the funding was available, we just could not receive co-operation and I do not know who to blame.

Chairman: I do not think either Mr. Walsh or Ms Magaharan would be able to comment on the last issue about which the Senator talked, but I also sense his frustration. Do Dr. Murtagh or Ms McCormack wish to have an input in response to the other questions posed by the Senator?

Dr. Aileen Murtagh: On the outstanding issues related to A Vision for Change, the document was based on a different population base. It has not been fully implemented. As a bare minimum, it needs to be implemented. In particular, it is a matter of looking at investment in community services in the first instance to ensure all of the recommended CAMHS teams are available and fully staffed. My colleagues have highlighted deficits which I have also experienced. These days families are much more informed. When they come to services with a young person with OCD, they know that cognitive behavioural therapy, CBT, is an evidence-based approach and ask for it. They are very well aware of the deficits within the team. It is, therefore, a matter of staffing and putting resources into the community teams in the first instance, certainly in liaison psychiatry. I worked in liaison psychiatry in one of the few such services in the country. On the whole, we were discharging young people from medical beds the next day - it is not the most appropriate placement for a young person with mental health difficulties - once they were medically stable, whereas if there was no psychiatrist available, a young person might have had to wait in a paediatric bed for quite some time in the absence of a mental health assessment to inform the medical practitioners that it was actually safe to send the young person home.

Another area at which to look that is really helpful is the day hospital, as it gives timely access to young people in crisis. There are very few day hospitals in the country. The one that was in Dublin is now shut and unavailable. Because of this sometimes there is nowhere else to send an acutely unwell young person where CAMHS is not sufficient to meet his or her needs and he or she needs a more intensive service. If there is no day hospital available for a young person in his or her locality, he or she will attend inpatient services which puts more pressure on and blocks capacity in them. Conversely, when one is discharging a young person, one wants to minimise the time he or she will spend in an inpatient unit. However, if there is no step-down facility available in a day hospital, he or she might actually remain in an inpatient unit for an extended period because the gap in intensity between CAMHS and the inpatient unit is huge. It is really a matter of looking at investment in community services, as well as the additional 100 beds envisioned in A Vision for Change to meet the needs of the population at the time. We probably need A Vision for Change for children and adolescents alone.

Mr. Michael Walsh: To go back to Senator Frank Feighan's question about nurse training, we are training nurses for export. In this country we have treated nurses terribly in recent years. Their wages were cut between 2011 and 2015 to 85% of staff nurses' wages. This caused many nurses to leave the country and they are still leaving. They are being trained here but going out the door the minute they have been trained. They are not even waiting to gain experience. One would normally wait for six months to gain experience, but they are leaving in droves. It must be said the packages in England are very good for anyone who wants to further his or her career. If I were 21 years old again and had just started training, I would be out the door. I would take

a prescribing course and a family therapy course. I would have a list of courses to take, but that is not possible here.

The other issue raised was the cap on consultants' pay. Yes, it has had an effect, but consultants are still being taken on by agencies. Some 35% are sent into the area of child psychiatry. As they are still on the same rates as permanent consultants, it is not making any difference. I do not see why they are not put in place and paid properly, the same as their counterparts. As has been said, consultants are leaving the country in droves. The situation does not make financial sense.

Ms Sonia Magaharan: I have experienced consultants leaving the country. Over an eight-year period my team had lots of vacancies and I worked with 11 consultants. We worked with probably one of the most vulnerable client groups because we looked after children who had mental health difficulties and an intellectual disability. The children and their families were the most vulnerable people because they had no voice and no service stability.

Chairman: Does Ms Magaharan mean there were 11 temporary consultants during the eight-year period?

Ms Sonia Magaharan: Yes, 11 temporary consultants. Some of them were only in post for a four-week period.

Chairman: For heaven's sake.

Mr. Michael Walsh: Such a situation is not unusual. In north County Dublin there have been 35 consultants over a six-year period. The statistics are available and prove that the situation is nothing new.

In order for a service to progress one needs a consultant who will stay and a plan of operation that he or she can implement. If a consultant only has a contract for six months or a year then he or she will not remain on and will have no interest in developing the service. Why would he or she put all of his or her energies into the job? Consultants spend most of their time arguing with management for the proper development of the service and securing safe and proper buildings in which to see patients as opposed to seeing children.

Chairman: As we have reached the end of the first part of the meeting, we will now open up the debate to the rest of the members. I call Deputy Buckley.

Deputy Pat Buckley: I thank the witnesses for coming here today and, in particular, I thank Ms Magaharan and Mr. Walsh for their honest presentations. I have been a member of a lot of committees and conducted a lot of research on this matter over the years. I can honestly say that the submissions supplied by Ms Magaharan and Mr. Walsh have left me feeling very upset. The system is absolutely shocking, disgusting and disgraceful and the staff who work in the sector have been treated like dogs. I have never heard so much honesty as I have heard today. I cannot believe that people had to wait 14.5 years for a liaison team.

It is 2018 yet Mr. Walsh has said that he cannot offer the service he offered the previous week and they lose the trust and credibility which they work so hard to earn by not being able to offer a service. Jesus Christ, does this Government listen to anything? I have never been so upset in my life. We are supposed to help the most vulnerable in society but they have been kicked around the place. I have a number of questions but I will concentrate on this matter. I admire the courage shown by Ms Magaharan and Mr. Walsh. I do not want to put them on the

spot. However, I will ask them two questions that they can choose not to answer. The truth must be told. I detest box ticking exercises and making up excuses that staff cannot be got and posts cannot be filled, talking in percentages and that one place is oversubscribed but people cannot be moved from A to B to fill vacancies in another team. The witnesses must have found it very difficult to come here because the powers that be batter people who tell the truth.

How do the witnesses feel about this meeting being televised? Can they honestly describe, without prejudice, their working environment and culture? I have read research material on the health sector for over 14 years and every time one comments somebody responds by spreading misinformation. I feel honoured and proud to be here today to hear the testimonies expressed by the witnesses because we must hear the truth. I am black and blue from approaching Ministers and telling them what does not work and asking for staff. We know why staff cannot be recruited because the Government will not pay them and give them self-worth. The witnesses hit the nail on the head when they identified the problem as the amount being spent on agency staff. I have spoken to the Irish Nurses and Midwives Organisation, INMO, about the matter. As much as €2 million a week is spent on agency staff. It will cost €1.2 million per year to fix the gap generated from 2011 to 2014, inclusive. Is there a political will to do so? No. Who is responsible? The last Government and the present one. I do not want the problem to persist on my watch. The people present and their colleagues deserve more. I cannot understand why the Government has not realised that prevention is better than cure. What will people do? To use a medical analogy, the Government waits for problems to fester and simply applies a bandage rather than a cast at the very start.

Chairman: I thank the Deputy for his comments.

Deputy Pat Buckley: The state of the service angers me and I apologise for my outburst.

Chairman: No need. The Deputy has merely reflected what most people are thinking.

Deputy Pat Buckley: Yes. I am so angry.

Chairman: I ask the witnesses to reply.

Mr. Michael Walsh: I thank Deputy Buckley for his comments. I feel his pain every day of the week as do the patients and parents who I look after in south Wexford. They are screaming for a service and are at their wits' end. The Deputy asked what is it like for us to be here today. I can tell him that it has been an arduous journey. If I got as much attention in the past ten years as I did in the past week from senior management then I would have a massive service and be very happy.

Normally, out of courtesy, I would have forwarded the invitation from the committee to attend here today to my managers. They took it as their own invitation. As part of that, they tried to suggest that they were going to send somebody to accompany me here today. I believe, as a citizen of the State, that would have meant I was being impeded in some way, was not allowed to speak freely and did not have free will to speak. I came here with great trepidation today for fear of losing my job in the future but I know a lot of people who want help. I feel the only way, after the past ten years, to help them is to say something. I am grateful to the committee for affording me an opportunity to speak. I do not know how it will turn out. I hope the committee will put a good report together that will do something to improve the future of the children of south Wexford. If even one life is saved, my being here today will have been worthwhile.

I have worked in child psychiatry for many years. Such experience has informed me how

best to design the buildings. As I have sat in all of the buildings, I was able to inform management how best to build the buildings and they were built when I was in another role. If that is what it takes, then I will do so. We do whatever it takes to get the job done but we want and need support. I hope I have answered the Deputy's question in some way.

Deputy Pat Buckley: Mr. Walsh has touched on his working environment and I would like to hear more.

Chairman: I ask Ms Magaharan and Mr. Walsh to explain their working environment, please.

Deputy Pat Buckley: Yes.

Mr. Michael Walsh: I am a very ordinary man doing an extraordinary job. I get to see children every day of the week who are very stressed or in crisis and I also get to see their families who are in crisis. I get to change some of that situation for a little period and, hopefully, the lives of the children will improve overall. That is what our job is and that is what we try to do. I love working with families day-to-day and enjoy my job. What detracts from my work is a dirty, rotten and cramped building that is not fit for purpose. Patients who suffer obsessive compulsive disorder, OCD, cannot touch the handles of the doors because they are dirty.

Deputy Pat Buckley: Yes.

Mr. Michael Walsh: That part of it is the part that hurts. It is not the work. I enjoy my work and love my job.

Chairman: I ask Ms Magaharan to describe her working environment.

Ms Sonia Magaharan: I echo what Mr. Walsh has said. I have been my job for 34 years and have worked in various settings. Again, I enjoy my job. My concern is that the job has changed since I joined the service. When I started working in Child and Adolescent Mental Health Services we were able to work with younger children and progress things quicker but now the work is more complex. In terms of 16 to 18-year olds, the issues are more complicated, we must deal with more emergencies and there is more ambulance chasing. As I said earlier, we often miss the younger children. It is often only when they bubble over that they also become emergencies. At the start of my career, I worked in adult nursing. I moved to child nursing to be able to make a difference earlier in patients' lives. We do not make a difference early enough. Most of my colleagues agree on that point. We usually deal with emergencies, which is not how it should be happening.

Chairman: What is the physical environment in which Ms Magaharan works?

Ms Sonia Magaharan: The physical environment is poor, as I have stated. There were recent difficulties involving radon in one of our buildings and we could not use certain rooms. Remediation work was carried out to make the building safe in which to work and we are still in that building.

Deputy Pat Buckley: That is a ridiculous situation to be in.

Ms Sonia Magaharan: We are due to move at some point, hopefully soon, but the building is an issue as it is too small for us. We sometimes have to see people in rooms such as a kitchen, which are unfit for that purpose.

Chairman: As Dr. Murtagh has worked in both the HSE and St. Patrick's, she might be able to see the difference in the physical working environment. What is it like for her?

Dr. Aileen Murtagh: In terms of the physical environment, much work went into the planning and design of the current inpatient unit to make it a very adolescent-friendly environment and it is now a far nicer place in which to work. Many young people who come to the unit for the first time have very pre-conceived notions of what an inpatient unit looks like and most expect it to be very dull and dreary and contain straitjackets. They are quite surprised to see that it is bright and cheerful. Having worked in the public and independent sectors, I recognise that there are similarities between them. People who work on the front line with young people are extremely dedicated and do their best, often with very few resources. That is a definite similarity.

In my current post, my job is far easier and I have more time for front-line work with children and families. My colleagues highlighted issues such as administrative deficits. I have not opened a door, written a letter or had to listen to an answering machine since I started in my current post because there is excellent administrative support and cover for leave. Such things make a huge difference. If that support was not available, I might have to check the answering machine three or four times a day, which is fine but means an hour of my clinical time is spent answering a phone rather than providing emergency assessment to a young person, for example. The training of nurses and allied heath professionals is very much supported.

The issue of recruitment and candidates not matching the required skill set was mentioned. Allied health professionals in the HSE are recruited from a panel. If a position becomes available, such as a senior clinical psychology post in adult mental health services, and the geographical location of the job suits the person at the top of the panel, because there is no clarity on when or where the next job may be he or she might accept the post even if he or she has no training in adult psychiatry and had been working in CAMHS for seven years. Such a recruit might stay in the adult service for two or three years until another post became available in CAMHS. In St. Patrick's there is a specific advertisement and a candidate whose skill set specifically matches the needs of the young people and the service is recruited.

Chairman: That seems to make much sense. Deputy Buckley has another question.

Deputy Pat Buckley: Why is it working so well in one area and not in the other? Is it because of funding or admission fees? One of the witnesses stated the HSE has indicated a willingness to fund admissions to private facilities. How many HSE patients are in that system or are they all private patients? There seems to be a huge disparity between the two services. Cash is king. The cash cow is working perfectly but most of those in the system that is funded by our taxes and which is supposed to be supplying the service will have to be admitted to the private service to try to sort them out and allow them to return to work the following week.

Dr. Aileen Murtagh: St. Patrick's is an independent, not for profit service but it is very well resourced and management is very open to listening to what the needs of young people and their families are and doing its best to meet those needs. We try to collaborate with the HSE if there are service gaps or deficits. The admission of two young people to the inpatient unit was funded by the HSE in 2015, one in 2016, eight in 2017 and four so far this year. Such admissions occur when the public inpatient units are at capacity.

Chairman: There seems to be a better relationship now between St. Patrick's and the HSE.

Dr. Aileen Murtagh: That is so.

Senator Máire Devine: I am somewhat biased but I think nurses are the nurturers of our nation. My heart sinks listening to my colleagues, as it did when I listened to members of my union. One could hear a pin drop in this room, listening to the experiences of workers at the coalface in the public service and the damage caused to the health of our children in particular.

Mr. Walsh mentioned the commission on nursing. That was put in place following the nurses' strike in 1999. It resulted in an expansion of nursing roles such that nurses did not all have to go into managerial roles but could stay in the clinical practice which they love. Will it take another strike or commission to ensure that we retain staff? Like the witnesses, I contacted staff who had gone abroad, who said there was no way they would come back because of the disrespect shown to them by the HSE before they left. There is no encouragement or offering of professional development because all one does day in, day out is fight fires and there is time for nothing else. Therapeutic interventions are in second place after fighting fires.

Ms Magaharan mentioned the lack of early intervention, which all present recognise is the kingpin in providing good resilience, health and well-being from birth upwards. However, there are no hospital-based teams to liaise with and go into maternity and paediatric hospitals in spite of there being a great need to assess patients there on a medical level. The important role of public health nurses in terms of going into homes should also be addressed. We have previously discussed the inclusion of a checklist for the emotional well-being of infants or toddlers in the assessments by public health nurses rather than only eye co-ordination, noise and voice recognition and physical development. Early intervention could very simply be facilitated in that way.

There are many other issues that could be addressed. My heart goes out to the witnesses but they should keep at it. They are the warriors, the brave people who are going to change the system. To hell with the HSE if it comes down hard on the witnesses. The witnesses need not worry because they will have the committee behind them. Let the HSE try. I very much appreciate the contribution of the witnesses. I hope they keep at it.

Chairman: I am curious about the management structure. Without naming names, to whom does Mr. Walsh report?

Mr. Michael Walsh: My reporting arrangement changed at Christmas. A clinical nurse manager, CNM, 3 and an assistant director of nursing, ADON, were appointed to our service at Christmas. Neither has any training in or knowledge of child psychiatry. However, if statistics on how many people are in child psychiatry were being compiled, they would be included as managers of child psychiatry.

Chairman: They would be included in spite of not having a background in child psychiatry.

Mr. Michael Walsh: They are qualified nurses and nice people but they do not speak for child psychiatry. At the next level, there is a director of nursing who covers adult mental health and child psychiatry. Above that, there are various lines of management. I would not care to say who is next in the reporting structure. We have a very good service manager who provided us with a QbTest and organised for the unit to be painted, which was needed. Without it, the place would look like a hovel.

Chairman: How often do senior management visit?

Mr. Michael Walsh: I have met the chief nursing officer once. I did not know who she was at the time, but I met her once, following the incident where I had sent a concerned message up the line, and was asked who I was to do that in the first place.

Chairman: It must be very difficult for them to make a comment-----

Mr. Michael Walsh: I spoke to her yesterday on the phone.

Chairman: I wonder how decisions are made about the service if nobody is going to visit. Has Ms Magaharan had the same experience?

Ms Sonia Magaharan: We have an interim director of nursing who is new in the post. We meet weekly with all of the nurses working in Child and Adolescent Mental Health Services, CAMHS, in the Cork and Kerry region. We have meetings on peer support, training and education, and the director of nursing always comes to part of that meeting. There is a management component that they attend, and we have an opportunity at that meeting to raise concerns, whatever they may be.

Chairman: Who initiated that?

Ms Sonia Magaharan: It was initiated because I had worked with the Brothers of Charity previously, which had provided CAMHS, and they were paid by the HSE. I and a couple of my nursing colleagues were in those teams and we initiated that because we had no direct nursing line manager then. We worked under a CEO but there was no nursing discipline in the service, so we set it up as a peer support mechanism.

Chairman: Very good.

Ms Sonia Magaharan: We met ourselves, and it spilled over from that into the HSE.

Chairman: It is important to specify from the beginning that it was initiated by the nurses in the service.

Deputy Gino Kenny: I thank the witnesses for their very honest opinions on front-line work in psychiatric services in Ireland. What front-line staff are facing is brutal and horrible. A catalogue of failures in psychiatric services means that many people have been failed by the system, and they will end up in a bad place. From the testimony I understand that psychiatric services in Ireland are undervalued, underfunded and understaffed. As other Deputies have said, other Governments have put the service into this disarray. Issues retaining staff, maintaining staff morale and indeed the pay and conditions of staff lead to this catalogue of errors. The chairperson of the Psychiatric Nurses Association of Ireland, PNA, was before this committee recently,and, as Senator Devine said, one could hear a pin drop. It was terrible. Sometimes there are many adjectives to use. We can give out, but there seems to be a perennial crisis in our mental health services, and if we do not deal with this as a country, and as elected representatives, it will continue. It is good to hear front-line staff speaking out about this, because they are the people who will change the system ultimately through the unions.

My questions are quite detailed and I am not sure if Dr. Murtagh will be able to answer them now, but perhaps she could revert when possible. How many consultants in CAMHS are not on the Medical Council's specialist register? Have any official clinical guidelines been adopted according to the national clinical effectiveness committee for use by CAMHS? Have British-based National Institute for Health and Care Excellence, NICE, guidelines been appraised for

use in Ireland, given the lack of emphasis on psycho-social interventions and their emphasis on the use of medication?

Dr. Aileen Murtagh: I do not have a figure for the number of consultants who are not on the specialist register. There is an international deficit of consultant child and adolescent psychiatrists, so it is a difficulty. Sometimes when gaps arise locally I become aware that there are consultants who are on the adult specialist register but not on the child and adolescent register who are working as locums, but I do not have an exact figure to hand.

We are very much aware of the NICE guidelines. I have noticed a big difference in the service I currently work for, given the resourcing. If I need access to particular psychological therapy, such as cognitive behavioural therapy,CBT, or dialectical behaviour therapy, DBT, I can access them in a timely fashion, which is a huge difference. We are able to offer that evidence-based intervention, including medication - which can be a very valuable part of the overall package - but that was not always the case. When I worked with CAMHS, if I had a young person who needed CBT a therapist was not always available. I am not sure if I can answer Deputy Kenny's second question.

Chairman: Can another witness answer that question? Perhaps the Deputy would repeat it.

Deputy Gino Kenny: Are there any official clinical guidelines adopted according to the national clinical effectiveness council for use by CAMHS?

Chairman: This is probably not the place for that question.

Deputy Gino Kenny: That is fine.

Chairman: What was the Deputy's third question?

Deputy Gino Kenny: Dr. Murtagh has answered that question.

Deputy James Browne: I thank the witnesses for their attendance; it is brave of them to turn up here today. I am from Wexford, and desperate parents ring me on a regular basis. One of the most horrendous things CAMHS in Wexford has to do is the triaging of desperate children. Children desperately need to be seen, and staff have to make a decision as to which are the worst cases when they all need to be seen. I have been told that a child is 30th on a list, then 12th and then they slip out further on the list because a worse case has appeared. However, every child on the list is in a very desperate situation. I can only imagine the mental health impacts on staff; it must be horrendous. If the witnesses get an opportunity perhaps they would address the impact working in such a service has on them.

Mr. Walsh mentioned that he had to travel to Cork, some 200 km away, to get an inpatient bed. I deal with many parents who are left in an invidious position whereby their children are left in the adult unit in Waterford, which I have visited and which is an extremely grim place which is not fit for purpose for adults, never mind children. Children are either left there or have to travel to Cork, Galway or Dublin. Perhaps the witnesses could discuss their experiences of the impact of that on parents and children.

In terms of retention of staff, we have heard about the issues of pay, but many nurses have told me that the conditions of work are horrendous and that no pay would convince them to stay on. I am talking about trying to triage in desperate situations, or not getting enough time to liaise with patients properly because there are other patients right behind who desperately need

to be seen. Can the witnesses talk about the impact of that?

I recently spoke to an associate professor from America who was considering moving to Ireland. He does not work in the mental health sphere. He is the kind of person we should be begging to come to Ireland. He was shocked at the hoops his family was being made to jump through to actually take up a position. Furthermore, in America he had a massive support team, including secretaries, in addition to the actual health care team. He realised that if he got a position in Ireland he would be spending his first two years trying to put a team together, without proper supports, instead of actually seeing patients. That seems to be one of the key issues. In terms of mental healthcare, we are almost in a death spiral now. One cannot get people to take the jobs because the conditions are so bad and the conditions will not improve unless one makes it better for people to take up those jobs. I suppose I am highlighting some of the issues. If anybody wants to know why we have statistically the fourth highest spend *per capita* on healthcare and yet probably the worst healthcare system in the western world, it is the dysfunctionality. One need only listen to the evidence given here today to realise how dysfunctional our healthcare system is. That is why we are spending so much money and yet we are getting such bad outcomes, in particular, in terms of waiting times.

Chairman: On the comment Deputy Browne just made that our healthcare is the fourth highest funded *per capita* in Europe, with apologies to Dr. Murtagh as this is directed definitely to Mr. Walsh and Ms Magaharan, where is the money going?

Mr. Michael Walsh: If one considers I got two new managers at Christmas - a nice Christmas box - I presume it is going all the way up the line. There has been the appointment of a new director-----

Chairman: Rather than on services.

Mr. Michael Walsh: -----for mental health. If one goes above front-line staff, there is lots of rejigging of chairs. I do not know how many managers there are. There are lines and lines of them. That is where I believe it is going. It is definitely not going towards the front line. It is definitely not going towards the paint, the furniture and the buildings. It is not going towards the best interest of the children who we are trying look after. It is career moves. That is the way I look at it. It is not filtering down to those who need it.

Chairman: Is it the same with Ms Magaharan?

Ms Sonia Magaharan: I spoke about something that might make a difference to a service, the QbTest. Sometimes in order to get something we feel like we have to go to lots and lots of meetings which, to me, is expense. If there are 20 people at a meeting, one must cost what it takes 20 people to attend a series of meetings. We do not have computer data to gather information that is requested by hand, which also is time consuming. There are areas where we could be more efficient.

Chairman: For how long has Ms Magaharan been asking for this software?

Ms Sonia Magaharan: We had a party over from the UK in December to present on it. There is interest from three of the consultants of three of the CAMHS teams. There is interest.

Chairman: Has it been signed off yet?

Ms Sonia Magaharan: It has not. We have hit a wall with it.

Chairman: We will have the Minister here next week and we will put that to him for Ms Magaharan.

Mr. Michael Walsh: Can I go back to Deputy Browne's question? The Deputy asked about the impact on the parents and on the child of being admitted to an adult psychiatric hospital. It has to be devastating. A child is admitted aged 14, 15 or 16 to an adult psychiatric ward. He or she is not allowed out onto the ward during the hours where the adult patients are moving around that facility. He or she is only allowed out in the company of a psychiatric nurse. If one brings the mother or father of that child into that facility, he or she cannot stay there and be with him or her. There is nowhere for the parent to stay in that facility. When the child is admitted to our inpatient unit in Cork, there is no place for the parents to stay when they visit that patient.

In England and every other developed service, one allows parents to stay with their child. The policy is that one would try to keep services near the patient. This is clearly not happening. We had Planning for the Future in 1984, if anyone remembers it. There was to be a 20-bed unit attached to every general hospital in the country, which would make sense for Wexford. Instead of traipsing across the county trying to get to Waterford to be treated, people could go locally to their own Wexford General Hospital and be managed there. One would have the psychiatric situation sorted and dealt with in that area. I listen to parents every day of the week who are devastated that their children are in an adult psychiatric hospital. As far as I am concerned, it is against the Geneva Convention and human rights.

Deputy James Browne: There must be an additional stigma then attached to the children being in an adult ward.

Mr. Michael Walsh: Children do not vote and they do not get a say in where they are going or what they are doing. The parents do not get a say. The child needs to be in some form of psychiatric hospital and they deem that the nearest one is appropriate because there is no room at the inn in Cork. We try to admit to St. Patrick's and St. John of God on occasion but at present we have four patients on a waiting list to go into inpatients. There are no beds in the inn. The parents have to look after these children and we see them on a daily basis. A lot of our clinical time is taken up with reviewing just to make sure that they are safe. Instead of seeing new patients, we are still trying to make sure somebody else is safe. The committee asked about the stress on staff. That is a big stress on staff. It takes up a lot of our time. One tries to come up with different solutions to the problem one struggles with.

Deputy Anne Rabbitte: I thank the witnesses for coming here today, for being so open, honest and frank with us and for giving us an insight, because, to be quite honest with them, we might not have had that before. We have been here a couple of months and I suppose today was a day when we got a better understanding. I thank them for that.

Earlier, Ms Magaharan spoke about the neurological conditions and she spoke about ASD in the same breath. It is something I would like her to expand on. Those listening today might want to know where the link is because in many of the other CHOs and CAMHS, they might be getting the run around. I am from Galway. I was at an ASD meeting yesterday and heard the voices of parents who were all getting the run around. That is why I want to focus in on that.

Dr. Aileen Murtagh spoke about what she has observed. In her presentation, she observed that the GPs are making referrals in order to get a quick appointment and also the use of medical beds. That is the point on which I want to come in. Deputy Browne discussed beds in adult wards. I am only talking about the use of medical beds maybe not meeting the needs of the

children either, which is a huge issue.

Then I want to talk about the sixth class children who have never had an assessment all the way through and whose parents have tried to get into CAMHS - I would not say there are road-blocks - but whose needs assessment was not high enough to get support. Now they are in sixth class, a few weeks from going to secondary school, and they still have not got the supports. They are going into secondary school with nothing in place and the parents are panicking. My fear is they will end up back in CAMHS in a situation that is possibly a hell of a lot worse than if they had got the early intervention. I want to know about such children who are presenting and what sort of a workload it is to the witnesses.

The same happens for those aged 17 and a half where the issue possibly has floated along and there has not been the support. I want to hear what the witnesses are experiencing in terms of the frustration of the parents who do not know where to turn. What signposts can they show the parents, or are there signposts for parents? I asked a lot of questions there but that is what I want to cover.

Ms Sonia Magaharan: ADHD, ASD, Tourette syndrome and dyslexia come under neurodevelopmental conditions. They affect the brain. The co-morbidity between some of these conditions is high. If one has ASD, there is a 40% chance one will also have ADHD. As I stated in the submission, they operate neurodevelopmental teams in the UK. What happens here is the child comes into CAMHS because we do not know what he or she has and we say maybe this guy has ASD. Maybe the child has queued and we say he or she may need to go into another queue. We tend to hold onto those cases if they do go into another queue because we feel that those who come in deserve a service. It would be good if we had an integrated service, such as the Deputy is talking about, where we have a paediatrician and can look at people's health needs because children with autism spectrum disorder, ASD, often have many physical health conditions too. One can provide wraparound support. Rather than us working in separate teams, there needs to be coming together to provide a more joined-up service. People are holistic. One cannot just treat a toe and forget about the leg. It is connected. That is how I would see a neurodevelopmental team. It would look at all these conditions because it is very rare to see ADHD on its own. Other conditions always exist with it.

Deputy Anne Rabbitte: If the Chair does not mind, I will interrupt there. The current format is that every case is an isolated case, depending on the label attached to it. One does not look at it in the greater sphere of what other tag-ons could be or what other associations are. That is not the model that we operate in child and adolescent mental health services, CAMHS, is it?

Ms Sonia Magaharan: We would look at it but we would screen and then say that it looks like there is ASD. We do not make the diagnosis of ASD. That comes under another team's remit. My expertise is mental health, not ASD.

Deputy Anne Rabbitte: Is there good engagement between the two Departments?

Ms Sonia Magaharan: We have been working on having good engagement. The two teams meet every two months. We look at the cases that we would hold jointly.

Mr. Michael Walsh: Every team in the country operates differently. No two teams work on the same principles. The Deputy was talking about a child in sixth class who is transitioning into secondary school. The problem is that that child may not have been seen. What is the

problem with the child? If he or she has been in school for eight or nine years at that stage, he should have had a National Educational Psychological Service, NEPS, assessment if he or she was having difficulties. That could have brought forward other difficulties. Schools would have informed parents. They do the Conners scale and the Drumcondra tests and get the the Drumcondra primary reading test, MICRA-T, and Drumcondra primary mathematics test, SIGMA-T, scores. They know the level of intellectual functioning of that child. If that intellectual functioning is challenged early, that should be brought to the parents and the parents should be able to find out where to go from there. The NEPS psychologist should be able to advise the child in the school prior to the child getting anywhere.

Deputy Anne Rabbitte: A problem is that in many schools, only two referrals might be allowed to NEPS on an annual basis which puts huge pressure on the system. That is a different conversation but Mr. Walsh is right about that.

Ms Sonia Magaharan: There has been a change. There was a case where children had to come into CAMHS to get resources. That changed last year. A child can now get resources in school based on a NEPS assessment or if the child has been seen privately by someone who says that the child has dyslexia or some such. The children can get the resources and do not need to come to CAMHS if it relates to an education issue. That can be provided by the Department of Education and Skills.

Chairman: We will go to our last member, Deputy Neville, but before I move on, I have a couple of questions. One is to Dr. Aileen Murtagh. What difference has the new eSwift software made to her and to her service? The other question is for Mr. Michael Walsh. We heard recently that when a psychiatrist is retiring or leaving, that his or her job is not advertised until he or she actually leaves. There will always be a massive period where there is no cover. Mr. Walsh mentioned earlier what that is like. The impact on the service must be even worse if a consultant is to be replaced. Will he talk about that? It does not make sense, does it? Then we will go to Dr. Murtagh.

Mr. Michael Walsh: No, we have experience of it year-in, year-out. The consultant is entitled to holidays and leaves the service for a period of eight weeks a year or whatever it is. During that period, we do not have a clinical lead. We are not able to see new patients and we are not able to even look at referrals from general practitioners, GPs, in that time because we would be clinically responsible for them. We do not see anything in that time. If a consultant plans to leave and has advised that he or she will leave in two months or whatever, the turnaround for a consultant to be re-employed is a year.

Chairman: A year, my God.

Mr. Michael Walsh: That is just the way it is. It leaves the team in limbo for a year. Management, in its wisdom, may look for someone to stand in. That could be an adult psychiatrist or a temporary psychiatrist. Most of the time, in my experience, we do not get cover during holiday time. We do not have anybody. One is left holding whatever one can to stabilise the place and our patients in that time. Most of the time, we take phone calls. There are questions about whether we should even take those phone calls. It is soul destroying when one is there and does not have a clinical lead. The clinical lead takes all responsibility for everything that happens in a clinic, including everything relating to patients and to their treatment. We work off the clinical lead.

Chairman: Does Mr. Walsh agree with that?

Mr. Michael Walsh: No.

Chairman: Does he agree that a psychiatrist should take the clinical lead and everything stops-----

Mr. Michael Walsh: It works because we deal with mental illness. The consultant psychiatrist is someone who has trained and is on a specialist register to do that work. I would not ask a surgeon to do a gynaecological operation, nor would I ask a gynaecologist to do a surgical operation on a hip. It is like chalk and cheese. If one was a gynaecologist, one would know the ins and outs. If one was a surgeon, one would know the operations and whatever else and would be specialised in that. It is the same in child psychiatry. The consultant psychiatrist is very adept at dealing with children and is very well-trained. Those I have worked with over the years have been brilliant. They are understanding of the family unit and of the child. They have knowledge and compassion, and are very tuned in to the family. They are very qualified people. I do not think anyone else could do that.

Chairman: Will Dr. Aileen Murtagh answer about the difference that has been made?

Dr. Aileen Murtagh: It is a big move from a paper-based system to an electronic health system. It would be difficult to go back now. There were nerves and trepidation but, overall, the transition went smoothly. It saves much clinical time. We are talking about efficiencies and managing our workload more efficiently today. If we have a re-referral, I can, with just a few clicks, get into a young person's file. It saves much time. One is not waiting for charts or for a file to be pulled before returning a phone call to the mother. The other benefit, moving forward, is that we will be able to pull data to determine what the service needs and what the profile of young people is. We will be able to easily pull those data at the end of the year.

Chairman: That is brilliant. I thank Dr. Murtagh. I call Deputy Neville.

Deputy Tom Neville: This leads on from what was just said about IT systems for the people working on the public side. The witnesses might not be able to answer this. The debate I had with senior management related to IT systems, their operation and how management prioritises what IT system has to be developed, enhanced or repaired, given the amount of money that is left over from the new money which the Government has given for the development of new services. I have not been able to get an answer to that and I have not been able to get a figure related to that. I am still waiting for a figure and I have submitted a parliamentary question about it too. If the witnesses are not able to answer this, I totally understand. In their experience, what would the top two or three things that could be introduced in IT to increase the efficiency of their job and help them? Have the witnesses been given a roadmap about how any proposals they have been made can be delivered? Have the witnesses ever been told how to present a business case to make sure that system can be put in place? Does any such communication go on?

Mr. Michael Walsh: IT is at a very basic operational level. As Ms Magaharan alluded to earlier, we have to get pen and paper out to record how many illnesses we have and how many kids we have seen. We cannot press a button to do that. We do not have a system that records every input, output and every medication a child should be on, which we should have. What Dr. Murtagh spoke about sounds beautiful. I would love to have a system like that.

Deputy Tom Neville: I will allow Mr. Walsh to finish.

Mr. Michael Walsh: Before I came to Wexford, I had a computer system that recorded a

lot of the stuff where I worked. I put it in place. The system I have now is a step back by ten years. It is archaic. Are we encouraged to look for new systems? No, it is not in our brief. We spend most of our time fire-fighting so we do not get to that stage. It only happens when we have time to think that it would be great to do something in particular or change something but one loses that thought very quickly.

Deputy Tom Neville: Mr. Walsh does not have the capacity and he is under pressure.

Mr. Michael Walsh: It is not in the ballpark.

Deputy Tom Neville: To follow on from that, I will go back to what Dr. Murtagh said about their system. She said she had quite a smooth transition when she introduced this system. How long did it take to introduce it?

Dr. Aileen Murtagh: It was piloted in the adolescent service so we were the guinea pigs. A date was chosen and we all knew it was coming. We had training in advance on a dummy system. We were also given a sandbox, mock system. A lot of us had some familiarity with the system. There were glitches.

Deputy Tom Neville: There always are.

Dr. Aileen Murtagh: There always are in IT. There will always be some speedbumps but overall the transition went quite smoothly. It did not take long to-----

Deputy Tom Neville: I will ask a final question.

Chairman: It should be the final question.

Deputy Tom Neville: Was the system built in-house or was it outsourced?

Dr. Aileen Murtagh: Ms McCormack might be able to answer that question.

Deputy Tom Neville: Dr. Murtagh might not be able to answer that question.

Dr. Aileen Murtagh: My understanding is there was a system in the UK that was adapted for our use.

Deputy Tom Neville: It was outsourced.

Dr. Aileen Murtagh: There were a number of team members whose time was ring-fenced to work on the development of the system.

To come back to the issue of CAMHS inefficiencies, when I was in CAMHS we were given access to computerised programmes for things like scoring questionnaires. One can sit down with four questionnaires and it takes an hour but if one has a computer system, one can score them in five minutes. Even simple little changes like that in CAMHS can make a big difference to one's working day.

Deputy Tom Neville: Going back to what we talked about with regard to the GDPR, every time one inputs something, one is building data. One is mapping. One can just press a button and see the map of the patients and collect data that correlates to other data. It allows one to make one's service better. That is what happens in the private sector.

Ms Sonia Magaharan: We have several CAMHS teams across the Cork area. It also al-

lows us to pool resources and run groups. If I am working with my colleagues in Cork city, I can say I have ten people and they have ten people and it allows us to be more creative.

Chairman: Before we wrap up, I will ask Dr. Murtagh something out of curiosity. We have looked at the struggles the witnesses go through on a daily basis. The witnesses have spoken eloquently about the children we are concerned about. There are lots of children in adult psychiatric wards. I received a call yesterday about a child who cannot be allowed outside of the room because of segregation, which has to happen. If she was charged with murder she would have an hour of fresh air a day but she gets none. Instead, she is listening to a man crying and screaming in a room beside her. It is one of the reasons I am very curious about the relationship between St. Patrick's and the HSE. Dr. Murtagh mentioned there has been an increase in requests from the HSE. Why is that? Could there be more and could there be a better way of creating a really solid referral pathway between the HSE and St. Patrick's?

Dr. Aileen Murtagh: What we hear consistently when we pick up the phone to triage referrals when we receive a referral from the HSE is that a young person has been referred to the public inpatient system and there is no bed availability. Sometimes we might have waited for two or three weeks so at that point it will decide to refer to the independent sector. We do not tend to get many referrals of young people in adult psychiatric wards. We have had quite a number of young people who have been in medical beds, generally in paediatric wards, which are not suitable places either for young people. They are not subject to the same restrictions that were mentioned, like being confined to a room, but we had one young person who was admitted after six weeks in Crumlin hospital. They are not geared up to meet the needs of these young people. Their sleep will have been very poor for six weeks because of the screaming babies or medical emergencies. Sleep is very important in terms of mental health. There is also no access to therapeutic programmes. In units like ours there is a group psychotherapeutic programme running Monday to Friday. Other than school, the young people have had very little to do. In essence they are in a medical bed although they do not have a medical need. They may have had initial medical needs but those needs are no longer a live issue but as a result of the level of risk, they remain in a medical bed until a bed becomes available in a psychiatric unit.

Chairman: That is the first time I have heard that. I do not know if any other members have heard that before that a child could be six weeks in a medical ward.

Dr. Aileen Murtagh: That is one of the more extreme examples but it is not unusual, in our experience, for a young person to be on a paediatric ward for two to three weeks.

Chairman: What is the best way of solidifying a relationship between the HSE, St. Patrick's and St. John of Gods? If there is a child that really needs to be helped, what is the best way of solidifying that referral pathway?

Dr. Aileen Murtagh: The world of child psychiatry is quite small. We try to collaborate as best we can. If we or St. John of Gods receive a referral we pick up the phone and ring and see if we can meet the needs of the young person and how best to meet them. At the moment it is on a case-by-case basis.

Chairman: That is a very good, respectful answer. Perhaps "diplomatic" is the word I am looking for.

I thank our witnesses. It has been an extraordinary meeting with Mr. Walsh and Ms Magaharan. It was probably a little bit easier for Dr. Murtagh and Ms McCormack. Mr. Walsh and

Ms Magaharan are so brave. I am grateful they have come here today. Our purpose is not to lash out at the HSE, but to ask for clarity about what it is like. We have seen today what it is like. We can only fix it if we can see what the problem is. I thank the witnesses most sincerely for coming here today.

The joint committee adjourned at 3.48 p.m. until 1.30 p.m. on Wednesday, 2 May 2018.