DÁIL ÉIREANN

AN FOCHOISTE UM MEABHAIRSHLÁINTE

JOINT SUB-COMMITTEE ON MENTAL HEALTH

Dé Máirt, 28 Meitheamh 2022

Tuesday, 28 June 2022

Tháinig an Comhchoiste le chéile ag 11 a.m.

The Joint Committee met at 11 a.m.

Comhaltaí a bhí i láthair / Members present:

Teachtaí Dála / Deputies	Seanadóirí / Senators
Neasa Hourigan,	Martin Conway.
Gino Kenny,	
John Lahart,	
Mark Ward.	

Seanadóir / Senator Frances Black sa Chathaoir / in the Chair.

Business of Sub-Committee

Chairman: I have one piece of housekeeping before I introduce the witnesses. Draft copies of the minutes of the meetings of 30 November 2021, 5 April 2022, 17 May 2022 and 14 June 2022 have been circulated to members. Are these agreed? Agreed.

Resourcing and the Provision of Services at the Linn Dara CAMHS Unit: Discussion

Chairman: Today, we are discussing the resourcing and the provision of services at the Linn Dara child and adolescent mental health services, CAMHS, unit. We have with us from the HSE: Dr. Brendan Doody, clinical director of Linn Dara CAMHS unit; Mr. Jim Ryan, assistant national director - head of operations, mental health services; Mr. Kevin Brady, head of service - mental health services, Dublin south, Kildare and west Wicklow community healthcare organisation, CHO; and Ms Mary O'Kelly, interim chief officer - Dublin south, Kildare and west Wicklow CHO. They are all very welcome.

All members and witnesses are again reminded of the long-standing parliamentary practice that 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, or otherwise engage in speech that might be regarded as damaging to the good name of the person or entity. Therefore, if their statements are potentially defamatory in relation to an identifiable person or entity, they will be directed to discontinue their remarks. It is imperative that any such direction be complied with.

I call on Mr. Jim Ryan to make his opening remarks.

Mr. Jim Ryan: I am the head of operations of mental health in the HSE. I thank the members for the invitation to meet with the joint sub-committee to provide an update on the Linn Dara CAMHS service. I am joined by my colleagues, Brendan Doody, Mary O'Kelly and Kevin Brady.

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

Linn Dara CAMHS in Dublin south, Kildare and west Wicklow provides the following services: community mental health teams; a community eating disorder service; Linn Dara approved centre, inpatient unit; ADMiRE-ADHD pathway; consultation and liaison psychiatry at the National Children's Hospital, Tallaght; and two mental health intellectual disability teams for mental health of intellectual disability services.

In line with the HSE CAMHS operational guide 2019, the Linn Dara approved centre provides acute, emergency and specialist inpatient child and adolescent mental health services and treatment on a tertiary basis for children and adolescents with severe and complex mental illness. The approved centre is registered, regulated and inspected by the Mental Health Com-

mission and subject to regulatory inspection in relation to care and treatment, facilities and premises, staffing and governance.

The Linn Dara approved centre is a 24-bedded unit, which is configured into three wards - Rowan, Oak and Hazel. The Rowan and Hazel wards both consist of 11 individual beds and the Oak ward has two beds, which provide high dependency and care. The Linn Dara approved centre provides services on a regional and national remit. Our primary catchment area is community healthcare organisations 6, 7 and 8. Linn Dara also works with the other specialist inpatient mental health services to provide services on a national basis as the need arises and where clinically appropriate. The 24 beds in the Linn Dara approved centre are as follows: two high-dependency CAMHS beds, eight specialist eating disorder CAMHS beds and 14 acute or emergency CAMHS beds.

The Linn Dara approved centre provides eight specialist eating disorder beds, SEDBs, to level 4 care and treatment for children and adolescents with severe and complex eating disorders. Level 4 in the HSE model of care for eating disorders is classified as the most intensive treatment setting.

I will outline the service developments at Linn Dara CAMHS. The Linn Dara community eating disorder service was officially launched in September 2019. It was the first Irish community-based dedicated eating disorder service for children and young people under the age of 18. The team operates at levels 2, 3 and 4 of the stepped model of care, providing specialised outpatient, day patient care and support to people with eating disorders with an enhanced range of treatment options.

The ADMiRE ADHD pathway, which stands for assessment, diagnosis, management initiation, research and education, is the first public specialist service for children and adolescents with ADHD in Ireland. Set up in September 2018 in south Dublin Linn Dara CAMHS, the primary goal was to reduce waiting times and provide early access to evidence-based assessment and management for young people with ADHD.

On the Kildare and west Wicklow community CAMHS team, in 2021 Linn Dara established a new community CAMHS team based in the Athy primary care centre serving south Kildare and south-west Wicklow, bringing the number of community CAMHS teams in Kildare and west Wicklow to a total of five. Linn Dara has also established two specialist teams to deliver specialist mental health service to the mental health intellectual disability, MHID, community across the CHO and continues to develop this service through the national clinical programme.

Regarding new development posts, building on existing services and investments in CAMHS, in 2022 Linn Dara was allocated an additional €950,000 to recruit nine new additional posts across the service, with recruitment currently ongoing. These posts were targeted at the further development of the ADMiRE ADHD team and the community teams in Kildare and west Wicklow.

There are challenges in this area. The Linn Dara approved centre treats complex and high-dependency cases that require intensive input from experienced and specialist staff. Nursing posts account for more than 75% of the multidisciplinary staffing complement of an inpatient service. The ability of the service to provide the necessary standards of quality care on a sustainable basis for patients over a 24-7 cycle depends on the necessary nursing staffing being in place. Unfortunately, due to the level of current and projected core HSE nursing staff vacancies, the service was left with no choice but to reduce the number of operational beds on a tem-

porary basis. Extensive efforts continue, both nationally and internationally, to recruit nurses to these vacant posts. This temporary reduction in bed capacity is being done strictly on the basis that the beds that will remain operational are available with a safe and sustainable staffing ratio, on a 24-7 basis.

Post Covid, there has been an increase in referrals to both to community and inpatient services within CAMHS. Such an increase in referrals will have an impact on the level of service delivery, with the likelihood of increased waiting lists. The response of CAMHS to the public health emergency has brought about some benefits, such as a rapid adoption and effective use of telehealth and video-enabled care. It also created a public discourse about the importance of mental health to personal and societal well-being, thereby strengthening the case for continued investment in CAMHS and service developments to meet these increasing demands.

Since opening in December 2015, Linn Dara has continued to develop a number of services, as I have outlined, using models of care supported by clinical evidence through the national clinical programmes. Notwithstanding the improvements, we are very aware of the continued need to further develop services and deal with identified challenges, including staffing vacancies, which impact on service delivery. We will continue to work with all stakeholders in this regard.

Senator Martin Conway: I welcome our guests and thank them for their contributions and the work they do on behalf of the people of Ireland. I understand that there has been a national review into what happened in Tralee last year and what was exposed there. Would the witnesses like to make any comments on that matter? Have they engaged with this review?

Chairman: Today's meeting is just about Linn Dara.

Senator Martin Conway: I thought Linn Dara would have been included in that review.

Chairman: It could be. The witnesses can answer if they want.

Senator Martin Conway: It is only for information purposes. There is no agenda. Everyone was discussing what happened in Tralee. I am sure the witnesses were as well. I am just giving them an opportunity to tell us if they have engaged with the national review, which we are told has been rolled out. What level of engagement did they have with it? Have they altered or changed any of their services as a result?

Mr. Jim Ryan: I will respond in general terms. The Senator referred to the south Kerry CAMHS situation. Since then, as members are probably aware, we have initiated a number of reviews. The Mental Health Commission is engaged in an audit of the 73 CAMHS teams and has been in two of the community healthcare organisations, CHOs. We are working with them on that. A medication audit has also commenced, with a pilot undertaken in four of our teams across the country. That is feeding into the wider audit that is happening over the next six months. We have two further initiatives ongoing, one of which is a stakeholder review that we have been running with University College Cork, UCC. The second is a review of the CAMHS operating guidelines. All of the teams have been asked for information, including Linn Dara community CAMHS. In summary, we have been engaging with the internal reviews as well as the review being conducted by the Mental Health Commission.

Senator Martin Conway: We cannot lose sight of how important that work is for preventing any repetition of what happened in Tralee.

There are two high-dependency CAMHS beds, eight specialist beds and 14 acute emergency beds at Linn Dara. What is the average turnover time for users admitted to the 14 acute emergency beds?

Mr. Jim Ryan: If it is okay, I will ask my colleague, Dr. Doody, who is the clinical director for that unit, to respond.

Dr. Brendan Doody: In 2021, we had a total of 153 admissions to the unit. In 2019, we had 138 admissions. In 2020, we had 139.

Senator Martin Conway: To those 14 beds specifically.

Dr. Brendan Doody: Those are overall admissions to the unit.

Senator Martin Conway: Is there a waiting list to access the 14 beds? What is the average time spent waiting?

Dr. Brendan Doody: Eight of the 24 beds are specialist eating disorder beds. The two beds in the high-dependency unit provide an intensive care environment for those who need a period of their admission to be in such an environment.

Senator Martin Conway: Are the two beds at 100% capacity? What would be the percentage capacity over a 12-month period?

Dr. Brendan Doody: Last year, our overall bed occupancy rate was 78%. That ranged up to more than 90%, so 78% is an average. The occupancy rate of the high-dependency unit depends on the case mix and the need for a young person to be admitted to such a facility.

Senator Martin Conway: What I am trying to get a handle on is whether the two high-dependency beds are frequently used. Clearly, they are needed. That is why they are there. Are they used all of the time or, if not, for what percentage of time are they occupied?

Dr. Brendan Doody: I do not have an exact figure for their occupancy.

Senator Martin Conway: Roughly.

Dr. Brendan Doody: I expect that one or both of the high-dependency beds are always in use.

Senator Martin Conway: Is there a need for more than two?

Dr. Brendan Doody: Within our unit, we feel that the two beds are adequate for the functioning of the unit. It is important that there be turnover. The Senator asked about waiting times for admission to the unit. If we break down the 153 admissions, 22% - 34 young people - were admitted on the same day of referral, a total of 56% were admitted within two days of referral and more than 70% were admitted within six days. The majority of young people who are admitted are admitted in a timely manner, although we have young people waiting longer than that for a bed. The group who are usually waiting longer are primarily those with specific eating disorders. There is not as quick a turnover in our eight specialist eating disorder beds as there is in our other beds, so young people sometimes have to wait longer to be admitted to those. Just 10% of our admissions waited more than three weeks to be admitted.

Senator Martin Conway: That is good. Does Dr. Doody find that Linn Dara does not see young people again after they have been treated in and discharged from the eating disorder unit

in particular or are there repeat presentations? What would the figures be for that?

Dr. Brendan Doody: If you look at eating disorders, the vast majority of young people presenting with them are treated in the community and we have seen the figures in our specialist community eating disorder services increase hugely in recent years. If you take 2019 for example, our specialist community eating disorder team had 47 referrals and in 2021 it had 197. There has been a huge increase in the number of people presenting with eating disorders specifically. The vast majority of eating disorders are treated in the community and a small number will require inpatient admission. As one would expect, one of the reasons for inpatient admission is that treatment in the community has not been effective. Young people who are admitted will be admitted because they require the treatment package that can be delivered in an inpatient setting. Some young people will re-present, given the severity of their conditions. The children who will be admitted are more likely to have severe and chronic disorders. A proportion will be readmitted but the majority of our admissions will be one-off admissions.

Inpatient services are dependent on the availability of community services to provide that level of intensive input at community level. We are fortunate at Linn Dara that we have developed the specialist community eating disorder service, which is on the Cherry Orchard campus. We work closely with that service and we transition young people. When there are services in the community, readmission will be less likely.

Senator Martin Conway: I refer to that increase from 47 referrals to 197 referrals. What would Dr. Doody attribute that almost fourfold increase in referrals to?

Dr. Brendan Doody: It is interesting because it is also mirrored in the presentations to the liaison service at the National Children's Hospital, Tallaght, where they have seen a fivefold increase in presentations of young people with eating disorders over eight years. It is difficult to put it down to one factor. In recent years we have seen an upward trend in young people presenting with eating disorders and we have seen that they are presenting at an earlier age. We also noted that the pandemic accelerated this increase. There was an upward trajectory and we would feel that if you look at our referrals there is a correlation. We have looked at referrals to the inpatient unit and in admissions and we definitely saw a Covid pandemic affect. The impact of the Covid pandemic on the mental health and well-being of young people was negative and we saw an increase in a range of disorders, particularly anxiety-type disorders. On that spectrum we also saw an increase in eating disorders. That is not just something that we have seen in this country but internationally we have seen a huge surge in demand for services for young people with eating disorders.

Senator Martin Conway: That is one of the negative and lasting legacies of the pandemic. I refer to family supports. Does Linn Dara have any family support programme for its inpatients and for the people it engages with?

Dr. Brendan Doody: When a young person is admitted into an inpatient unit he or she is moving from their home environment into an inpatient setting. Working with the family is key because the goal after the admission of any young person into an inpatient unit, from the day they arrive, is to plan for their discharge. Part of that involves working with the young person and another part of that involves working with parents. We actively involve families and we work with parents. Through our multidisciplinary team, which includes family therapists, there is a strong focus on families and on working with families. Within the unit there is education as well and there is a school linked to the unit. That is about young people and it prepares them for returning home and going back to what young people do, which is attending school and being

at home. Everything is geared towards working with families and working towards discharge. You work with the young person and the family at the same time. The families are part of that process.

Senator Martin Conway: Okay. It is hoped that in the autumn the committee may have representatives of the Irish National Teachers Organisation, INTO, before it to talk about what they are doing, their mental health programme and how they can support the work Linn Dara does.

Finally, there is the issue of aftercare. Does Linn Dara have aftercare or is it at such a level that aftercare is under a different ambit?

Dr. Brendan Doody: The Linn Dara inpatient service has a regional remit. Linn Dara community services have a remit for south Dublin, south-west Dublin, Kildare and west Wicklow, whereas we will admit young people from our primary catchment area, which extends from all of County Dublin across Kildare and Wicklow and into the midlands. We also take young people under the age of 18 years from north Leinster, Cavan and Monaghan. When a young person is being admitted, part of the discharge planning is working and planning with the community team with regard to the supports the young person and his or her family will need post discharge. We are working with community teams across all these counties. In some cases, for example, where the young person is attending a specialist eating disorder service or a community one, we are working with whatever team the person is engaged with in the community. We work with them and part of the discharge planning is planning for the package of supports that the young person will need following discharge. In other words, if the person is going back to a Linn Dara service, it is within our service remit. Again, however, we are taking children from a much broader area and from other services.

Senator Martin Conway: In an ideal world what extra supports would the Linn Dara service like to have? Is there an ask, essentially?

Dr. Brendan Doody: It was with great regret that we had to take the decision to temporarily reduce the number of beds. There is a particular pressure in staffing, which my colleagues can also discuss, with regard to the provision of nursing. As we said, more than 75% of the multidisciplinary staffing in an inpatient setting is nursing staff. In other words, for us to be able to continue to provide that service, and it is a very specialist inpatient service, we must have adequate staffing. From an inpatient perspective, our ask is to look at what the fixes are with regard to being able to provide adequate nursing for the inpatient service. That is probably a much broader question. Some of the things are within our control and some of them are outside our control.

One difficulty has been that as we develop services in the community, and we talked about developing our community specialist eating disorder service, developing our additional community team in Kildare-west Wicklow and developing our ADHD ADMiRE pathway, often one is pulling from a small resource to begin with. In other words, staff, rather than leaving the service, are moving to other opportunities within the service. As we develop services, the ask is for the workforce planning to match that so we can be assured that we have the staff in place to fill these services, rather than taking staff from other services.

Senator Martin Conway: That is wonderful. I thank the witnesses and thank them for the work they do.

Chairman: The next speaker is Deputy Ward.

Deputy Mark Ward: I thank the witnesses. It is great to put a face to some of the names because I see a lot of the people mentioned in the replies I receive to parliamentary questions. I thank them for all the responses I have been receiving from them during my time in the Oireachtas. I know the decision to close the beds in Linn Dara was not taken lightly. I thank the staff who work in CAMHS and other front-line mental health services. I had the privilege of meeting Ms O'Kelly in the primary healthcare centre in Tallaght recently as well as the staff there. I found them absolutely brilliant and very passionate about the work they do. Sometimes I am critical but I do not want that to be seen as critical towards staff or even to the witnesses. I also pay tribute to the nursing staff who are on the front line of all this.

However, the reality is that the decision to close 11 inpatient beds in Linn Dara is another abject failure of the Government to address children's mental health services. According to the latest figures I have, there are 308 admissions of children into CAMHS. Of those 308 admissions, 138 went to Linn Dara, which seems to be the primary place for inpatient admissions. There are only 53 beds throughout the State at present. A reply I received to a parliamentary question on 16 June indicated Linn Dara went down from 24 to 13 beds, St. Vincent's dropped from 12 beds to ten and Merlin Park in Galway has been reduced from 20 to 14 beds. The only unit that had no change is Eist Linn in Cork. The reductions seem to be almost right across the board. We have heard from stakeholders and parents who are all very concerned that this closure of beds could lead to a further decrease in the services children get. It could also lead to the placement of children in adult psychiatric facilities, which is another concern they have.

To return specifically to Linn Dara, this is the second time in five years this has happened. The last time beds were closed in a similar situation was 2017. What lessons have been learned? What is being done differently this time?

Mr. Jim Ryan: I will ask the chief officer to respond specifically on Linn Dara. I acknowledge the points Deputy made regarding the other three units throughout the country.

Ms Mary O'Kelly: I thank the Deputy for his acknowledgement of front-line staff. It is much appreciated. He is right that the decision to reduce the number of beds in Linn Dara on a temporary basis was not undertaken lightly at all. It is an excellent inpatient service and one we rely on heavily.

We are in an entirely different space compared with the last time this happened. Dr. Doody and Mr. Ryan spoke about the additional services provided in the area at present. At the time beds were previously reduced, we did not have our Assessment, Diagnosis, Management, initiation, Research and Education, ADMiRE, or attention deficit hyperactivity disorder, ADHD, team. We did not have the additional teams we now have in community, which is all part of that Sláintecare work we are progressing. We did not have an eating disorder team or mental health intellectual disability, ID, services.

We are in a space where we know that, nationally, 25% of nurses who qualify do not take up a job. When we look at higher education in the context of the number of graduates, 25% of them do not take up jobs.

Deputy Mark Ward: What are we doing to attract that 25% of people? What are the reasons they do not take up jobs?

Ms Mary O'Kelly: As Dr. Doody said, we are now in a position where we are competing

internally. We have additional services for the 75% who take up jobs. As Dr. Doody said, when people want to move, we try to accommodate them within our services but we are in a competitive environment internally, externally with other providers, and with the fact that borders are opening. Since we are in the Dublin area, we are also at a disadvantage with regard to people not being able to afford rent and mortgages in that area and having to travel long hours, which they cannot commit to on a long-term basis.

Deputy Mark Ward: Is the HSE capturing that data in exit interviews?

Ms Mary O'Kelly: We are.

Deputy Mark Ward: Okay. Very good.

Ms Mary O'Kelly: We have that information across all our services. It is not exclusive to mental health in our community healthcare organisation, CHO, area. We are at a disadvantage geographically in working in the greater Dublin area, with house prices and rents being what they are. In addition to prices, there is a lack of availability. That is something for consideration. I have brought up that matter with the Deputy previously. To Senator Conway's point, it is an ask to look at Dublin weighting for staff who have to pay over the odds for accommodation or mortgages, whatever it is, in that area.

The team has been very creative. Its members have instituted a piece where they look at the rosters every nine to 12 weeks so they are planning ahead all the time. We have a mixed methodology for staffing, which is something we have to do, that is a combination of permanent, temporary and agency staff. We look to work with the same providers, when we need to go to an agency, to ensure we have continuity on the ward or in the inpatient unit because it is specialist. We look for the same staff who have the knowledge, expertise and experience in those units.

Deputy Mark Ward: I presume that Linn Dara is saving money because of these vacancies. Has any consideration been given to using those savings to incentivise people to work in the organisation?

Ms Mary O'Kelly: That is something we would welcome, and I believe it is being considered at Government level. We are aware that this is a competitive environment and we must comply with the consolidated pay scales, but we would like to be able to use creativity in acknowledging the experience of the student nurses coming on board and incentivising them.

Deputy Mark Ward: Am I correct in saying that the hope is that the next batch of qualified nurse recruits are the ones who will fill the positions in Linn Dara?

Ms Mary O'Kelly: Yes. The recruitment campaign for graduates is already under way, and 30 people who will graduate from the graduate programme this year have been empanelled. Mr. Brady and his team run rolling campaigns whereby every time we receive a CV, the person is interviewed immediately. There are also targeted recruitment campaigns for the Linn Dara inpatient unit.

Deputy Mark Ward: Does Mr. Brady wish to contribute?

Mr. Kevin Brady: I will add to Ms O'Kelly's points. We have been running a rolling campaign for the past number of years for staff nurses in the area. It has yielded little across the full CHO that I am responsible for, that is, mental health services in St. James's, Tallaght and Kildare and CAMHS. People have a choice in where they work, which poses a significant

challenge. I will pay credit to the director of nursing and the nurse management staff who have been very creative in determining how to incentivise people, notwithstanding the issue that Ms O'Kelly mentioned, and engage with higher education institutions, for example, making site visits, providing lectures to staff and showing how good the service is. It is a flagship service and its facilities are second to none.

Deputy Mark Ward: I know. I live close to it – it is almost on my doorstep.

Mr. Kevin Brady: That is a credit to the specialist work it does. We are actively engaged with nursing students throughout their four-year programmes. It is important to take into consideration their skills and competency to work within the area and determine how we can support them in moving from being graduates to staff nurses. The staff speak highly of the opportunities they have been given in the inpatient unit through working with senior staff, who buddy up with them. We have developed clearly defined nursing career pathways, clinical nurse specialist, CNS, posts, advanced nurse practitioner posts and nurse prescribing. We have personal development plans for the staff that we engage and invest in considerably and we provide significant training for them. The regrettable part of that is that, when some qualify and go for interviews with us, those are actually their exit interviews because they are leaving for other services around the country, which is a major challenge for us.

Deputy Mark Ward: I thank Mr. Brady. I appreciate his reply. I will move on to another matter because as I only have a little time left.

Dr. Doody mentioned that a small number of young people with eating disorders needed to be admitted to eating disorder services. When I asked a parliamentary question, the reply I received – it was actually signed by Mr. Ryan – stated that 49 children had been admitted to Merlin Park or Linn Dara in 2021 but that, in the same period, 115 children whose primary presentations were for eating disorders had been admitted to non-eating disorder inpatient public acute mental health facilities. I have spoken to parents whose children are going through this process. Their children are brought in and are not getting the specialist treatment and food intake supervision that they need. All that seems to be done for them is to increase their body mass indices, at which point they are released, but it is a vicious circle, with them going back in and back out again. While I welcome that there were places for 49 children to be admitted to specialist eating disorder units, there were another 115 children who needed that specialist help but were not getting it. Is anything being done to address that? I find it quite startling. It is a red-flag issue.

Mr. Jim Ryan: Looking back over the last four or five years, the development of the eating disorder service in Linn Dara has been in response to the increased demand that there is for services. I have been involved in the service for more than ten years. We had very little services ten to 12 years ago. What we are seeing now is a response to that. The challenge is that there has been a very significant increase in demand over the last few years, as Dr. Doody mentioned earlier. We are running to catch up. A few years ago there was significant criticism of the practice of transferring young people abroad for the treatment of eating disorders, in particular. I do not think anybody has been treated abroad in the last three years, which is a significant improvement. That does not mean we are meeting the demand that is there at the moment. Dr. Doody might speak to that issue. It is about the journey we are on, particularly in relation to community care for patients with eating disorders and inpatient care. Perhaps Dr. Doody wants to add to that.

Dr. Brendan Doody: I think the Deputy was referring to the children who are required to

be admitted to a medical bed for stabilisation, whether it is in a paediatric hospital or an adult medical facility.

Deputy Mark Ward: In the parliamentary question, I asked the Minister for Health for the number of children who presented to the HSE looking for treatment for eating disorders who were referred to non-eating disorder inpatient acute mental health facilities in a number of different years. The figure supplied for 2021 was 115. That is an increase from 97 the year before.

Dr. Brendan Doody: I will just speak for the Linn Dara service. We have eight eating disorder beds. Obviously, that is a finite resource in respect of the number of young people we can admit. Due to the fact the beds are specialist eating disorder beds and that we also offer the option of nasogastric, NG, feeding, we are able to admit young people who are much more unwell from paediatric ward settings. We can treat them in a service where they are getting more than just the nutritional treatment, but also all of the other therapeutic interventions and the comprehensive therapeutic care package. The team assesses all children with eating disorders who are referred to the service. We make an assessment and prioritise the young people who we feel require and would benefit from inpatient care. Given that we now have a specialist eating disorder community service, there may some cases where the needs of the young person can be met by that service. We talked about the number of referrals earlier. Looking at the figures from the community eating disorder team, the number of children that the community eating disorder team is referring on for inpatient admission is usually less than five per year. The national clinical programme is about the need to provide specialist services in the community to enable parents to access specialist treatment in the community such that their child does not require to be admitted to hospital or an inpatient CAMHS setting. On the one had, thinking back, when A Vision for Change was launched all those years ago there was a view that nationally, all we would require would be four inpatient beds for eating disorders. Looking at what has happened over the last few years, we recognised the increased demand for the services, but we did not anticipate the degree to which the demand would explode. We are obviously, in a sense, trying to catch up with something that is increasing. It is important that we take a whole-system approach, particularly given the fact that the majority of young people with eating disorders can be treated successfully in the community. Those specialist services need to be there. The fact we have that specialist community service in Linn Dara is really positive. It enables the young people and families to access specialist treatment at a community level, without having to wait for it. That reduces the likelihood of negative outcomes. We know that the longer an eating disorder persists, the more likely it is to become chronic. The young people who are more likely to require inpatient treatment are those who have a disorder that persists. In other words, the key is being able to access the specialist treatment in a timely fashion in the community.

Deputy Mark Ward: I also want to raise the issue of the referrals to CAMHS that are not accepted. According to the information I have, one third of referrals to CAMHS are not accepted. There were 21,000 referrals to CAMHS in 2021, which shows how busy it is, but only 14,000 of these were accepted. I have met with parents of children who have autism who feel their children are falling through the cracks. They are being told to go to another service due to their children's autism. They want me to make it very clear to the HSE that children with autism can have acute, moderate or severe mental health difficulties as much as any other child. What services are provided in Linn Dara for children who are due a diagnosis of mental health difficulties and autism?

Mr. Jim Ryan: I will take the first part of the Deputy's question. He may have heard of CAMHS operational guidelines, which have been in place since 2019 and which we are cur-

rently reviewing. That review was intended to look at what exactly CAMHS does. Part of that is about defining what it provides as a service, and part of it is about the difficulty people have in saying CAMHS does not meet their needs. We acknowledge that. When we look at the number of young people who may not be accepted as meeting the criteria for CAMHS, certainly within the HSE we have a responsibility to try to provide the service for young people who do not meet the criteria for CAMHS but who absolutely need a service.

We are not saying they do not have a need. We are saying that the 2% Dr. Doody mentioned earlier - internationally it is normally 2% to 3% - who require CAMHS may fall outside of it but that does not mean they do not need services. I will ask Dr. Doody to address the Deputy's point specifically.

Dr. Brendan Doody: The first point to acknowledge is when children are referred to CAMHS there is an identified need. Children are not referred without a need. A question arises when CAMHS believes that need does not fall within its acceptance criteria. For families, that does not mean a child does not have a need that needs to be met by services. The reasons community CAMHS will not accept a referral are that the young person's presentation is such that he or she does not require the accessing of specialist mental health services, or the child's needs primarily require other interventions, as the Deputy said, with regard to disability services. He specifically mentioned children with autism.

Again, the Deputy is correct that if children have a neurodevelopmental disorder, that does not mean they cannot have a mental health problem as well. It is about steps with us. We have looked at forums, which the chief officer can also talk about, regarding how we as a much broader HSE service - we are one part of a service - integrate the various components of HSE service work more closely together such that families do not feel, as the Deputy said, they have slipped between the gaps of two services. Some of that is about recognising that these children have needs. We then need to look at resourcing primary care, which we also talk about. Sometimes the issue can be one of gaps in primary care, for example, if there is not adequate resourcing of primary care psychology services. Young people are then referred to a specialist service, when their need would be much better met at a lower or primary care level. It is something within the CHO area for which there is an acknowledgement of how the wider and broader range of HSE services meet the needs of this group.

Deputy John Lahart: Quite a number of the questions I wanted to ask have been very comprehensively covered. I thank the CAMHS team for coming in. I thank them for the work they did and for their availability during Covid.

I have a question on treatment versus outcomes. How do CAMHS measure that? In other words, let us say, a child or adolescent comes in for a period and Linn Dara does its work. Is that then it, when it comes to monitoring? If additional assistance is needed, does that child or adolescent go back to the end of a queue? Is there an ongoing facility, structure or protocol in place for them if they remain vulnerable?

Mr. Jim Ryan: It might be more appropriate for Dr. Doody to respond from a clinical point of view.

Dr. Brendan Doody: To answer the Deputy's question, again, the young people who are admitted to an inpatient setting may have a range of difficulties. We talk about young people, for example, with eating disorders, for whom, clearly, the primary goal of inpatient is weight restoration and normalisation of dietary intake such that the young person is able to function

and return to be with their family and in the community. In a sense, when it comes to a clear outcome, that would be the target for a young person with an eating disorder.

All young people who are admitted will have care plans, which identify the goals of treatment and admission. These are updated on a regular basis. During the admission, the team will work closely with the community service to which the young person will return to on discharge. That is very important because the inpatient setting is very intensive and stepping down to a community setting can at times be both daunting and challenging, that is, going from a very intensive service to a community service. Again, it is very much about identifying what additional supports will facilitate and allow for that transition. That transition obviously takes working with the young person, the family, but also the services in the community. Are there additional supports that can be provided within the service that the young person is attending?

With regard to the young person reintegrating, our school is also a very important part of our service. The Linn Dara schools will link with the young person's school to make sure that young person has a smooth transition back into his or her school and assess if a different type of schooling is required. We also run a kind of a transition school programme. Young people can step down within our educational programme. That is, again, very helpful in that transition from inpatient back to the community. Should a young person require readmission, and a proportion of our admissions every year will be readmissions-----

Deputy John Lahart: What proportion is that?

Dr. Brendan Doody: I do not have the exact figure to hand for our unit, but generally 20% to 30% of admissions are readmissions.

Deputy John Lahart: That is kind of one in three or four.

Dr. Brendan Doody: Around that.

Deputy John Lahart: How does that compare? How does Dr. Doody interpret that?

Dr. Brendan Doody: Again, I suppose we have to look at that figure and then look at each particular case. We could ask why a young person needs to be readmitted. It could be a function of his or her illness. If he or she has a relapse and requires more intensive treatment, we have to look at whether it is that. We have to look at whether the level of support that the young person requires in the community perhaps is not readily available. Alternatively, it could perhaps have to do with something outside this. Sometimes the reason for readmission could be something outside the family or treatment system. There may be another breakdown, let us say, in school attendance and the young person's level of functioning.

It should be remembered that the vast majority of young people who attend specialist CAMHS are never admitted and do not require admission. The group that requires admission are-----

Deputy John Lahart: Acute.

Dr. Brendan Doody: -----particularly vulnerable. If someone is admitted once, he or she has an increased likelihood of being readmitted, as opposed to somebody who has never been admitted.

Deputy John Lahart: Is there any data on that? Is it any particular age group or any particular presentation of symptoms that perhaps has to return a bit more?

Dr. Brendan Doody: Again, for example, I can speak about eating disorders. If someone is being admitted to an inpatient unit with an eating disorder, it increases his or her likelihood of needing to be readmitted because, again, the nature of his or her illness is such that he or she required inpatient admission and, therefore, is at a much greater likelihood for readmission. Clearly, our goal related to services where he or she can have intensive intervention is to not allow, for example, the eating disorder, to develop a more chronic nature. It is important that we have that intensive intervention. For example, for the eating disorder group of patients in Linn Dara, we have a specialist community service so that when a young person is admitted, they are stepped down to a very intensive specialist service. We would say that is going to reduce the likelihood of readmission but it does not mean it will never happen. We will have some young people who, due to the nature of their condition, require periods of inpatient treatment.

Deputy John Lahart: I am sorry for interrupting but I am time-limited. That can sometimes make for what appears a rude intervention but it is not meant that way.

If, as Deputies and Senators, we were to take away a rough rule of thumb, it is that for those who present for a second or third round of treatment, it can, more often than not, be in the realm of eating disorders.

Dr. Brendan Doody: It is not exclusively children with eating disorders but that is one group where, once a person has been admitted, they have an increased likelihood of being readmitted. However, our goal must be for that not to happen. Our goal is to find how to work with the family.

Deputy John Lahart: After a second or third admission, does the success increase? Is it fair to say the service meets with more successful or acceptable outcomes as more treatment is given?

Dr. Brendan Doody: If we talk about eating disorders, there is a small group whose illness follows a severe and chronic course, unfortunately. Again, it is important that intervention-----

Deputy John Lahart: What might that be? Dr. Doody can supply the answer in writing, if he likes.

Dr. Brendan Doody: When we are looking at inpatients, we are looking at children with the most severe disorders. If we look at this across all of the young people presenting with eating disorders, it is a very small percentage. However, if a person is in an inpatient setting or has a required inpatient admission, the likelihood is that bit more.

Deputy John Lahart: If it is appropriate, can Dr. Doody give us an example of what intensive intervention involves?

Dr. Brendan Doody: Is the Deputy asking in regard to eating disorders?

Deputy John Lahart: Yes.

Dr. Brendan Doody: Again, this is through the national clinical programme. There is a recognition that, given the nature of the condition, the best response to community treatment is through the provision of specialist services. There is a clinical programme which develops specialist community eating disorder services for children and adolescents but also for adults. That programme is being rolled out. We were fortunate that the first child and adolescent community eating disorder service was developed in Linn Dara. Services have also been developed

in Cork and there are plans to develop a number of other services, and also to develop services for adults because not all of the people involved are young people.

Deputy John Lahart: I am getting a message from the Chair that I have to wrap up. I might come back in again at the end. I would like to know more about intensive intervention and perhaps that could be communicated in writing. What was the youngest presenting patient with an eating disorder that the service has dealt with?

Chairman: Dr. Doody might keep his answer short as we have to move on.

Dr. Brendan Doody: From looking at our statistics, about 15% of our admissions are at age 13 or younger and the majority of our younger patients suffer from eating disorders. We have seen not only an increase in eating disorders but the age profile of eating disorders is going down. In our unit-----

Deputy John Lahart: I will stop Dr. Doody because I want to be fair to other members. However, I would love to have Linn Dara in again at some stage. I found it fascinating. I thank Dr. Doody. I hope there is enough time for Deputy Hourigan.

Chairman: There will be plenty of time afterwards. I call Deputy Hourigan.

Deputy Neasa Hourigan: I am trying to make it to a number of meetings today so I am probably putting everybody under pressure.

I understand the staffing issue. When there was a reduction in beds, a timeline was implied as to when we might be back online, and I think it was September. Are we on track for that?

Ms Mary O'Kelly: We are very much reliant on the graduates and the recruitment drive I discussed earlier. We have conducted interviews and we have 30 people on a panel. They will express interest in where they want to go and we have to look at that. We also have an ongoing recruitment campaign. In saying this, the relatively short notice was due to extenuating circumstances regarding sick leave, maternity leave and attrition. As a team we have agreed we will look at this constantly. If we receive CVs, we will interview and recruit. We have a problem with the multidisciplinary teams and recruitment in general, but as we get more nurses on board, we will revise the numbers. If we were to get a cohort in the coming weeks, we would increase the numbers. We are looking at it constantly.

Deputy Neasa Hourigan: By increase the numbers, Ms O'Kelly means increase the number of beds.

Ms Mary O'Kelly: Yes.

Deputy Neasa Hourigan: There is a panel of 30 people who have been notified they are on that panel.

Ms Mary O'Kelly: For September.

Deputy Neasa Hourigan: My husband is in the Civil Service and I am aware of what a panel is. It will then be an issue of regional distribution of the people.

Ms Mary O'Kelly: It is a CHO panel but for all of our mental health services. It is for community teams, more specialist teams, inpatient teams and adult services teams. We are doing a targeted campaign on top of this for recruitment for Linn Dara.

Deputy Neasa Hourigan: I am very mindful it is now the end of June and the goal is to have these people in place by September. I presume the HSE has done this process before. Out of a panel of 30, how many will actually go into places? How long will it take to get people into the roles?

Ms Mary O'Kelly: The graduate campaign is one part of it and the national recruitment campaign is another. On average, the bespoke panel could take three to four months to put in place between interviews and going through pre-contract, Garda clearance and referencing.

Deputy Neasa Hourigan: We are already down to the wire for September.

Ms Mary O'Kelly: Yes. We are absolutely down to the wire.

Deputy Neasa Hourigan: How many of the 30 people on the panel are graduates?

Ms Mary O'Kelly: That is the graduate panel. We also running a bespoke campaign for Linn Dara. We hope to recruit through these two panels.

Deputy Neasa Hourigan: For how many places are we trying to recruit?

Ms Mary O'Kelly: At present we have 27 vacancies out of 51 positions.

Deputy Neasa Hourigan: Is that in the particular CHO?

Ms Mary O'Kelly: It is in the unit.

Deputy Neasa Hourigan: There are 27 vacancies.

Ms Mary O'Kelly: In the Linn Dara inpatient unit there is a whole-time equivalent staffing of 51 nurses. We have 27 vacancies.

Deputy Neasa Hourigan: That is stark.

Ms Mary O'Kelly: It is.

Deputy Neasa Hourigan: One of the issues Ms O'Kelly referred to was attrition. Are we speaking about graduates going into these positions? The service has been under pressure and has had a dearth of staffing. These graduates will be going into a very pressurised environment. We speak a lot about pay scales with regard to attrition. Often it is the quality of the work and people being under pressure. Graduates are particularly vulnerable. Is work being done by the HSE to support new graduates who are going into services that are under particular stress?

Ms Mary O'Kelly: This is what Mr. Brady was alluding to with regard to continuing professional development and making sure we have the appropriate skill mix. One of our issues at present is we do not have the appropriate skill mix among senior staff and less experienced staff on the wards for decision-making to maintain a safe level.

Deputy Neasa Hourigan: I want to follow up on the aspect of continuing professional development. In a previous life it was something I had to do in my profession. It is often a bar people have to reach. I am not sure it is about reducing the levels of stress for people. Is work being done on the well-being of graduates?

Ms Mary O'Kelly: Yes, it is. We have a targeted well-being programme for the team in Linn Dara at present, understanding the pressure they are under. We are working with their

health and well-being colleagues in the CHO. The staff on Mr. Brady's team are also working on this.

Mr. Kevin Brady: We also have Schwartz rounds whereby staff throughout the CHO attend debriefing sessions with colleagues. It is very therapeutic and a good reflective practice for staff. It is important there is protected time for this reflective practice in Linn Dara given the staff's significantly challenging working environment. It is not easy work but, as I said, they have the buddy system. They are very much supported from a senior staff perspective because it is not only about recruitment but about retaining those staff. If we create that environment and we build on it, we will see the fruits of that labour the director of nursing and the senior nursing management staff are putting in and in which we are investing.

Mr. Jim Ryan: It may be useful to say that, five years ago, we invested additional mental health funding in psychiatric nursing. We literally bought additional places in the third level colleges. We spend €6 million a year on doing that. That gives us an extra 130 nurses. It is a four-year cycle and 2020 was the first year in which we saw an additional benefit from that. That was about trying to increase the pool of people who were available. We have obviously had to work on the process. As Ms O'Kelly has said, we have tried to reduce the length of time from one stage to another. The pool bit is very important because that increases the numbers coming through from the colleges.

We have also invested in 40 additional postgraduate psychiatric nursing positions every year. What we are trying to do is make sure that when we put in new developments nationally, which we have spoken about, whether it is Sharing the Vision, A Vision for Change etc., because many of those posts tend to be at promotional level and we denude our basic care level, there are people coming out of college who are able and willing to take up those posts. Interestingly, our west of Ireland services tend to find it easier to recruit staff nurses.

Deputy Neasa Hourigan: It is cheaper to live there.

Mr. Jim Ryan: Exactly.

Deputy Neasa Hourigan: I will move on. Is it 56 operational beds we have right now?

Mr. Jim Ryan: Fifty-three.

Deputy Neasa Hourigan: That is still approximately 50% of the 100 set out in A Vision for Change. Are we still working to the targets of A Vision for Change?

Mr. Jim Ryan: In fairness, A Vision for Change includes the two private facilities as well. It was a population approach. Looking at where we are, in addition to those 53 there are ten beds in the Willow Grove unit in St. Patrick's hospital and in the Ginesa Suite in St. John of God Hospital. We also have the ten beds that have been constructed in the new Central Mental Hospital in Portrane for forensic, and they were included in the overall figures. We will also have the 20 beds in the children's hospital in 2024.

Deputy Neasa Hourigan: Mr. Ryan might be up more around the 70s or 80s. Is the HSE, explicitly, as an organisation, working to the numbers contained in A Vision for Change?

Mr. Jim Ryan: Yes. The beds will be there. Our issue is the operationalising of those beds. That is the issue.

Deputy Neasa Hourigan: I accept that. For the purposes of clarity, is the HSE still work-

ing to the numbers in A Vision for Change?

Mr. Jim Ryan: Yes.

Deputy Neasa Hourigan: With Sharing the Vision, it is sometimes not clear that is happening.

Mr. Jim Ryan: In Sharing the Vision, as the Deputy will be aware, there is a subgroup that is looking into acute inpatient capacity. I am involved in that. Looking at the growth in population and the beds that were included in A Vision for Change, we have not quite finalised that acute bed provision work yet but I do not see any reason it will be dramatically different. We are working towards what was in A Vision for Change.

Deputy Neasa Hourigan: It was mentioned that people are pleased we are not sending anybody into services abroad at present. Deputy Ward has done work on this. How many people contained in adult facilities are under the age of 18 at present?

Mr. Jim Ryan: In 2018, we had 83 who were admitted to adult units. The number went down to 50 the following year. The year before last, it was 27. I think it was 25 last year. So far this year, we have had eight.

Deputy Neasa Hourigan: There are eight this year.

Mr. Jim Ryan: There are eight this year. We have two today, as we speak.

Deputy Neasa Hourigan: We have two in right at this moment.

Mr. Jim Ryan: Yes.

Deputy Neasa Hourigan: Would Mr. Ryan suggest it is mirrored in the lack of staff and the lack of beds in the adult service or is it that we are actively removing children from those adult services and putting them into children's services? It would seem we do not have those beds in the children's services. Where are those children being moved to? Why is there a big fall-off? By the way, I am happy to see the fall-off.

Mr. Jim Ryan: Absolutely.

Deputy Neasa Hourigan: I am merely wondering what is happening there.

Mr. Jim Ryan: In some ways, it is a better use of our existing resource. Professor Doody chairs a group every Tuesday morning that is triaging all the referrals into the four units. We have a national system whereby, every Tuesday morning, we have, to use the jargon, a bed meeting. Essentially, it is triaging any referrals for inpatients that would be made during the week to any of the four units. Each of the four units have their individualised regional areas they would be referring into but if there is a situation where there is no bed available in that unit it then can become available for the other three units to see if it is more appropriate. Dr. Doody knows this day in and day out.

Dr. Brendan Doody: Yes. Obviously if you look back, in 2010 more young people were being admitted to adult units than to child units. As a percentage of admissions it is now down to 7% of admissions to HSE. There was a total of 361 admissions in 2021 and 27 were admitted to adult units. Of those, 16 subsequently transferred to CAMHS units. If, as Jim has said, we have the national tele-call - if a young person is admitted to an adult unit they are seen and

assessed and what we find is on average a young person is three or four days in that adult setting and then either transferred to a CAMHS unit or discharged. Last year, 60% of those admitted to an adult unit were subsequently transferred to a CAMHS unit and again the average age was 17 and a half years. The vast majority of these young people are actually aged 17 years. Although it is 7% of admissions if you look at actual bed days it is much smaller than that. Clearly, one would like to reduce this as much as possible. However, I do not think it is realistic as in a crisis situation admission to an adult unit may be in the young person's best interest but again, if that occurs it should be for the minimum amount of time and the young person should be transferred as soon as possible.

Within our particular primary catchment area we have had very few admissions to adult units in the past two and a half years. However, again the focus should be not only on reducing the number of admissions but also ensuring if an admission occurs the young person is assessed, triaged and transferred if that is appropriate and if they are not, that they are discharged, so it is not that young people are spending extended periods of time in adult units. They are either transferred or discharged within four days.

Deputy Neasa Hourigan: Okay. I thank our guests.

Deputy Gino Kenny: I thank all our guests this morning. My first question is on the nine posts at Linn Dara that have been advertised. How many of them have been filled thus far?

Mr. Kevin Brady: They have not been filled yet. The primary notification has just issued in the past month and we are currently actively recruiting those through the national recruitment service. In some cases we will look to putting in place some agency staff in the interim if the national recruitment service does not have panels in place.

Deputy Gino Kenny: Okay. How confident is the HSE those 11 beds in Linn Dara will open come September?

Mr. Kevin Brady: With the extensive efforts we are putting in we are, as Ms O'Kelly has already indicated, reviewing that on a constant basis and we are certainly very hopeful and confident of reopening in September. It is similar to what happened a number of years ago, as Deputy Ward has indicated there, back in 2017. That is the plan and we are sticking to that.

Deputy Gino Kenny: Okay. This is not a criticism. I understand there are mitigating circumstances in the health services and especially mental health ones. There are reasons this is happening but why was it not envisaged that this could happen again? It happened four or five years ago and the same situation has arisen again. Surely with facilities such as Linn Dara, which is a vital service, this is down to planning and seeing what could happen in the future. Surely this could have been averted in some way? Notwithstanding the mitigating circumstances around the retention and recruitment of staff, why has it happened again?

Ms Mary O'Kelly: As we said earlier, we are in a really competitive environment internally in that we have opened our additional services across the CHO area for CAMHS. The team in Linn Dara works very hard and, as I said, forecast on a nine- to 12-week basis, but it has been very difficult to recruit in recent years. We have never achieved full recruitment to the 50-plus posts. We do have a combination of strategies in place, including agency work. Recruitment has become particularly difficult in a very short time span over recent weeks due to a number of factors, including, as I said, competition from other providers. We try, where possible, to stick to the same cohort of procured nurses, that is, the same agency, because they have built

up an expertise. That agency has also found it difficult to recruit, which has not happened to us before. Borders have opened, so people have resigned and left. We also had some sick leave. It has been a perfect storm in recent weeks; hence our present position. It is not a decision we took lightly, but we had to look at the skill mix on the ward and in the units, and we were in such a position that we could not, unless we took this action, guarantee safe, quality care for the service users of the unit.

Deputy Gino Kenny: As said earlier, the unit has a nursing complement of 51, whereas at the moment it has less than half that number. Am I correct in-----

Ms Mary O'Kelly: Yes.

Deputy Gino Kenny: Obviously, to fill that gap will take a considerable amount of time.

Ms Mary O'Kelly: It will. Again, we will work on a mixed methodology whereby we will look to recruit from the panel that has been created for the graduates and from the bespoke campaign we have out at the moment. We will most likely still have to rely on the agency staff.

Deputy Gino Kenny: That will go on for a considerable amount of time, I gather.

Ms Mary O'Kelly: At this time we cannot envisage operating the inpatient unit without that mixed methodology.

Deputy Gino Kenny: I have one final question. I know it is a difficult question, but for those families and young people who use vital services such as Linn Dara, when the beds are reopened come September, could the same issue with recruitment and retention of staff arise again in three to four years' time? Obviously, if seven beds are not being used, young people who need intervention are not getting it, and time is of the essence with services such as this. That is why many public representatives are deeply concerned about facilities such as Linn Dara having to suspend temporarily some of the inpatient beds. If that has happened, it will have a ripple effect not only on the staff who work there but also on the young people who will need the services. Can Ms O'Kelly guarantee this will not happen again? People will want to know whether we will be in the same situation in two or three years' time.

Ms Mary O'Kelly: We cannot guarantee that. We do not like to be in this position at all. Mr. Ryan spoke very well about the increase in the number of higher education institution, HEI, places for psychiatric nurses. We are being as creative as possible in this area. We absolutely acknowledge we are having difficulty recruiting across the CHO area and not just in mental health. People are interested in working and willing to work, we have excellent services, and they want to come to work in those services, but they are unable to afford to live or rent in the area. We have staff driving from the midlands and west and that is unsustainable. They are all the matters we are looking at organisationally. As Paul Reid mentioned in his interview on Sunday, there is a lot being looked at nationally in terms of facilitating staff to work in the areas they would like to but cannot afford to work in.

Deputy Gino Kenny: That is a very important point. There is no doubt that graduates want to work in the Irish health system, but because of circumstances regarding the proximity to the workplace, rent and so forth, it is not viable. If it was made viable for graduates, they would work in the Irish public health system. Circumstances are not allowing them to do that. If those issues were addressed, we would not have this perennial situation in which facilities, such as Linn Dara, have to suspend some of their inpatient services. Hopefully this will not happen again and the beds will be reopened in the autumn so that we will not be in this circumstance.

It is no good to anyone having a service, such as Linn Dara, in a situation where it cannot offer inpatient beds for the young people who need them.

Deputy Mark Ward: I again raise the issue of children being admitted to adult mental health facilities. I accept that CHO 7 has the best record in the State for not admitting children into adult facilities. I am concerned that the closure of Linn Dara could lead to more children entering adult facilities. The HSE's stance was mentioned whereby children are admitted for the least time possible. In CHO 9, for example, one child was admitted to an adult facility for 13 days and two children were in an adult facility for more than a week in 2021. In both cases, the reasons given by the HSE were that there were no beds available in CAMHS units at the time. When I looked at the beds that were filled during the same time as these children were admitted, there seemed to be capacity available in CHO 9. I am aware that is not the same CHO, but I am concerned that this could happen in CHO 7, an area in which this was not happening much previously.

It was mentioned that eight children had been in adult facilities this year. Were they in CHO 7? Are the two children currently in adult facilities also in CHO 7? What is being done to make sure this does not happen?

Mr. Jim Ryan: They are not in CHO 7. Of the two young people, one is in CHO 9 and the other is in CHO 5. When a young person is admitted, I immediately know because a note must be sent to me and the Mental Health Commission when a young person is admitted to an adult unit. It is protocol that must be followed within the approved centre in order to make sure that the children are appropriately looked after. This means they are treated and nursed separately from the adults on the unit.

On whether the closure of the beds in Linn Dara will impact on the CHO's ability to manage, it would be useful to talk about the assessment process we have to triage and prioritise on a weekly basis.

Dr. Brendan Doody: It is a very reasonable concern. If 11 beds are taken out of the system, be it done only temporarily, there is less of a resource available. Is that a risk? Yes, it is. If a young person is admitted to an adult unit, it usually happens in crisis. They are not planned admissions. If it happens in our area, we will see that young person straightaway and make an assessment. Sometimes the crisis passes and he or she does not need to be transferred to a CAMHS unit and can be discharged. As was the case last year, 60% did require transferring.

The cases are discussed on the national call. Our primary catchment area extends from south Dublin CHO 6, CHO 7, and half of CHO 8. We take all under-15s for CHO 9 and all of CHO 8. There is a discussion with regard to assessment and we have the weekly tele-call. A child in an adult unit is seen and coded as a priority. Each unit will have its own primary responsibility linked to that area and that unit will have the responsibility of finding a bed. On occasion, we have taken children from adult units outside our catchment area. Even though each unit has its own defined catchment area, it is not that it cannot admit a child from another catchment area in such a situation.

Deputy Mark Ward: Would the closure of the beds in Linn Dara impact on referral from other areas?

Dr. Brendan Doody: It is less of a resource.

Deputy Mark Ward: There are fewer resources.

Dr. Brendan Doody: There are fewer beds. Proportionately, the number of children with eating disorders in the remaining beds has increased. Now, more than one third of the young people who are inpatients have eating disorders. Those beds have lower turnover and longer lengths of stay. When the number of beds is reduced, even though all of those beds are occupied, the number of admissions will drop because, by the very nature and mix of cases, the patients will be those with more severe conditions who require longer lengths of stay, so beds are being taken out. All young people are assessed. If a young person is admitted to an adult unit in our catchment area, consultants and members of the team will assess that young person and make sure that if he or she requires transferring, the transfer is prioritised to our own unit or we would seek a transfer to another unit, if there was capacity nationally.

Deputy Mark Ward: What would lead to a situation, for example, the one I mentioned, which I know was not CHO 7, where a child was in an adult inpatient facility for 13 days and another two children were there for more than a week? I was just wondering. I am looking for information more than criticising.

Dr. Brendan Doody: It is very difficult to comment on an individual case without having all of the necessary facts. All I can say is that what would happen in our catchment area is we would prioritise the young person so that he or she would be the first young person to be admitted to the next available bed. With our having a larger unit of 24 beds, we may have a greater capacity to so do, with the unit fully functioning. I can only comment on what we would do. Within our primary catchment area, there has been an extremely limited number of young people admitted to adult units in the past while.

Chairman: I thank the witnesses for coming in today, even at short notice. I thank them for all the work they are doing in this area. The subcommittee often hears about how HSE staffing is in crisis and how understaffing is causing crisis throughout the healthcare system. I really hear what the witnesses are saying about accommodation. It is especially difficult in the Dublin area for people to work and pay for accommodation. Hardly any accommodation can be had now. There are mile-long queues of people looking to rent. When the witnesses look at that issue, how do they think the HSE can make itself a more attractive employer, in general, bearing in mind there is an ongoing housing crisis? What is the answer? Will they give us an overall view of what they think the answer might be?

Mr. Jim Ryan: If I could give the answer, I would be in a different job.

Deputy Mark Ward: Mr. Ryan would be sitting over here.

Mr. Jim Ryan: Exactly.

Chairman: Mr. Ryan would be a Minister.

Mr. Jim Ryan: I was going to ask the members what they thought the answer was. We have done a few things over recent years. There is an increasing demand for health services generally, and our ability to meet that demand has to be met in different ways. One of the things we have done in mental health is around e-health and e-mental health, and that is a way in which we can reduce the number of young people or adults who need to go up the line. Under the tiered model of care, we are trying to have as many people as possible seen at the lower level. Taking youth mental health as an example, we have a service agreement with the likes of Jigsaw, Turn To Me, MyMind, SpunOut, etc. All these organisations are able to pivot very quickly. They can upscale their operations. That is an attractive way for young people to access services when

traditionally they might have come to mental health services. We have attempted to take that approach over recent years, and mental health was one of the initiators of that approach. It has made a big difference. The numbers attending Jigsaw are increasing significantly. It has the same issues that we have about providing bricks and mortar services but it is able to upscale its online service much quicker because people can work from home and work more flexible hours, as we mentioned earlier. We must do a combination of things. We must ensure our secondary and tertiary care services are delivered by professionally qualified and appropriate staff. We must reduce the numbers moving up the system through our services and by working with non-governmental organisations, NGOs, which have a significant role to play.

I worked for an NGO in Tallaght as a youth worker years ago. Treatment from an NGO makes a considerable difference because young people are in their own communities and within their own settings. We are trying to reduce the numbers of people moving up the system. On the point Ms O'Kelly made earlier, we will have to look at some way of trying to incentivise some services. Other people will come in here and say we are not prioritising their area. We are in competition with the likes of enhanced community care. "Competition" is not the right word. Citizens need more services and we are trying to deliver them. The way in which we provide services must include face-to-face consultations but the other ways of doing it online will make a difference. Rather than seeing those alternatives as less positive, we should instead be saying how much more positive they are. We have many examples of that. Some young people much prefer texting and online consultations to face-to-face consultations. Rather than seeing that as a problem, we should see it as a benefit and take advantage of social media and different ways to try to deliver services. We are not going to be able to deliver services for everybody in every part of the country in the manner people might have thought we could. Consultants in more peripheral areas of the country find it difficult. South Kerry was mentioned earlier in that regard. It is more difficult to get consultants in such areas. However, remote consultation works quite well.

A combination of approaches is required. There is no silver bullet. We need to prioritise certain of our services and that is why we have found the need to prioritise the 2% of young people who require secondary care and those types of services. Those are the sickest young people we have from a mental health perspective. I do not believe there is any one solution because if there were, somebody else would have thought of it before me. We must continue to do those type of things. It is about trying to broaden the way in which we deliver services.

Ms Mary O'Kelly: One thing we would like to be able to look at it, which we have discussed in the CHO, is growing our own. We are a population of more than 700,000 and a large part of the area is socially deprived. Families are striving hard with children in secondary education. The first academic primary care centre in the country is in the Russell Centre, Tallaght, which Deputy Ward visited recently. Trinity College Dublin is its academic partner. One of the pieces we would like to look at is being able to grow our own within our population. There is an anchor of people who live in the area. We had that discussion. There are people who live in the area and who are passionate about working in their local communities. That is definitely something to consider from a national point of view. Deputy Ward will be sick of hearing me say this but we must consider being able to assist people with accommodation and a weighting in addition to basic pay. We need to recognise that we are comparable to international cities in expenditure. London and other European cities have a weighting on top of basic pay for people who live in areas where rent and mortgage repayments are higher.

Chairman: From my experience with the RISE Foundation, I totally agree with regard to

online services. We deal with families who are impacted because someone they love has an addiction problem. An awful lot of family members come to the RISE Foundation with mental health issues. Initially, we would not have thought online consultations would have worked but they are actually working better from a therapeutic point of view. The foundation has fully qualified therapists and the service is working better from a therapeutic point of view, whether it is one to one, a group dynamic or aftercare. It is definitely working, which was a real eye-opener for us, and it expands our services countrywide. People do not have to travel from Donegal anymore, for example. They can avail of our services in their homes now. We find that very beneficial. It is one of the ways forward but, obviously, it does not suit everyone.

More and more people are being diagnosed with attention deficit hyperactivity disorder, ADHD. This is an area in which I have a specific interest. Many of these diagnoses are of adults who suffered greatly in educational or workplace settings because their needs were not recognised. This definitely demonstrates the importance of early diagnosis. Will the witnesses tell me a little more about the assessment, diagnosis, management initiation, research and education, ADMIRE, ADHD pathway? What level of demand is there for this service and is it adequately resourced?

Dr. Brendan Doody: When we looked at our services in our base in Cherry Orchard, Dublin, we developed the ADMIRE pathway because of the need to provide a pathway with a robust and evidence-based assessment and treatment process. It is about how we improve the service and, following the programmatic approach, assess children in a comprehensive, effective and efficient manner to ensure a diagnosis is made and treatment is initiated. We found that we often do well in the diagnosis service, but the quality of aftercare and treatment, which will often include medication, needs to be looked at and optimised.

The pathway, which is linked academically with Trinity College Dublin and is led by Professor Jane McGrath, is new and innovative and looks at taking the best from models abroad as to how to deliver for this group of children. A diagnosis of ADHD for children and families can be life changing. It gives families an understanding that their child's difficulties are something over which the child does not necessarily have full control. The thing about ADHD is that it is not just a condition. If left untreated, the outcomes for young people going from childhood to adulthood are not good. Children with ADHD often have other difficulties that need to be picked up on as well.

Our pathway has won a number of awards. For families, the link between academic and research has been very important. When we were allocating a new development post, we saw that we needed to develop and strengthen the ADHD pathway team further because of the level of demand and throughput. As a service, the pathway has been developing and putting together assessment packages that will be widely available. Professor McGrath has received a lot of interest from services around the country as to what they can learn in regard to providing the best possible assessment and treatment for this group.

Children with ADHD make up a significant proportion of those who attend CAMHS services. It is important we optimise the diagnosis, treatment and aftercare. As was pointed out, it is often the case that when parents attend services with their children that they recognise they had those difficulties when they were a child. We now need to develop services for adults because we have children who are being diagnosed and treated reaching their 18th birthday but where are the adult services to take them on? That is one group. You could say the young people are graduating. There are also adults who, for the first time, are realising they need access to a treatment service. The need to develop this has been recognised within the clinical programmes.

Once upon a time there was a belief ADHD was just a condition of childhood and that when you reached adulthood you grew out of it. For a proportion it lessens in adulthood but for some their difficulties continue into adulthood and there is a need to not only diagnose it but also treat appropriately. That is something for the national clinical programme and Mr. Ryan can perhaps talk about the development of services for adults.

Mr. Kevin Brady: Just to add to that, we have recently received an additional five posts for the development of an adult ADHD team as well. It is for the Dublin south-central St. James's-Tallaght service. The national programme was allocated an additional five posts for CHO 8 and the Kildare portion of our CHO as well so later this year, all going well, we will have those two teams operational. That will support the transition Dr. Doody alluded to as well as adults who need the service themselves.

Chairman: How could I get information around that going forward, if I was somebody who knew somebody who had ADHD and probably needed those services? How could somebody access that or how do they get to find out about it or know about it?

Mr. Kevin Brady: The service is literally just being recruited. The consultant post is just being recruited in CHO 7 at the moment. The closing date was only in the past week or two, so as soon as that is ready to go we will be doing media campaigns on social media and giving information out about things. We recently had a communications officer appointed in the CHO. To go back to the initiatives that were talked about, he will be working with our director of nursing and our HR colleagues on looking at how we make Linn Dara look attractive in terms of the services it provides. We may get staff to do personal testimonies about their experience of working in Linn Dara to try to get that extra little piece to support Linn Dara and get up to that 51 members of staff we have been alluding to over the last while. Again, that goes across the full NDT with the clinical posts but nursing is our critical gap as well. If the Chair wants to contact me afterwards I can give her an up-to-date briefing. I corresponded with Deputy Ward recently on the development of that team as well. That will be later this year or early next year.

Chairman: Fantastic.

Ms Mary O'Kelly: The other thing we do when we have teams such as that development, is we have GP groups in the area. We have one for the catchment area for St. James's. That is the South Inner City Partnership. We have one for the Tallaght area and one for the Kildare area of the CHO. Dr. Doody and Mr. Brady regularly come to those meetings with GPs. We roll out that information through our own networks but also our partners, like our GP practices, our public health nursing and our local primary care centres.

Chairman: Fantastic. I thank the officials so much.

I want to talk about families, which Senator Conway touched on. Obviously mental health waiting lists are very long at the moment. It is particularly stressful for families in the context of the CAMHS. How could families be better supported as they wait for the care? You can imagine what it would be like for a family that has a child who is suicidal or who has an eating disorder. How can families be supported while they are waiting for that service? I ask because we get a lot of family members asking where they should go and what they should do if that child has an eating disorder or an addiction problem or is maybe on the way there. How do we support the families?

Mr. Jim Ryan: I will start and then Dr. Doody will come in. One of the things I want to say

is 94% of urgent cases are responded to within three days across the country and the 73 teams. The Chair may recall a couple of years ago there was an individual situation that happened that was tragic and that we responded to. We want to say that where a young person comes forward they are actually responded to very quickly, the vast bulk, because we are aware of the point the Chair made. We also try to make sure that where information that will support parents in the meantime may be available, it can be made available immediately.

Dr. Doody wanted to come in on this issue.

Dr. Brendan Doody: One would hope that all young people would be seen in a timely fashion. When a referral comes in, it is triaged. It is not the case that everyone goes to the back of the queue. Urgent cases are prioritised. A child who is suicidal or a child with a serious eating disorder absolutely would be prioritised. The concern about children who just meet the threshold is that a young person's presentation may not be seen as being as severe or as acute. In other words, the concern is that the priority cases will forever jump to the top of the queue. As for those on waiting lists, things change and families are encouraged to make contact and to speak to the team involved. The Chairman talked about eating disorders, for example. Currently, in our community specialist eating disorder service there are 15 on a waiting list, but 13 of those have an appointment and are seen in a very timely fashion. The children who have that more acute presentation will be seen. Sometimes the children waiting are those whose presentation is not as severe or as acute. The case is made that if the children are waiting, things will deteriorate because they are not getting intervention. That is a very valid point. When our overall number of referrals are climbing and climbing and the complexity of the cases attending or being referred is increasing, we have to look at how we, as a service, meet the needs of all the young people who are referred. It is challenging. The children with more acute or severe presentation are seen and prioritised. All referrals are prioritised, and those with the greatest need will be prioritised to be seen.

Chairman: I have one more question. We have only ten minutes left. I wish to follow on from the discussion about ADHD. This is probably more from a therapeutic point of view, but are children who have ADHD more inclined, when they get into their teenage years, to pick up substances? I am talking about the link between ADHD and - I will not even use the word "addiction" - let us just say substance misuse or alcohol misuse. Is there a strong link in that regard?

Dr. Brendan Doody: There is evidence that untreated ADHD increases one's risk of developing the very conditions and difficulties you have described, Chairman. There is a cost to the individual of not being diagnosed and not being properly treated. We know that young people who are not diagnosed and treated are more likely to experience difficulties at school and to drop out of school. What we are about is how we help young people to achieve their full potential. It is important that if children have conditions such as ADHD, they are detected, diagnosed and treated. That will improve their chances of achieving their potential. It will also decrease the likelihood of their developing addiction problems, so there is a link. It is not that every young person who has ADHD will go on to develop those problems; it is just that those young people are more likely to do so.

Chairman: I thank the witnesses for coming in and for that comprehensive discussion. It has been a really interesting session. I will certainly keep in touch with them all.

The joint sub-committee adjourned at 12.49 p.m. until 11 a.m. on Tuesday, 12 July 2022.