DÁIL ÉIREANN

AN CHOISTE COMHAIRLIÚCHÁN POIBLÍ AN TSEANAID

SEANAD PUBLIC CONSULTATION COMMITTEE

Déardaoin, 6 Iúil 2017

Thursday, 6 July 2017

Tháinig an Roghchoiste le chéile ag 10 a.m.

The Select Committee met at 10 a.m.

Comhaltaí a bhí i láthair/Members present:

Seanadóirí/Senators	Seanadóirí/Senators
Maria Byrne,	Joan Freeman,
Martin Conway,	Colette Kelleher,
Máire Devine,	Pádraig Ó Céidigh.

I láthair/In attendance: Senators Frances Black, Victor Boyhan, Marie-Louise O'Donnell and Keith Swanick.

Seanadóir/Senator Paul Coghlan sa Chathaoir/in the Chair.

Children's Mental Health Services: Discussion

Chairman: Apologies have been received from Senator Jerry Buttimer, who is away on official business at a meeting of the Organization for Security and Co-operation in Europe, OSCE. I warmly welcome the Senators, witnesses and the visitors in the Gallery to this, the second day of the Seanad Public Consultation Committee's public hearings on children's mental health services in Ireland. This public consultation on children's mental health services in Ireland is providing us with a unique opportunity to consider and hear from all facets in the debate on the provision of mental health services for children and adolescents. As I said last week, through sharing their experiences the witnesses will set out the reality of those in need of mental health services and those providing these services. We will also hear from policymakers. Following our two public hearings, a draft report will be prepared for the committee by our rapporteur, Senator Joan Freeman. The committee will review the draft report and publish its final report as soon as possible thereafter.

Today's meeting will consist of two sessions. In this morning's session we will hear from representatives of professional bodies and clinicians as well as from a children's law specialist. In the afternoon session we will hear from representatives of State and other bodies.

On behalf of the committee I would like to welcome the following witnesses to this morning's session, Dr. Elisabetta Petitbon, forgive me-----

Dr. Elisabetta Petitbon: Petitbon, yes.

Chairman: That is a new name for me. I also welcome Professor Brendan Kelly, Professor Fiona McNicholas and Dr. Blánaid Gavin. I welcome Dr. Brendan O'Shea and Dr. John O'Brien from the Irish College of General Practitioners as well as Mr. Paul Gilligan and Ms Orla Gogarty from St. Patrick's Mental Health Services. I welcome Dr. Brendan Doody and the representatives from the College of Psychiatrists of Ireland, Dr. John Hillery, president, and Dr. Maeve Doyle. I also welcome Dr. Yvonne Begley, Dr. Eddie Murphy and Mr. Gareth Noble. They are all most welcome. We thank all the witnesses for engaging with the committee in its consideration of this most important and sensitive topic.

Before we begin, I must draw witnesses' attention to the following procedural matters. I advise them that by virtue of 17(2)(*l*) of the Defamation Act 2009 witnesses are protected by absolute privilege in respect of their evidence to this committee. However, if they are directed by the Chair to cease giving evidence on a particular matter and they continue to do so, they are entitled thereafter only to a qualified privilege in respect of their evidence. Witnesses are directed that only evidence connected with the subject matter of these proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. Any opening statements that have been submitted to the committee will be published on its website after the meeting.

To commence proceedings, I invite Senator Joan Freeman to make a few introductory remarks. I will then invite each witness to make a short presentation to the committee. They may share their time with a colleague if they wish. Witnesses should indicate this to the Chair when they are invited to speak. As there is a large number of witnesses in this session I ask that presenters keep their opening statements as brief and to the point as possible. I suggest they limit their remarks to five minutes. When the presentations have finished there will be time for

questions and comments from the Senators and responses from the witnesses.

Senator Joan Freeman: Today is important. I am sure many of the witnesses, most of whom I have met at some stage during my previous life, would agree. I will give a very brief summary of what we are trying to do. We are trying to paint a picture of truth, a picture of what our mental health services for children are really and truly like. That truth is so important, because if we do not tell the truth we cannot fix what is wrong. Last week we had a very harrowing day. We heard witnesses including parents who gave testimony about their children and what they have experienced so far. Some of the stories were very reflective of what is really going on in this country, but not once did the witnesses point the finger at any particular person or at the Child and Adolescent Mental Health Services, CAMHS, or at any of the agencies. They were pointing the finger, as am I, at a system. It is a system that is broken. This is nobody's fault, but I need the witnesses to tell the truth today so that we can see the true reality of what is happening to this country.

Our mental health services are dying. There is no two ways about it. I need witnesses not only to tell the truth, but also to come up with the most amazing ways of fixing that service, which I know they will. The next thing we have to do is to listen to that. Last week Dr. Geoffrey Shannon talked about outrage. Our country is very good at outrage, but after outrage comes action and that is where we are now. We are on the point of action starting today.

Dr. Elisabetta Petitbon: I thank the committee for inviting me here today. It is important. It is an honour and a privilege to be here. Over the last ten years of working in primary care in Ireland as a clinical psychologist and psychotherapist in private practice, there is one thing which I have consistently seen. It seems that we are not able to listen to our clients. Our clients come to us but we are not able to listen. That means that we are unable to provide an adequate service according to the needs of our population. I am saying that because I am trying to be brief. I want to get straight to the point and to the reason I am here today.

I am here today not really as a clinical psychologist but as a psychotherapist. Psychotherapy is a profession which I think is not looked upon and considered properly here in Ireland. Psychotherapists make up a fantastic workforce which is being overlooked. We have the resources. We have the people to employ as psychotherapists but it seems that we do not consider it as a good enough profession for the Health Service Executive, HSE, to employ. In my experience working in primary care in Ireland, the things that I could see include a very long waiting list and that CAMHS works only on an emergency basis. They are not able to provide treatment.

Families go away from CAMHS with a label but they have absolutely no idea what to do with that, as after there is no support. There is no social inclusion or education in the school. Primary care has a model with six sessions. In six sessions it is very rare to address the issue or the problems of families that come to us. When we speak about children, we talk about families and children in those families. We must provide a service for the children and families. Another issue is a lack of clarity. Working in primary care as a clinical psychologist, sometimes I do not know who I can refer and for what reason. There is not general clarity in Ireland for all services, such as CAMHS and primary care. It changes according to regions. That leads to much confusion for GPs, the population, social workers and everybody who works in the health service.

I am going to try to go straight to the point. There is one thing for which we have the resources, which is to try to better address the needs of our population and listen to what they need. An idea could be to create a walk-in clinic, as we do not have a 24-7 service for mental

health emergencies. We do not provide prevention or social inclusion like many countries have done in the past ten years. They are trying to ensure people are involved with prevention and education when it comes to mental health issues. If I am not mistaken, a couple of years ago the HSE produced a very catchy advertisement stating that if a person had any issue, he or she should speak with somebody. We did not follow up on that. Adolescents may be in quite a difficult time in their lives and emotions may go to the roof and back down. If they want to speak with somebody, there is a very long waiting list.

I want to bring an example to the committee's attention today relating to the resources we have. It is the Luxembourg example. It is a very small country and of course it is different from Ireland. Between 2000 and 2004, Luxembourg had a very difficult time with abuse of drugs and alcohol and the rate of suicide was 15 per 100,000 people. They injected much money into the health service, so much so that in 2016, it was ranked as the best European health service. They created many resources for mental health, including services that started to employ psychotherapists. Psychotherapy is a long-term treatment and it is cost-effective. This is not just my opinion and there is much research, especially lately, proving that if we want to stop the abuse of psychoactive drugs or self-medication, such as alcohol abuse, one must provide psychotherapy. It is exactly what they did in Luxembourg, providing psychotherapy everywhere, so much so that in 2013, a new report indicates that the suicide rate was 7.3 per 100,000 people, or half of what it had been. That is amazing.

Why am I using the Luxembourg example? With mental health, the only action it took was to provide psychotherapy and ensure that psychiatrists and psychologists, a fantastic work force for the public, worked together and agreed a template of what services would provide. That is exactly what Ireland can do. We have the Irish Council of Psychotherapy, which is the body guaranteeing a high standard for all the five modalities included in psychotherapy. We are not looking at that. In the HSE, unless the head of department has a special interest in psychotherapy, there are only clinical psychologists on staff. Some issues can be addressed with psychologists and screening but also with a trained psychotherapist.

I want Senators to remember one point. We are not looking at other professions that could be very useful for the population. One of those is psychotherapy.

Professor Brendan Kelly: I thank the committee for asking me to appear before it. I am a general adult psychiatrist, not a child and adolescent psychiatrist. I will speak a little about some of the knock-on effects of the state of the child and adolescent mental health service in Ireland. I will start with a fairly typical case I might see in a hospital emergency department. For example, it is not uncommon to see a 16-year-old or 17-year-old boy or girl who has self-harmed and is in need of some kind of crisis intervention. Very often, admission to a facility may be helpful in the short term. As an adult psychiatrist, I try very hard to meet the need of a person and family. For the most part, there is no admission bed available in the child and adolescent mental health service so it is very common for us to spend many hours on the telephone looking for a child and adolescent bed while trying to put in place a plan. Often I would have a very distraught and desperate family seeking a solution when it is the first time they would have encountered this kind of issue. They will need something. Those are the circumstances in which, occasionally, a child is admitted to an adult psychiatry unit. The point I make is that this is not something that is ever undertaken lightly but rather it is done in extreme and exceptional circumstances because there are many down sides to it. Very often it is done at the request of a very distressed family.

This is a very high-risk group, particularly adolescents. For Ireland as a whole, the rate of

suicide has fallen over the past six years by approximately 19%, which is a very significant national reduction. There is an exception, particularly in young males aged between 15 and 24, where the rate has actually gone up. There is a counter-trend going on and this is a very high-risk group. We also know children and adolescents account for approximately 25% of the population, and as far back as 2005, the College of Psychiatrists of Ireland pointed out that the mental health budget for children and adolescents is approximately 5% of the mental health budget. There is a disproportionate distribution of budget in this respect.

I am keen to focus on solutions and I share very much many of the points made by the previous speaker about the availability of psychological therapy and particularly psychotherapists. When we encourage people to speak, there should be someone for them to speak to. Many of these people come from settings where there may not be people to speak to and it is very important that is provided.

In terms of mental health policy, the long-term goal should be to implement A Vision for Change, the 2006 policy, which must be altered slightly and upscaled. We now have a population of 4.7 million people. The policy is quite good and with some tweaking it will be good for some time longer. However, we need a short-term solution as well because the situation is exceptionally difficult now, particularly with the recent closure of some of the child and adolescent inpatient beds owing to staffing problems. This must be addressed. The admission of children and adolescents to adult psychiatry units should cease, and there is no doubt about that. The question is how can this be achieved in a safe, sustainable fashion and how quickly it can be done. Some adolescents, such as 17 year olds, might present with the problems of adults. Some of them can be as large as adults and present with mental health problems like adults and admission to an adult unit might be indicated. Even then, however, an adolescent unit that examined their educational and broader needs would be preferable.

The key at present is retention of staff, in particular nursing and medical staff, as well as expansion to other disciplines. There must be a programme of meaningful incentives for staff to be recruited and, even more importantly, retained. Experienced staff are leaving the service owing to difficulties with retention. The incentives must be tailored and meaningful. This is not always or even chiefly about money for medical or nursing staff. It is to do with conditions of work and, in particular, career progression and an assurance about a career progression pathway. In the short term, a comprehensive staff recruitment and, especially, retention programme is required to try to operate the resource we already have. In the long term the implementation of the A Vision for Change recommendations is required, slightly changed and increased to account for a population of 4.7 million people.

The importance of this cannot be overstated, in particular the very acute plight of adolescents who end up in emergency departments following episodes of self-harm or other types of disturbance. As an adult psychiatrist I never admit such a person to an adult psychiatry unit unless all other options have been comprehensively examined and we have a person unable to go home and a family unable to deal with an outpatient option. However, there are times when it is necessary, given the circumstances. I urge that both a short-term and long-term approach be taken. That is all I recommend to the committee.

Chairman: The next speakers are Professor Fiona McNicholas and Dr. Blánaid Gavin who are sharing time.

Professor Fiona McNicholas: I thank the committee for this opportunity. I will add to what the committee has heard about the effects of the chronic and ongoing under-resourcing of

child psychiatry services by giving it an example from my perspective as a paediatric liaison psychiatrist. That is a sub-specialty of child psychiatry that provides treatment and assessment of children with co-morbid medical illness, for example, a child with leukaemia who develops psychosis as a result of the medication they are on or a severely medically compromised anorexic.

With the cessation of the on-call CAMHS and the ongoing CAMHS difficulty in accessing inpatient beds there has been an increasing number of presentations over the years to the emergency department. There has been a six-fold increase since 2006. Last year, there were 333 presentations in Temple Street and in Crumlin there were 105 acute mental health presentations and admissions to the hospital, on average staying about four days. Those bed numbers are not counted anywhere and are not collected. The Mental Health Commission does not look at them. I propose that they might also be as inappropriate as adult admissions in the absence of adequate resourcing of the liaison department staffing and also adequate training of the paediatric staff who are providing that care. Compared to our colleagues in the UK where the liaison departments see approximately 24% of urgent psychiatry cases, in Crumlin alone 60% of the liaison time is delivered to acute psychiatry, at the consequence of not being able to give care to the paediatric psychiatry complications. Many years of advocacy for services in Crumlin have not led to any improvements. I sincerely hope that Senator Freeman's initiative with this committee will address that.

To conclude, treatment of mental health disorders for children exists and is evidence based. Children can have and can look forward to good quality of care. In fact, over 400 parents and children surveyed attest to the value of and satisfaction with services once they access them. From the Government to ourselves, we all have a collective responsibility to continue to prioritise child mental health services so there is parity of esteem between those with medical conditions and those with mental health conditions.

Dr. Blánaid Gavin: I am a consultant child psychiatrist and I will pick up on the points made by my colleagues. Service provision in CAMHS is of grave concern to all those working in it. One of the fundamental issues that arises regularly, and has a direct impact in terms of the retention issues which have been mentioned already, is the fact it is a very harrowing experience to be placed in a position where children are presenting with acute mental health conditions where there are treatable evidence-based interventions yet the practitioners are not in a position to provide those interventions in a timely way. It is an incredibly helpless and harrowing position.

Much of the discourse that occurs about CAMHS has a quality that appears to be personalised in regard to the CAMHS system and does not reflect the fact that those working within the system can only work within the system as it is currently established. There are many issues of contention within that system. Clearly, CAMHS does not and should operate as a silo and is dependent on an array of additional services. However, within the current standard operating procedures there is an assumption of multiple layers of care and availability that quite simply do not exist. This adds to the significant barriers to access that parents experience on an ongoing basis, and also squeezes the available resources and expertise within CAMHS that should be targeting the severe end of the mental health spectrum.

There was a request at the outset for truth. The essence of truth is obviously the availability of facts, which are dependent on data. Unfortunately, there is no data available in regard to what is happening in CAMHS. To speak the truth we must have information and data that tell us what are the quality outcomes and what are the differences that the services make, so we can

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

Much of the focus to date has been on the idea of throughput and driving increased numbers without looking at a system-wide change and the quality of service provision. Key to quality is the integration of the voice of the service user and parent, which must inform the changes and the system-wide overhaul that is necessary. This requires not just tweaking but a root and branch change, with international expertise being brought to bear. They are changes that require the most thorough oversight of the available international evidence to ensure that we have a service fit for purpose for the generations to come.

Chairman: The next speakers are Dr. Brendan O'Shea and Dr. John O'Brien and I understand they are sharing time.

Dr. John O'Brien: My colleague, Dr. Brendan O'Shea, and I are general practitioners. We are here at the behest of the ICGP whose remit is educational training standards and research in Irish general practice. General practice provides a comprehensive, holistic and an ongoing care of individuals and families over prolonged periods of time, often extending over many generations of a family. It does not simply look at diseases, although it does that also, it addresses the physical, psychological, social and existential problems patients present with. It is a service that is available 24-7, 365 days of the year. GPs know their patients and the context within which they live their lives and, accordingly, they address their problems in that context. It is generally the point of first care and it is also the last resort when other services are insufficient or inaccessible. If the problem cannot be mended, it will eventually end up back in general practice.

Some 75% of the presentations to CAMHS are referred from general practice, with the remainder coming from a multiplicity of other sources such as social workers, schools, paediatricians and many others. The national audit of waiting times for CAMHS done in 2012-2013 showed that 50% of people were seen within a month and that 70% were seen within three months, but these figures, while sub-optimal in themselves, mask another problem in that they do not demonstrate the variability between one area and another. Furthermore, these figures do not accord with recent reports from GPs of their experience of waiting times, most especially in areas of deprivation.

The distribution of CAMHS is population-based - one team per 50,000 of the population. This crude allocation of resources takes no account of the greater need for mental health services in areas of deprivation. The Deep End Ireland group of GPs has conservatively estimated that the need is twice that of less deprived areas. This is yet another example of the inverse care

law where those with greatest need are least likely to have it met.

The composition of CAMHS is a psychiatrist along with a multidisciplinary team of nurses, psychologists, social workers, occupational therapists and junior doctors. These teams have been missing key staff to varying degrees in different areas. The net effect of this is that these teams are not able to do their work. The case load increases and more staff members leave the team because they are not able to work in a manner which is consistent with their own professional values. In Dublin 15, for example, we had a period where we had no child psychiatrist and this was followed by a further period of repeated changes of psychiatrists. This was not a service in any meaningful sense since lack of continuity is very disruptive. In recent years, CAMHS has defined the limits of what it does and has formalised this in its standard operating procedure. Regrettably, this was done without meaningful reference to its main source of referrals, general practice, and the result has been a cumbersome and fragmented referral structure. A GP must decide at the initial consultation if the child presenting has a leaning disability problem, an autism spectrum disorder, a severe mental health problem or a more minor one. Depending on the evaluation, the child will be referred to the assessment of need service, primary care psychology or CAMHS. Often, this is well within the clinical competence of the GP. However, since the initial presenting story is often complex and poorly defined at the front end, and also since the child's condition often changes while on the waiting list, the referral can very easily be misdirected, thus extending the waiting time even further. A more unified referral structure is badly needed and there needs to be an end to children being referred back to the GP with their problems unaddressed, a not uncommon experience for GPs and their patients.

There are 1.15 million people under the age of 18 years in Ireland. It is estimated that 115,000 have a mental health illness, causing some impairment, and 23,000 have severe and disabling mental health problems. Some 5% of the budget is spent on CAMHS. I am not sure if that is 5% of the national budget or the mental health budget, but with that allocation there is still a struggle to provide sufficiently for the need. GPs provide 25 million consultations every year but they are even more poorly resourced at 3% of the national budget.

The cheapest way to deal with childhood mental health is to intervene with resources as early as possible in the evolution of an illness in the domain where it is least expensive. GPs struggle to provide the care needed as they have little and often no resources to assist them. The ready provision of child psychology, family therapy, outreach workers and counselling psychotherapy is often insufficient, patchy or absent. If CAMHS is very expensive, and clearly it is, then the best solution is to properly support GP care where interventions are at their earliest and cheapest. Most importantly, this would save children and their families a great deal of unnecessary pain and distress.

The care of those with an autism spectrum disorder is also fragmented with service schemes for younger and for older children. CAMHS specifically excludes these children from their standard operating procedure, except where acute short-lived mental problems arise. The mental health intellectual disability service for children and adolescents is meant to look after that. This repeated fragmentation of care makes it nigh on impossible for the GP to make sense of what is going on.

The transition from a childhood mental health service to adult care is not working. The GPs are being left to care as best they can with the meagre resources at their disposal. The lack of a timely user-friendly mental health service for younger people is undoubtedly a cause of great concern. The unaddressed mental health issues these children suffer now will continue into adulthood and, along with the great distress suffered by them and their families, it is extremely

wasteful. The neglect at this early juncture inevitably leads on to greater cost of ensuing grave mental health problems, addictions and criminality. GPs who think in terms of decades and generations can see this unfolding from the perspective of their community-focused clinics. I will now pass over to Dr. Brendan O'Shea.

Dr. Brendan O'Shea: In preparing for this presentation, we consulted our colleagues within the ICGP and, in particular, colleagues in the Deep End group. Some of their feedback, when asked about their experience in this area of care, was that they were actually pretty good at working through the problems with these families when they come in but that they are eaten alive for time, that if they spend 40 minutes with an adolescent, the man with the prostate cancer, arthritis or dementia or the lady with diabetes and hypertension in the waiting room gets left out, that their practice nurse is deadly with these kids, especially the girls, but that she is hopelessly backed up and that it is a real pity because children and teenagers know them and even though adolescents find any interaction with adults challenging, most get on well with them when they make and sustain contact.

We have seven recommendations for consideration. Briefly, we recommend that a review of the referral structure for all childhood mental health problems, with an emphasis on the needs of children as they present in general practice, is undertaken and this should be informed with a formal input from families and as far as practically possible children and adolescents themselves. We also recommend that an out-of-hours CAMHS is put in place to cater for acute presentations in the out-of-hours setting and we recommend that close consideration should be given to integrating this with GP co-operatives. Those co-operatives are one of the few parts of the health system that stay switched on after 5 p.m. They are muscular organisations. They field 1 million consultations in the out-of-hours setting and a strand of CAMHS integrated into this would be well worthwhile considering. We recommend that as general practice is the principal referring agency and also the service to which these children and family will be referred back, far tighter liaison where the GP team is enabled to participate in an effective multidisciplinary process is essential. At present, we have major manpower problems in general practice. We need more general practitioners and we need many more practice nurses. Having more general practitioners and more practice nurses will allow people to engage in the process at the lower end of the pyramid before problems become more neglected, delayed, complex and severe.

We observe that general practice is the only part of the health system with electronic medical records and we recommend that child and adolescent mental health services, CAMHS, and the rest of the health care system should, in 2017, be using electronic medical records. It is inexplicable that this is not already the case in this State.

Regardless of configuration, all mental health services for children must be sufficiently staffed to carry out work in a timely manner and we should not have children and their families waiting and disimproving over months. The distribution of teams and resources must not be solely on the basis of population, but must have a deprivation weighting to account for greater need in such areas. Saying a certain amount of resources in Bray will do the same in Clondalkin or parts of Newbridge simply does not work out.

Rather than creating a stand-alone psychology service, psychologists, counsellors and family therapists should be allocated to specific general practitioner, GP, practices or groups of practices. We know that the majority of general practice is delivered by two, three and four doctor teams. Any of these teams, particularly in areas of deprivation, would be well able to and would benefit from having family therapy, counselling and child psychology located in the practices, where most of the children and families live in close proximity.

Community-based services should be sufficiently resourced to get in earlier into the lives of these vulnerable children, adolescents and their families.

I thank the committee for requesting input from the Irish College of General Practitioners. We strongly recommend this focus, which is pragmatic and centred on the needs of the families and children and not on the considerations of the health care professions. We also see that there is a bigger question for society. Why is the rate of suicide among adolescent males increasing? What is society putting in place for younger families and for children? We certainly have some of the answers in the health care professions, but society has other answers to provide as well.

Chairman: I thank Dr. O'Shea. We now have Mr. Paul Gilligan and Ms Orla Gogarty. I take it they are sharing time as well. I call Ms Orla Gogarty.

Ms Orla Gogarty: I thank the committee on behalf of St. Patrick's Mental Health Services for the opportunity provided to our organisation to present today. In particular, I thank Senator Joan Freeman for her tireless efforts in bringing a spotlight to this very important and serious issue in our society. I am a director at St. Patrick's Mental Health Services, which is Ireland's largest independent, not-for-profit mental health service provider. It is committed to the provision of the highest quality mental health care, the promotion of mental health, advocacy and the protection of rights and integrity of those experiencing mental health difficulties. These principles are central to how we deliver care. Willow Grove Adolescent Unit, an approved centre for our organisation, provides inpatient care and community care through our Dean Clinic in Lucan for children between 12 and 18 years of age. It is the only child and adolescent mental health service in the country to provide service users with a dedicated advocacy service for young people to support them to assert their rights and entitlements while being treated for their mental health difficulties as an inpatient.

I wanted to state that, having looked at some of the submissions from last Thursday, much of what we have to say has the themes of resourcing, integration and systematic integration of how we approach this problem. There are a number of points we want to emphasise in our submission. A report on the implementation of A Vision for Change, produced by Mental Health Reform in 2015, outlines that progress continues to be hindered by shortfalls in staffing and the lack of a clear, integrated implementation plan. According to this report, the development of all areas of specialist mental health care delivery has been weaker than anticipated and, indeed, Dr. Geoffrey Shannon referenced there being much vision and less change.

This is especially true of child and adolescent mental health services. The fifth and most recent HSE report on CAMHS, published in 2014, indicates that more than 100 children are admitted to adult inpatient units annually. The HSE performance report for October to December 2016 indicates that in excess of 1,250 children and adolescents waited for longer than three months for a first appointment, and that more than 200 waited for longer than a year. The report indicates that in 2016, of the children and adolescents admitted to inpatient units, only 69.2% were admitted to dedicated child and adolescent inpatient units, despite this being considered a priority issue.

The Mental Health Reform report on the progress of implementation of A Vision for Change outlines that there are no CAMHS-specific quality standards and guidelines and no quality and outcome monitoring system for CAMHS in Ireland. The report identifies that in March 2015, the operational capacity of the child and adolescent acute inpatient units was 58, out of a total existing bed complement of 66, and we know the trajectory in recent months has moved downwards again. A Vision for Change recommended 118 child and adolescent inpatient beds, based

on the 2011 census population data. Dr. Brendan Kelly has spoken about the need to revise the proportionality of bed provision with regard to population growth.

The report further identifies a number of specific gaps in specialist services for children and young people, and a lack of capacity in primary care services - which we just heard about - to detect effectively, treat and refer appropriately child and adolescent mental health difficulties. In addition, a number of children are sent annually by the HSE to the UK, the USA and Canada for highly specialised inpatient treatments which are not available in Ireland. Apart from the HSE, independent service providers in Ireland, like ourselves, also provide inpatient services. St. Patrick's Mental Health Services also provides a community-based mental health care clinic, our Dean Clinic. Waiting times for admission to independently run inpatient services is short when compared with statutory services.

I will let our CEO, Mr. Paul Gilligan, speak.

Mr. Paul Gilligan: As Ms Gogarty has said, we welcome the opportunity to come here today. Specifically, we welcome the opportunity because we are in the independent sector, which has a very important role to play in trying to resolve what we believe is a crisis in the child and adolescent mental health services. We have kept our submission specific and tried not to be repetitive, but it is worth saying that the solution to the difficulties is a long-term solution. We were asked for honesty and it is important to state that, over a number of years, there has been a lack of investment and a lack of forward planning in child and adolescent mental health services. That is not to criticise everyone. It is impossible to provide a comprehensive service with the sort of budgets that are being allocated. The result is that we have an understaffed service. It is very hard to keep or attract staff. We do not have any 24-7 services, and therefore the bulk of issues arising at weekends and evenings present at general hospitals, to GPs or to those services that are 24-7.

We believe a long-term plan must be put in place that will tackle this issue, specifically the issue of resourcing child and adolescent mental health services. It is at crisis point. We have heard from others about the angst and trauma of having to deal with a child who cannot get a service. We deal with that all the time in the independent sector. Distressed families ring who do not have health insurance and cannot gain access to independent services or get a service anywhere. We try to help those families to find appropriate services.

Specifically, we believe that a key thing that could be done in the short term would be to establish emergency inpatient assessment units. We believe that it is not ideal to ask families to travel from Waterford to Cork, but given that the bulk of admissions to adult units happens as a result of a lack of services available on a 24-7 basis, unless we can deliver CAMHS 24-7, which will be a medium-term solution, emergency inpatient units would go some way to addressing that specific issue. We believe that in the medium to long term we need a proper strategy around child and adolescent mental health services. We are signatories to the UN convention. If we do not provide children and adolescents with adequate and timely mental health services, we are not recognising their rights under that convention.

Dr. Brendan Doody: I thank the committee for inviting me here today. I welcome the opportunity to speak further to the submission I made on behalf of the consultant child and adolescent psychiatrists who work in the four HSE inpatient facilities. I will address the demands placed on inpatient services and will reflect on the goal set out in A Vision for Change that all young people under the age of 18 should be treated within age-appropriate facilities.

It is important to remember that prior to A Vision for Change, child and adolescent mental health services were organised primarily for children under 16. A Vision for Change set a challenge in extending the age threshold to 18. As we were starting from quite a low base to begin with, this was placing an additional demand on services. A significant investment in child and adolescent mental health services was thus needed at both community and inpatient levels. The recommendations for inpatient services, referred to earlier, called for a total of about 108 inpatient beds. It was also recommended that a proportion of those 108 beds be dedicated to the more specialist provision of a secure inpatient facility and the development of a dedicated inpatient eating disorder service. In 2007, there were just 12 inpatient beds available for the admission and treatment of young people under 18. Although there has been great progress over recent years, we are still not at the recommended level as set out in A Vision for Change.

The purpose of inpatient admission is the assessment and treatment of young people with the most severe mental health disorders through the provision of specific evidence-based treatment plans. There is a goal of achieving the earliest possible discharge in order that the young person is an inpatient for the shortest time possible. There must be an adequate number of beds available for access to be provided in a timely fashion. However, that is very difficult when the demand for inpatient admission exceeds the availability of inpatient services. The number of beds within the public system has now increased to a total of 76. However, not all the beds have been operational due to staffing challenges in respect of nurses and consultant psychiatrists.

I can speak to this matter as clinical director of the Linn Dara unit, where it has been necessary to close a number of beds temporarily because of nursing staff shortages. That was a very difficult decision to have to make, and it was made when it was not possible to continue to have the beds open. As a service, it is our priority to ensure they are reopened as soon as possible. I very much concur with previous speakers on the reasons for staffing difficulties. They have to do with a range of issues including pay, career progression and, particularly in certain parts of Dublin, the cost of living and accommodation. Within our service, most of our nursing staff travel quite a distance to work. When posts become available closer to where they live, it is not surprising that they take up those positions. As we increase and develop community services, we often draw staff from other existing services.

Over the past ten years approximately, a number of developments have taken place in respect of inpatient services. Since 2010, there has been a 40% increase in referrals to community child and adolescent mental health services. This is mirrored by the increase in admissions of young people under the age of 18 to inpatient beds. In 2007, there were 364 admissions and by 2015, the figure had increased to 503. The number of young people admitted to HSE and HSE-funded units over that time increased from 78 to 312 in 2016. While the number of children accessing beds in age-appropriate inpatient settings is increasing, so is demand. If we are to achieve the goal of having the minimum number of children requiring to be admitted to adult facilities, we have to adopt what I would describe as a whole-systems approach. It is about ensuring we have adequate resourcing of services at primary care level, adequately resourced teams in community services, and the option of intensive day services as an alternative to admission.

As the units are regional, often the young person may be admitted to a unit quite a significant distance from where he or she lives. If we have well-resourced services in the community, this may reduce the need for admission but, more importantly, it will also facilitate earlier discharge. When there is admission, there is obviously a very intensive treatment and support programme available to parents. Families find the step down to community services to be quite steep. Really it is sometimes very difficult for very stretched community services to meet the

needs of these families, a factor which may prolong admission unnecessarily. Children who are admitted to inpatient settings may also have complex needs. Some delayed discharges may be influenced by deficiencies in other services, for example, community child and family services or the specialist disability services we discussed earlier. There is a need to address resourcing within community services and to build up capacity at all levels. Then we need to look at the inpatient setting.

We must address the problem of beds that have been provided not being fully operational and available. The reasons for this clearly come down to issues of staffing. We also need to undertake a needs analysis in respect of the number of inpatient beds that are required. The report, A Vision for Change, recommended that a review take place in this regard. Comparison of bed numbers is often made only with the United Kingdom. To make a comparison with other countries with populations equivalent to the population of Ireland, Norway has a slightly larger population than Ireland but has more than 300 inpatient beds. Interestingly, its workforce in CAMHS numbers more than 3,000, whereas the total workforce in specialist child and adolescent mental health services in Ireland is 800. In addition, Finland, Germany, Denmark and New Zealand recommend inpatient bed provision significantly above what is currently provided here.

A review must be undertaken to determine the need for inpatient beds. We know secure inpatient facilities will come on stream and specialist inpatient beds are being developed as part of the new paediatric hospital. Having been involved in building and commissioning an inpatient unit, I know that a long lead-in time is needed to bring inpatient services online because the facilities must be commissioned and built and staff need to be recruited. We face challenges recruiting staff for the new unit in the new paediatric hospital.

To be able to provide the best inpatient service, we must be able to provide the best possible service at all levels. The key must be that children access a service at a level that is most appropriate to their needs and do not have to attend specialist or inpatient services where this would have been unnecessary if the appropriate intervention had been available at another level.

Chairman: We will now hear from the College of Psychiatrists of Ireland. I understand Dr. John Hillery and Dr. Maeve Doyle will share time.

Dr. John Hillery: I thank all members of the Seanad committee for shining a light on a neglected area in the health service. I am the president of the College of Psychiatrists of Ireland, the body statutorily responsible for training all psychiatrists in Ireland and ensuring the ongoing training and professional development of fully trained psychiatrists up to retirement and beyond if they are working in some way after they practise.

As doctors, all psychiatrists have undergone six years of medical training. After this, they do at least four years of basic specialist training followed by four years of higher specialist training. They may do several more years of training before they are entitled to apply for specialist recognition and, subsequently, for consultant posts. They are, therefore, a group of highly trained individuals.

As previous speakers noted, psychiatrists are not applying for jobs in the Irish health service. The first question we must ask is what employer running a business would have vacant posts which highly trained persons, whom the employer will have often trained, do not want to take up. We must also ask whether the employer is asking why this is happening and I am not sure employers are asking those questions. I am aware, however, that representatives of the

Health Service Executive will appear later.

The College of Psychiatrists of Ireland places a few regular messages in the public domain with varying degrees of resonance. The first is the total lack of funding for mental health services in general. Ireland falls far behind the countries to which Dr. Doody referred in this regard. Approximately 6% of the national health budget goes to mental health services in general, compared with figures of between 10% and 14% in some of the countries mentioned by Dr. Doody. The college has long called for the national budget given to mental health services to be increased progressively to 12%. My colleague from the Irish College of General Practitioners asked about the 5% figure. As I said to Dr. Doody, I am sure he would love to have 5% of the national health budget. Unfortunately, he probably has less than 5% of the 6% of the national health budget that is allocated to mental health. This is, as we keep saying, a scandal and I hope that message will go out from today's meeting. Child mental health services need much more funding, as do mental health services in general.

Recruitment and retention has been a major issue since I have been involved with the College of Psychiatrists of Ireland. The college has a manpower document, which lays out the needs for mental health services as regards consultant employment in 2020. The issue, however, is not only one of having somebody in post. I am the only person available in my current job, which means that if I want to take time off, there is a risk that the service will have to be closed down, which is not really possible, or we have to trawl around looking for someone to cover for me for a few days. That is not an uncommon scenario. Those of us in attendance who are in clinical practice are also stretching our time and our colleagues' patience because there would not be enough people in the system, even if every post were filled.

The College of Psychiatrists has stated there should be 180 child and adolescent psychiatrists in post by 2020 to allow people to do their clinical work, take the leave they are allowed, attend forums such as this to inform people as to what needs to be done, take part in personal professional development and train other psychiatrists. At the moment, we probably have between 80 and 90 posts and, as members will have heard, many of these are unfilled. One of the reasons is that people who train in the system see what happens to people like me who are losing our hair and getting wrinkles and decide there is a better world than this, one where they can practise as a psychiatrist in a team with other health professionals. They see their boss working alone without access to psychology and occupational therapy services and unable to take leave days when needed. They know there is a better environment elsewhere because they will have heard from friends in Australia and Canada about the systems there. This does not seem to be recognised. I was told recently, for example, that the HSE considers the time a consultant should have for non-clinical work, by which is meant activities such as supervising a junior doctor, is two hours per week. I have three junior doctors and I am meant to give them one hour of one-to-one supervision per week in addition to my supervision at clinics. I am already well ahead of what the HSE considers allowable and my attendance at this meeting is pushing me into unknown territory. We need people to act on the advice of the experts and we need to have more specialists in place.

There are simple issues around retention, some of which members will have heard. One of the basic issues I have raised recently is that I have junior doctors who are not paid at times because they have not been registered by their employer to pay them. Simple things are occurring in the public sector that no employer in the private sector would tolerate.

We heard also about waiting lists. The college has pointed out regularly that there are children with very serious mental health issues on waiting lists with children who need educational

assessments, assessments for anxiety and, as my colleague from general practice stated, assessments for the autistic spectrum. These children do not need to be on waiting lists for psychiatry; they need primary care assessments. Those who need secondary or tertiary care should then be allowed through the system to get this care.

I will conclude and ask Dr. Doyle, a former chairperson of our faculty of child an adolescent psychiatry, to continue. As a practising psychiatrist in a rural area, Dr. Doyle will be able to give many examples of what is taking place. She is also our college representative on the European Society of Child and Adolescent Psychiatry.

Dr. Maeve Doyle: I am very grateful for the opportunity to appear before the Seanad Public Consultation Committee. I am here assisting Dr. John Hillery, president of the College of Psychiatrists of Ireland, in my role as an executive member of the child and adolescent faculty of the college. As Dr. Hillery stated, I am a former chair of the child and adolescent faculty. I also served on the Mental Health Commission for a five-year period finishing in spring of 2017. I am currently the secretary of the board of the European Society of Child and Adolescent Psychiatry and, perhaps more important, I have been a practising child psychiatrist for the past 17 years in a rural catchment area.

Child psychiatry is a very young speciality in this country, with the first child psychiatry service established in 1963. I echo the concerns already outlined regarding the percentage of the health budget designated for mental health. A 6% spend on mental health as a proportion of the total health budget is scandalously low compared with other countries. For example, in the UK 12% of the budget is allocated to mental health services. In addition, A Vision for Change, the blueprint document published in 2006 in regard to the provision and development of all mental health services, advocated that 25% of the mental health budget should be designated to CAMHS. As stated earlier, 25% of the population are under the age of 18. The chronic underfunding and under-recognition of the importance of development of CAMHS is critical.

The most recent census of the Irish population indicated that there are 4.7 million people in this country, one quarter of whom are under the age of 18. It should be borne in mind that the recommendation of A Vision for Change, which is more than ten years old, was based on a population of 3.6 million. Briefly, what was advocated in A Vision for Change was that there would be 99 multidisciplinary CAMHS teams, headed by a consultant child and adolescent psychiatrist. Each team would be allocated 11 clinical whole-time equivalents for a population of 50,000. Currently, there are only 64 multidisciplinary teams for CAMHS throughout Ireland and, on average, only 50% of the multidisciplinary staff are in place.

In regard to the provision of appropriate child and adolescent inpatient psychiatric beds, the working groups emanating from A Vision for Change advocated between 106 and 116 beds for the population of 3.6 million. Although there has been progress in this area, it is insufficient. Currently, there is designation of 76 beds nationally but as of today only 48 of these are operational. The public inpatient beds are located in Cork, which can currently operate only 12 beds; Merlin Park in Galway, which can operate only 20 beds and in Linn Dara, Cherry Orchard, which has two units of 11 beds each, one of which, unfortunately, from 1 June had to be closed due to lack of staffing, meaning its capacity is reduced to 11 beds. There is another adolescent unit, St. Joseph's, Fairview, which is currently operating at a capacity of six beds rather than 12 due to a consultant departing and another consultant job-sharing. I refer to both St. Joseph's, Fairview and Linn Dara and therefore my ability to secure a bed for a person over or under 16 years of age has reduced considerably in the last couple of months.

It is obvious that the capacity of the system to provide assessment, diagnosis and treatment and to manage the risk of severely ill, mentally unwell young people is not adequate. It appears as though many people are not aware that mental health problems can and do present in our population of children and adolescents aged under 18. The types of problems seen by CAMHS include attention deficit hyperactivity disorder, ADHD, anxiety disorders such as obsessive compulsive disorder, school refusal, generalised anxiety disorder, mood disorders such as depression, anxiety, bipolar disorders, psychotic disorders such as schizophrenia, and eating disorders. The consultant child and adolescent psychiatrist is a professional who has completed medical training and has gone on to specialise in psychiatry and further sub-specialise in child psychiatry. He or she has the knowledge and expertise by virtue of their knowledge of physical conditions in childhood, developmental issues in children, psychiatric disorders in children and adolescents and psycho-pharmacology, as well as the clinical risk assessment, to be the clinical heads and leads of multidisciplinary teams. The complexity of the nature of some of the presentations to CAMHS, together with the risk inherent with many of these conditions, warrants leadership by a consultant child and adolescent psychiatrist.

The college is aware that there should not be a reliance on the admission of children to adult psychiatric units. A number of points need to made in this regard. As outlined by many speakers, there is an inadequate number of child and adolescent beds for the population in need of them. This means that in some cases a child or adolescent will have to be admitted to an adult unit because of the severity of his or her mental condition and the risk he or she poses. In general, these admissions are for short periods, with the aim of transferring to an appropriate adolescent unit. In some cases, capacity will delay this transfer. In other cases, particularly in the case of older adolescents, parents will want them treated in their geographical locality. I do not believe that people appreciate that often children and adolescents have to travel, on average, 100 miles to Dublin and back, to receive inpatient treatment whereas adults have a service in their local areas. In some cases, for example, a 17.5 year old with acute paranoid schizophrenia and co-morbid substance abuse who believes all of the staff on a unit are trying to kill him or her, the staff of an acute adult unit may be far more appropriately trained to manage this young man or woman's complex needs and the risk that he or she poses to himself or herself and others. In addition, he or she is likely to transition to adult services because of the nature of his or her psychopathology.

In regard to the issue of waiting lists for CAMHS, it would appear that the development of a single track of referrals needs to be dealt with as a matter of urgency. Many children and adolescents are placed on waiting lists for CAMHS inappropriately due to the lack of development of primary care services and disability services. For example, in my own area the number of primary care psychologists has declined from four when I started up my practice 17 years ago to only one. Although it is outlined in their brief that they can deal with children with mild anxiety by providing a brief number of sessions, by virtue of the fact that the waiting list to see a primary care psychology is 18 months, the problems of these children and adolescents will have escalated to the extent that they then present with severe anxiety problems that need to be addressed by CAMHS. A similar situation pertains in many areas around the county with regard to services for autism and autistic spectrum disorder. In some cases, including in my area, there are waiting lists of up to four years for this population. Many of these children are complex and will also have co-morbid psychiatric conditions and so they will be referred to CAMHS while their underlying condition, the autism, or ASD, will not be assessed or addressed.

A Vision for Change outlined a tiered approach to the complex needs of children, with primary care practitioners, such as GPs and public health nurses being the first port of call for

identifying psychological difficulties in children. Referral should then be to well-resourced primary care psychology services, which unfortunately have been seriously under-resourced. If intervention occurred at this juncture, some patients would be referred on to the more specialist tertiary services of CAMHS but others would remain in primary care. Another major deficit in service provision is for those children who present with emotional and behavioural difficulties due to learning problems. The roll-out of the National Educational Psychological Service, NEPS, has been disappointing in terms of people being inappropriately referred to CAMHS.

I cannot emphasise enough the issue of recruitment and retention in CAMHS that already has been addressed. A number of factors contribute to the ongoing crisis in this area, salaries being one, but as part of their contract, consultant psychiatrists are meant to assist with the development and progression of their services. In many areas governance structures do not permit the voice of child psychiatry to be heard. There is a lack of understanding of the clinical expertise, professionalism and training necessary to be a child psychiatrist, as well as a belief others can hold the risk and have this expertise. The lack of respect for the professionalism and expertise of child psychiatrists has led to a decrease in interest in this career. The lack of visibility of child and adolescent psychiatrists is clearly demonstrated in the disappointing fact that none was present on the expert group in the review of the Mental Health Act, despite many representations being made by the College of Psychiatrists. The college has advocated for distinct and separate mental health legislation for children, compliant with the UN Convention on the Rights of Persons with Disabilities, the Assisted Decision-Making (Capacity) Act 2015, the Mental Health Act 2001 and the Child Care Acts.

It is also disappointing that the new Mental Health Commission has no member from the profession of child psychiatry. Given that children and adolescents constitute almost one quarter of the population, one wonders if it is reflective of a lack of concern for young people. Once again, nominations from the College of Psychiatrists were sought and the president of the college wrote expressing concern that no child psychiatrist was a member of the Mental Health Commission. The body is charged with inspecting, visiting and addressing quality issues in approved mental health centres and community services.

I thank the representatives of the Seanad Public Consultation Committee for providing the College of Psychiatrists with the opportunity to address members on the current state of child and adolescent psychiatry services.

Dr. Yvonne Begley: I thank the Seanad Public Consultation Committee for the invitation to attend.

In 1998 I was fortunate to get my dream job as a child and adolescent psychiatrist with CAMHS in Limerick, having trained in London and spent eight years as a general practitioner in Hackney. When I arrived in Limerick in 1998, there were ten staff; now we have 66.

Fifteen years ago I set up a child and adolescent emergency system based on two simple principles. First, a young person and his or her family, teacher or GP who needs to access our service should be able to do so on the same day. The second principle involved continuity of care. If a young person comes to the service in crisis and speaks to somebody about being suicidal, he or she continues to see that person who is his or her key worker until he or she recovers and is discharged from the service. He or she does not have to tell three or four people his or her innermost thoughts and feelings. He or she does not have to keep repeating his or her story. Those are the two principles that underlie our emergency system which is accessible between 9 a.m. and 5 p.m., Monday to Friday. Out of hours, there are excellent crisis psychiatric nurses

who will also see children and adolescents in Limerick University Hospital, as well as a 24/7, all-year-round consultant child and psychiatric on-call rota to ensure consultant expertise is available.

From my position as a psychiatrist in the mid-west for 18 years, if Senator Joan Freeman's legislative proposal that children no longer be admitted to adult beds is passed, my job will become a nightmare. The last time I had a patient on the adult ward in Limerick, Ward 5B, was in April. She was admitted, having lacerated herself with a Stanley knife and required 74 stiches. She told me that if she went home, she would hang herself. She was refused access to the usual inpatient admission unit we use in Galway, as well as units in Dublin and St. Patrick's Hospital. Like every other patient I have admitted to the adult ward in the past 18 years, with the full consent of her parents and family, I admitted her to the ward until a more suitable alternative was found. The nurses on the ward are wonderful. They are kind, caring and human. They actually cleared the gym and a little garden to allow the patient in question to have access without being bothered by any of the other patients.

What has not been talked about is the agony of seeing a member of one's family lose his or her mind. The only reason a person is admitted is he or she is beyond reason. Speaking as a mother, if one of my children was beyond reason and suicidal, I would be glad if the Ward 5B nurses helped me to detain them until they saw sense again. I would not be complaining as they would still be alive.

People have spoken about the lack of money for our services. It would be a way of improving the services we provide. Another item of which we are short is managerial time and attention. The current management body in the mid-west has no child psychiatrist on it. The people whom I look after are in no position to talk about what is happening to them and their backs are to the wall. They need advocates who can speak for them. Child psychiatrists around the country need a voice in management circles. I would like 25% of managerial time to be given to my service. Limerick was the only place which did not receive an inpatient unit as recommended in A Vision for Change. If someone would like to help us build one, we would be happy enough.

Dr. Eddie Murphy: I am making this submission as a concerned citizen, the parent of two boys, Oisín and Darragh, and a practising clinical psychologist, with over 20 years' experience in health care. I see and understand the negative impact of the lack of services and vision for children and adults with mental health difficulties, autism and disabilities, as well as their families and communities. Mental health services are now where cardiac and cancer services were in the 1970s, namely, neglected, underfunded and tokenistic. As the cancer services launch their third national cancer strategy, we are waiting for a first national strategy focusing specifically on children's mental health.

Having recently experienced the youth mental health task force, although well meaning, it was essentially tinkering at the edges of a broken system, akin to putting an engine on a paddle boat when what was needed was an aeroplane. It underwhelmed, as well as lacking measurement, accountability, resources and, most of all, a vision.

Children's mental health needs to be seen beyond health care, a task that involves all of us. It is a societal issue covering the areas of justice, health and education. Gardaí, dedicated teachers, youth services, statutory, voluntary and charity partners all play vital roles. It is an equality issue, with vulnerable children at the brunt of social, educational and health inequalities and, particularly, the two great inequality challenges of 21st century society - health and housing. It is about more than the absence of mental illness. It is about services which offer positive

well-being through vision, passion and authenticity to advocate for rapid access, quality-driven, compassionate and evidenced-based therapies which promote hope, optimism, mental fitness and resilience. Effectively, services must be needs-led for children and their families.

I propose a vision which centres on three pillars, namely, children's centres of excellence with a one-stop shop and single point of entry; a needs-led step-care model and getting real about youth suicide prevention. The current system is broken. The dual track of CAMHS secondary care. on the one hand, and primary care, on the other, does not work. Children, families and carers are overwhelmed in having to navigate fragmented health care systems and bounced around local services, creating delays and causing further distress. Many times they fall through the cracks in service provision. CAMHS is a secondary service. It is the absence of appropriate primary care services, as well as school and community-based services, which exacerbates needs in CAMHS. GPs are totally frustrated by the system of referrals for children and refer simultaneously to important, underfunded and understaffed CAMHS secondary care services and primary care psychologists, where they exist. There are only 110 primary care psychologists. Medical classification models which use the diagnostic and statistical manual, DSM-5, or the international classification of diseases, ICD-10, as the sole criteria for acceptance into CAMHS are too narrow. They are not child or family-friendly or needs focused.

Children continually fall between the cracks. Recently, Mary, a 15 year old child with depression and self-harming whose name I have changed, was deemed not unwell enough for a CAMHS service. John, whose name I have changed also, who is on the spectrum with ASD and anxiety based issues, was not accepted in CAMHS and referred to a non-existing disability services where parents are overwhelmed and clamouring already in disability services for scarce resources and over the absence of intervention services. I see this on a daily basis. This is replicated right throughout the system. The system is broken.

A radical rethink on how services are provided is needed for children and families. We need to focus. It is better to light a candle than shout at the darkness.

We need one stop, single point of entry children's centres of excellence with appropriate staff governed through a broader psycho-social model - not a medical model - to deliver child and family centred care services. It would include psychologists, family support workers, child care workers, youth workers, play therapists, psycho-therapists, social care workers, medical staff such as GP, child psychiatrists, paediatricians and AMOs, audiologists, physiotherapists, occupational therapists, social workers, speech and language therapists. If we want to build a secondary school in the morning, we have a model and we can go out and build it and deliver that within a year to 18 months. We can deliver these appropriate centres if we have vision. All the care needs - the physical, sensory, emotional, disabilities and mental health - need to be seen from these sites. Significant strategic investment needs to ensure that these centres have family spaces, crèches, playgrounds, etc.

We need a single, open point of referral. Currently, there is no seamless single open point. If one asks any GP in the country, he or she is totally frustrated with the existing system. GPs cannot get children into the non-existing primary care services or CAMHS services. The CAMHS have raised the entry requirement so high, it is very difficult to get them in. I note my GP colleagues nodding here. They know it. They are at the front line. They see it every day. We see it every day and we see families in distress every day.

If we are serious about children's mental health, we need to be serious about funding and resources. Functioning and staffed children's centres of excellence need funding and resources.

Currently 6% of health funding goes to overall mental health. The corresponding figure is almost 13% in advanced economies. This is why I am saying mental health is neglected, underfunded and tokenistic.

The next thing we need is a needs-led stepped care model. That is what people are talking about. A needs-led model would start by being population based. Then it would be school based, with school guidance services. If one can imagine it like a pyramid, the top of the pyramid is the inpatient unit or day hospital, the next layer under that would be a CAMHS service but we need to look at making it broader. We need to look at the school based services, youth services, GP services and then primary care centres of excellence that encapsulate all of this.

With that stepped care model, one has a graded level of intervention appropriate to the needs of the child so that it is developmentally appropriate. It delivers rapid access initial assessments to prevent the escalation of presenting difficulties and the subsequent requirement for specialist health care services. We need to ensure that there is effective gate-keeping for specialist health care services and that way we will increase their capacity to see the most ill children. It would improve continuity of care for service users via co-ordinating shared care activities with specialist services. It would provide early intervention focusing on at-risk groups. My presentation includes some other bits in that regard but I want to talk about getting real about youth suicide.

Rapid access to primary care services serves an important suicide prevention function. For example, evidence indicates that many of those who complete suicide have prior contact with primary care staff. It is critical that those individuals in distress can rapidly access primary care mental staff who can reliably evaluate risk and organise care to meet their needs.

We need increased access to psychological therapies. Families are increasingly requesting more evidence-based talk therapies. We need to promote recovery-focused partnerships. A recovery focus for children needs to be adopted across children's mental health services, as in adult services where we ensure we are getting recovery focus.

It is important that we provide care in appropriate settings and provide emotional and mental health care outside of physical care environments, such as accident and emergency, on a 24-7 365 days-a-year basis once the person has been medically assessed. We need to increase access. People typically engage, and by increasing next-day access, we will achieve greater traction and a faster turnaround for individuals. Important quick actions would include the need for a focus on well-being, early intervention and prevention, enhanced well-being and mental health. We need to progress with passing the Public Health (Alcohol) Bill 2015 because alcohol and gambling impact significantly on Irish society.

We need to address the issue of children and families who are in direct provision, which is Ireland's new industrial schools outrage. We need to support families by prioritising affordable and quality child care services. We need to get a helicopter view on this and to get away from the issue of beds. We need to look at how we are delivering mental health care and wellness and well-being for our children.

We need to prioritise disability, autism and emotional support. There is nothing new there. There are children waiting two years or four years haphazardly around the country. It is important that children with disabilities get supported. Otherwise, they or their families are impacted with significant mental health needs. In education, we need a full restoration of guidance counsellors and to deploy more counsellors to secondary schools, and provide life skills for primary

and secondary school teachers.

Finally, there is the issue of legacy. I encourage the committee to think strategically and highlight the need for new thinking for 21st century services for children and families. The 1916 Proclamation refers to cherishing all the children of the nation equally but a line often forgotten is that the Republic declares its resolve to pursue the happiness of all its citizens. Let us have children's centres of excellences based in communities, appropriately funded and staffed, with partnerships with parents and children so that our children get the best physical, sensory, emotional, mental and psychological care where and when they need it. That is the measure of a society and the legacy I want for my children and all children in society.

Chairman: I thank Dr. Murphy. Finally, I call Mr. Gareth Noble.

Mr. Gareth Noble: I thank Senator Freeman for the invitation to address the committee as part of this ground-breaking initiative in identifying the challenges children and young people confront in accessing appropriate mental health services.

This day and period ahead is long overdue for families throughout our great Republic who have been affected by the challenges arising from a mental health crisis within their homes and communities. It has been too late for some but is an opportunity to assist so many others.

I address the committee as a solicitor who acts for children and young people and their families in a range of welfare cases. Through my work over ten years, I have witnessed at first hand the challenges families face in accessing mental health services at times of trauma and crisis. I have spoken to and advocated for many children directly who struggle with their mental health and well-being. I have collaborated closely with front-line staff employed by the HSE, Tusla and other public bodies which recognise and share many of the frustrations families and young people experience. Those committed people working within depleted services and dwindling budgets are in many individual cases heroic in their endeavours but they are also burnt out and the recruitment and retention of such talented committed and caring people is now also at crisis point. There has developed a culture within many parts of our mental health services of fire-fighting, but the fire has started by the time most children are seen and its often beyond the point of recovery by the time the problem has been identified and addressed.

The seminal document in reforming Ireland's mental health strategy published in 2006, the year I qualified as a solicitor, was entitled A Vision for Change. The strategy aimed to modernise our system and ensure better co-ordination and improved practices. As I reported to the Oireachtas Joint Committee on Children and Youth Affairs last week, I regret to say that this vision has not progressed at a rate that meets the demands and challenges placed upon services. The recent suspension of 11 beds from Linn Dara in west Dublin for inpatient care for children was accompanied almost with a resigned and collective shrug of the shoulder rather than with the urgent intervention at the highest levels that was required.

The Ireland of 2017 is one where 2,419 children and their families are currently awaiting a CAMHS appointment. Some 218 of these are waiting more than a year and 762 more than six months. This is a country where 15 of our counties remain without an out-of-hours and a weekend crisis service. Those of us who do provide a 24-hour service know only too well that most incidents occur after 5 p.m. and during weekend periods. This is a modern progressive western democracy and yet 67 children were admitted to inappropriate adult wards in 2016. I strongly welcome and support the publication of a Bill by Senator Freeman in December 2016 to provide that no child under the age of 18 years is placed in an adult psychiatric unit. As far

back as November 2006, the Mental Health Commission issued a code of practice relating to such admissions. This code was intended as a transitionary model of care pending the ending of such a practice by 2011. The year 2011 came and went, as did the following years, and now we are in 2017. It is my view that such a continuing practice is a potential breach of many legal rights instruments, including Article 24 of the UN Convention on the Rights of the Child, and indeed our own Constitution, in respect personal rights guaranteed by Article 40.3. and most recently by Article 42A. At a European level, the practice of detaining children in certain adult wards could well constitute a breach of Article 3 of the European Convention of Human Rights, which *inter alia* prohibits degrading treatment. Article 8 of the same convention promotes and provides a right to respect of one's private and family life. There are serious legal issues which arise out of this continuing practice. Our nearest neighbour in the United Kingdom has moved beyond us in providing a legislative basis for discontinuing such a model in line with best practice.

Adult psychiatric facilities are challenging and difficult environments, populated by very vulnerable individuals who often present with a range of mental health concerns. Some exhibit huge levels of distress and on occasion can be physically threatening. Such situations are difficult to manage and deal with for all concerned. Yet we are demanding that dozens of our most vulnerable teenagers each year cope with these placements and recover in them. I have seen many examples of young people returning home, having been exposed to such environments and being lost for ever. Effective recovery can happen only within the confines of a dedicated, safe and appropriate facility. The refrain from some who should and do know better is this: some bed is better than no bed. Are we so lacking in ambition, resolve and a rights-based approach that this is the best we can do?

I have spoken to many families and young people who talk about the sense of loneliness, rejection, fear and isolation in adult psychiatric facilities, often far from home. In contrast I visited adolescent facilities, including the service provided by Mr. Gilligan. In those contexts and in those care situations I have seen at first hand how young people supporting one another do so within a context where their care is managed by appropriate specialists in adolescent care, and where that sense of fear and isolation can be massively mitigated. We have a moral, political and legal duty to these children and this Bill is a crucial first step in achieving outcomes for children in situations of crisis.

This Bill may ultimately involve some timetabling and a need for staggered commencement orders to ensure staffing levels, protocols and facilities are available. Those timeframes need to be identified and they need to be short. They need to be driven by the same thirst for delivery as is present on the ground and in what this Bill sets out to achieve. Let the passage of the Bill proceed on those child-centred values, rather than on the pre-manufactured and restrictive concepts of ifs, buts, savers, exceptions, derogations etc.

Aside from the scandalously long waiting times for appointments for CAMHS there is also the lack of further CAMHS operating reports since 2014. This is a cause of massive concern and is despite the fact that annual reports were envisaged by A Vision for Change. Many CAMHS teams are excluding many young people from their services because they do not fit within the increasingly strict confines of their criteria and we find an increasing lack of flexibility in relation to same. Children with a dual diagnosis who experience mental health concerns but are also on the autism spectrum, for example, are not being provided for in a manner that has due regard to their needs. This non-inclusive approach to children with autism who experience mental health difficulties is something to which meaningful recognition must be given in

any proposed national autism strategy.

Children between the ages of 16 and 18 years are often referred to as being in the Cinderella age in accessing mental health services, too old to avail of adolescent care and too young for many other services. While children at the age of 16 years can often provide consent for general health services and procedures, it remains a grey area in respect of psychiatric care and interventions. Paediatric emergency departments are often accessible to children under 16 years; therefore the emergency presentation of children between 16 and 18 years occurs at adult hospitals, most if not all of which have woefully inadequate child psychiatry cover. Officially CAMHS refers to services being provided for young people until they reach adulthood. On the ground, however, referrals being accepted for children beyond their 16th birthday are virtually non-existent. Given that in 2010, 16 and 17 year olds constituted 68% of inpatient hospital admissions, the provision of care for this age group remains woefully inadequate. A full review of CAMHS services and priorities for this particularly vulnerable age group is required as a matter of priority.

The Government must lead in clearly identifying the terms of reference and areas of responsibility for each part of our mental health service, resource it and demand reporting mechanisms and protocols for accountable delivery. It can no longer be left to the HSE to dictate the rules of engagement. Such an approach since 2006 has demonstrably failed our children in crisis. Notwithstanding these many great instances of hardship, doors being closed, never-ending battles and burgeoning waiting lists, I have great hope and reason to be optimistic that the tide is turning in our endeavours to deliver for children. I am genuinely excited by the efforts by so many that are ongoing and are leading to real change. In 2012 I was asked by a small group of parents from across Ireland who had come together through the medium of Facebook to provide legal advice, advocacy and support. The DCA Warriors group was created as an online forum to lobby for change on behalf of parents and families who had children with additional needs, a disability or a specific life challenge. When I was approached by that group in March 2012, they numbered just over 200. As of yesterday evening, the number has grown to 14,152 and they are growing. Many of their stories relay shocking instances of State neglect in assisting parents as carers. I am seeing increasing numbers of cases where the mental health needs of children are deteriorating sharply and a rapid response to those presentations from State supports are simply not there. Those brave warriors are not going anywhere. Their bravery, resilience and fortitude should inspire us all. I could spend the rest of today highlighting examples of their successes in reversing adverse decisions made in respect of their children.

I met a grandmother from the south of the country recently. She took her hands in mine and she very quietly told me that the greatest challenge her family faces is ensuring that their very vulnerable teenage family member makes it through each day alive. When we as a country strive to assist those who get up early in the morning, let us also strive to ensure this approach includes those who do not get to bed at all at times of crisis. I refer to those who seek to secure the life and welfare of their children without appropriate support, respite or service provision, those families who remain on high alert and maintain a vigil, sometimes on shifts with other family members, sometimes carrying that burden alone to carry on fighting for their loved one, caring for them and willing they survive, never mind thrive. It is an intolerable position for so many. It is so far removed from child-centred approaches to policy making and policy delivery that it beggars belief.

This committee has demonstrated in its support for the public consultation process a proactive approach to leading a conversation on the specific requirements of a modern mental health

service from the perspective of a child. Statutory obligations regarding children refer to the rights and needs of the child being of paramount consideration. Using this as our guiding principle, we need to develop policies and services that truly do put children first.

The Mental Health (Amendment) Bill 2016 is a vital first step in progressing the rights of children. It requires cross-party, cross-departmental collaboration in ensuring its safe passage and subsequent implementation into law. Families and children across Ireland will look back on this period with great regard and great pride if we all work together to prioritise children's mental health and if we walk that walk together.

Chairman: I thank all the witnesses for their presentations. I will now take questions from Senators. I will ask the witnesses to respond. Let me stress that in view of the time, I will ask everybody to keep their questions and answers brief and to the point. To assist with that I will take the questioners in groups. I will start with Senator Freeman.

Senator Joan Freeman: I thank the Chairman and witnesses. I have three very brief questions, but beforehand I would like to address Dr. Begley. The Bill is also inclusive of exceptional circumstances. Her patient sounded like an exceptional circumstance but may I add that I am a little bit concerned with what she had to listen to when she approached two or three units and they said that they did not want to take the patient.

Dr. Yvonne Begley: Will I comment now?

Chairman: No. I will call Dr. Begley in time.

Dr. Yvonne Begley: Okay.

Senator Joan Freeman: My first of three questions is addressed to Dr. Brendan O'Shea. Will Dr. O'Shea indicate the changes that need to be made from the perspective of general practitioners? My second question is to Mr. Gilligan. I have visited mental health services all over the country and there seems to be a disconnect between public and private, or independent, services. Why is there a disconnect and what does Mr Gilligan suggest we might do to improve the situation? My third question is to Professor McNicholas. I am stunned to hear that the beds she mentioned are not included in the emergency beds for children out of hours. To be honest, it frightens me. Could she elaborate a little on that, particularly as I am not sure that everyone understands the importance of her remarks?

Senator Colette Kelleher: I thank all of the 14 witnesses for their different perspectives. The bit of conflict is also helpful. We are not all in agreement and there are different ways of addressing child mental health.

I was struck by Dr. O'Shea's and Dr. O'Brien's presentation, which drew our attention to the structural and societal reasons driving child mental ill health. They referenced the work of the Deep End group in particular. There is more mental ill health among poor children. The 2,700 children living in emergency accommodation have not had a good start in the context of their mental health journeys. The 1,200 children to whom Dr. Murphy referred who live in direct provision and the children who live on halting sites without access to basic services, such as running water in some cases, have not had a brilliant start in life in the context of their health and well-being. There was a young person from a LGBT background who spoke of the particular challenges they face and how those challenges manifest. Then there are people with disabilities and there are people with autism who do not fit into disability supports. I like the idea of a deprivation index and was shocked to hear that in Finglas in Dublin 15, where I started

my life as community worker, there is not a child psychiatrist. That seems both shocking and amazing.

On a more positive note, there was synergy between Dr. Murphy's and Dr. Petitbon's presentations regarding a one-stop shop, based at a particular level. I was involved in something similar when I worked on the Sure Start programme in England. When I walk around London now, I see children's centres so I do not think that what Dr. Murphy is suggesting is a pipe dream.

I have two questions. I agree with the recovery model to which Dr. Hillery referred. In the absence of this kind of walk-in service for primary care and the lack of services in CAMHS, is the use of medication discussed? There are many doctors in the room. Is medication something that is used in the absence of anything else? What are the witnesses' views on medication for children and those under 18 years in general? I have particular views but I would like to hear those of the witnesses, as doctors. We want the radical rethink about which Dr. Murphy spoke. If there was one thing that witnesses could insert in the report, they might let me know. However, I am most interested in their views on medication.

Senator Victor Boyhan: I thank all 14 witnesses. This is the Seanad at its best; it is the people's Parliament. The witnesses represent the people, as do we. They come from a different perspective, however. It is critical that all of us here can be proud of how this Parliament - the people's Parliament - is addressing an issue of such importance. I also acknowledge the professional values which are clearly enunciated by the witnesses, as professional people at the coalface. I do not intend to ask too many questions, although I do have one or two. I acknowledge the work done by Senator Freeman, the rapporteur, in co-ordinating this. She started this morning by saying that we want to have the truth and to have a truthful conversation. We have had that in buckets. I acknowledge that and thank her for it.

The witnesses have an advocacy role, as do we. I looked at A Vision for Change when preparing for today's meeting. I paid particular attention to the foreword, which was written by a former colleague of mine and then Minister of State with responsibility for mental health, Tim O'Malley, who is based in Limerick, and thought about how little has been done since 2006. On behalf of the then Government, the former Minister of State set out a clear policy in a clear document. How little of that has come to fruition.

Today, we have heard witnesses outline a litany of problems and huge challenges for the sector, for politicians and policymakers. The practitioners here clearly have a thirst for change and its delivery. I have three questions for them. While the witnesses engage with us, it is important that we engage with them in order to ensure that the process is meaningful. Can someone explain why we have seen a continued increase in suicide among young males? That is important. A number of people spoke about the recruitment and retention of staff. Can they provide an example of how that can be improved and how we can incentives the services to retain very capable and important staff?

Someone observed that 16 and 17 year olds seem to be overlooked in this service. Do the witnesses feel that we need a stand-alone service for 16 to 24 year olds and would it alleviate the pressure? Finally, there was a proposal for a national mental health service directorate. What are the witnesses' views on this? Is there a need for a specialist national mental health service directed with authority and accountability and controls that would be resourced?

I thank the witnesses for once again shining a light on this very important issue.

Chairman: I am calling the Senators in the order in which they indicated. Some of them indicated a long time ago but we are only getting there now, so I ask them to bear with me. I will take two others and return to the witnesses. Senator Máire Devine is next.

Senator Máire Devine: I thank all the witnesses for attending. It is our second full day of hearings and our eyes have been opened. I have spent a lifetime as a psychiatric nurse and I know the ins and outs and intricacies of it all. As my colleague observed, recruitment and retention are important. I would say to Dr. Doody that the events relating to Linn Dara highlight the shambles - in its entirety - that is our child and adolescent mental health service. Every day, I plead with the Minister of State, Deputy Jim Daly, to place the response to this matter on an emergency footing. There are solutions available. There are solutions in respect of recruitment and retention, including fast-tracking and putting in place acting clinical nurse specialists. I say that as someone who comes from a nursing background. These are imaginative solutions, as are those relating to education support and housing. The closure of 11 beds at Linn Dara should never have happened. As a result of the closure, there are now only 48 beds available for children and adolescents. This is the cause of so much sadness for parents and children who are waiting for access to those services. We have the capacity to place the response to this matter on an emergency footing. That is what we should have done; we should not have waited.

Can Professor Kelly say what a typical Friday night in Tallaght hospital is like when there are no inpatient beds available and when it is necessary to admit a child to an adult unit? Can he speak of the admission process and what he has to do?

My alma mater is St. James's primary school, where I have been involved in listening to the input of people from St. Patrick's Mental Health Services, the Department of Education and Skills and other organisations into a programme called Mission Impossible. The programme starts in junior infants and the proposal is to give 600 hours of well-being to children from first to sixth class. I want to ask the witnesses from St. Patrick's Mental Health Services for their perspective on a programme that seems to be achieving great results. The programme relates to the education aspect of this issue, as well as to matters involving housing and health.

On the review of the Mental Health Act and the emphasis on children in their own right, will the representatives from the College of Psychiatrists of Ireland say how we might begin this as soon as possible in order to help and enable our children?

Finally, I commend Dr. Murphy. He spoke from the heart and gave us the step programme for children's and adolescents' mental health. I commend him on doing so and I am delighted that he used my phrase, which was used by the leaders in 1916, about the pursuit of our happiness. Happiness is a central element of childhood. When we think of that, we think of children jumping, laughing, screaming, crying and fighting. All of that is childhood. It is so finite; we do not have it for long. I commend the witnesses and I believe they make great sense. Go raibh míle maith agaibh.

Senator Pádraig Ó Céidigh: Gabhaim buíochas le chuile dhuine a rinne-----

Chairman: As briefly as the Senator can. Ceisteanna.

Senator Pádraig Ó Céidigh: Ceart go leor. Déanfaidh mé i mBéarla é. I thank Senator Freeman, in particular. This has been hugely important and is way overdue. It is the first time anything like this has happened in these Houses, as my colleague, Senator Victor Boyhan, has said. I have a couple of quick questions. I made a lot of notes on what the witnesses said. I

will ask for their general opinions and views to help us draft the document that will be led by my colleague, Senator Freeman. I also have two specific questions.

First, I noticed a huge amount of frustration and despair as well as the witnesses' willingness and desire to do their job professionally. I also noticed that the witnesses are under serious stress in trying to do their job and are really struggling to get their job done for a couple of reasons. One of those reasons is the blockage with regard to access. There is no joined-up thinking. There are huge issues with regard to staff. Dr. Hillery, in particular, highlighted that. He has to find the time today to fill up the gap of work he has to do, which still does not fill up his week's tasks. Other issues include the out-of-hours CAMHS and the lack of electronic medical records.

With regard to solutions, I want to check with the witnesses to see if I have this correct. This came up during the session last week as well. Primary care teams and primary care centres seem to be critical to this. I would concur with what Senator Devine said to Dr. Eddie Murphy about that triangle. I did a triangle out and at the bottom of it is community. I want to get the views of the other experts on that. Community has got to do with primary care and schools. It is not good enough putting an ad on television costing €200,000 or €300,000 that tells people to talk to somebody. That is absolute rubbish and slightly disingenuous to say the least, as well as a waste of good money. The second part is about inpatient facilities. The third part of it is about emergency care. The triangle is turned upside down. Do the witnesses agree with that? I would like to hear their views on how we can influence the Government to turn the triangle and have it working the right way up in the short, medium and long term. In regard to the long term, the witnesses mentioned A Vision for Change. That is more than ten years old. The witnesses are fighting a fire that is growing bigger and bigger. I believe the witnesses and their colleagues are getting seriously burnt in that fire.

I have two questions for Dr. Brendan Doody. The generic inpatient units cannot meet the needs of a fraction of young people. How does the witness see a way to change that? What is his short, medium and long term recommended strategy for that? He mentioned the admission to an adult unit takes place where there is a clear clinical imperative and that many factors contribute to this. What about the lack of qualified staff? That seems to me to be priority number one. The first thing I thought of is that if we do what we always-----

Chairman: A question.

Senator Pádraig Ó Céidigh: I have asked a general question and I now have specific questions-----

Chairman: With respect, we do not need answers from this side.

Senator Pádraig Ó Céidigh: If we do what we always did, we will get what we always got. In this case, we are not getting what we always got. We are getting a lot worse than what we always got.

Chairman: Mr. Paul Gilligan got the first question from Senator Freeman. Senators are used to making Second Stage speeches. I ask all to concern themselves with answers to the questions that are as brief as possible. If the witnesses miss a question or two, they need not worry too much about it. Mr. Gilligan got the first question.

Senator Colette Kelleher: I think-----

Chairman: I do not want Senators contributing again.

Senator Colette Kelleher: The people were Dr. O'Shea, Mr. Gilligan-----

Chairman: I have them in turn, but as I recall it, the first question went to Mr. Gilligan. Am I wrong on that?

Senator Colette Kelleher: It actually went to Dr. O'Shea.

Chairman: My apologies. I call Dr. O'Shea and ask him to be as brief as possible because I am afraid we will run out of time.

Dr. Brendan O'Shea: I am happy to take the first question, but we felt there were several questions directed at general practice. Will we take-----

Chairman: Whatever questions the witness thinks appropriate.

Dr. Brendan O'Shea: I thank the Chair. Senator Freeman asked about changes from the perspective of general practice and what would we do if we had a magic wand. We are looking at this as a clinical pyramid. Much of the conversation is focused at the top end of the pyramid. Extreme cases involve suicidality and the suicide of young male adolescents. These are really important aspects of it. If we want to impact the health of the community and the nation, we will target resources into the middle and the bottom part of the pyramid into the less severe spectrum and at an earlier stage in the process of complex histories. If we had a magic wand in general practice, we would have some more general practitioners in the system and a lot more practiced nurses in the system. These are the health care professionals who are the most accessible for children, adolescents and their stressed parents. These are the health care professionals who live in closest proximity to the community. We think we are very skilled in terms of generalisms and provide generalist care. We are confident, based on best international research, in particular from the United States, Canada and the Commonwealth countries, that investment in primary care and community medicine pays huge dividends in the long term. There are analogies in education. Every €1 spent on children under five years of age gives a €15 or €20 return in the long term. If that €1 is spent on children between ten and 15 years of age, we get less of a return. We need to put the resources into the communities.

A second observation in response to Senator Freeman's question is that, again, when we are looking at resources based on small area research, whether secondary care, primary care or CAMHS, we need deprivation weighting. We know that our colleagues in the HSE have expertise in small area health research. We would recommend that this be reflected in whatever it is decided to do. We also recommend the onset of smart medicine. It is a curious society we live in. Adolescents are perfectly at home with electronic media. Health care professionals, the health services and, in particular, secondary care services are seriously uncomfortable with it. All over our society we do very clever things with smart media, social media and so on. We need electronic medical records and better interfaces with the demographic we are trying to serve. This is not now expensive. It has become far more reliable and has become accepted in more advanced health care systems than our own.

Senator Ó Céidigh asked about primary care teams and centres. The ICGP has a very well thought out position on this. We have been talking about them since 2001 when Deputy Micheál Martin launched the health strategy. Our colleagues in the HSE have a perspective on it and the ICGP has a different perspective on it. It is a fact that the composition of the primary care team has no mental health professional on it. That is incredible. The ICGP regards pri-

mary care teams with some degree of hope, but they are not functional. We have similar feelings towards primary care centres. In effect, in the whole body of general practitioners, we have not been able to effectively engage with primary care centres. We will go back to the drawing board in the interest of the well-being of this demographic. In the interest of all our patients, we will talk until the cows come home. They are not working. That is the message of the ICGP on primary care teams and centres. We reiterate some of our other recommendations that a strand of child and adolescent mental health services should be integrated into GP co-operatives. I will stop now because we are well into injury time.

Chairman: I appreciate that-----

Senator Colette Kelleher: What about medication?

Dr. Brendan O'Shea: In response to the Senator's question about medication, we regard the need for medication as clearly indicative of serious spectrum child and adolescent psychiatric disorder. It should be embarked on with caution. It is not any sort of solution for adequate talk therapies, whether that is family therapy, counsellors or psychologists, who should be located in general practices. If the primary care centres are working, they should be located there. They should not be located 20, 30 or 100 miles away.

Chairman: I think there was a question directed at Professor Brendan Kelly. Would he like to make a brief comment or answer the question?

Professor Brendan Kelly: The point about anti-depressants is an interesting one. Generally speaking, Ireland is a low-medication society. We are on the EU average for anti-depressants in adults. In children, the rate of prescribing anti-depressants was 4.7 per 1,000 in 2002. That fell over subsequent years to 2.6 per 1,000. It is important that medication is only used when appropriate and, when indicated, always as part of a broader treatment plan.

With regard to Senator Ó Céidigh's comment, I support the idea of the pyramid very strongly, and our comments focused on the top of that pyramid. That is the part that one is involved in professionally, and as a citizen and as a parent one is aware of the need for intervention in schools and of the sociological awareness that deprivation is a huge driver of distress at population level.

With regard to a Friday night in an emergency department in a hospital, as a general adult psychiatrist on call, I have been in all the major hospitals. One would commonly see a 16 year old or 17 year old child who presents with a very distressed family, possibly following self-harm or an overdose. His or her medical needs are attended to by the emergency department staff but then comes the difficult part, which is dealing with the underpinnings of what brought that child to this point. The emergency departments in our hospitals are busy and noisy places. I have always been impressed by the way the staff try their best to accommodate the emotional and psychological needs of children and families, but they can only do so much. I see the person, or the junior doctor might see the person, and if the child or young adult requires inpatient care, we embark on the search for a bed. It is not always the case that they need inpatient care as the vast majority do not. We seek a bed in a child and adolescent unit. When a child might need to be admitted to an adult unit, we need to fill out a statutory Mental Health Commission form detailing the efforts we made to find a bed in an adolescent unit. We try to phone every single one in the country during the middle of the night. I might be in at 2 a.m. and spend three or four hours on the telephone trying to see if there is a bed but knowing in my heart that if I am in Dublin and I do identify a bed in Cork, it is very unlikely that it is the right move for the

patient or the family. It can be very difficult at night to do that anyway, and it is under that kind of circumstance where there is no other alternative that a child is admitted to an adult unit.

I share the experience of my colleague, Dr. Begley, in that I have been impressed by the adult psychiatry staff's efforts to make special bespoke arrangements for any admitted child, but it is a fact that most of the admissions do not meet the requirements in terms of educational provision for children or separate occupational therapy for children. We do it in the circumstances described and it has always been with the support, as it were, of parents or guardians who appreciate that this bad option is the best of the bad options.

Dr. John Hillery: Four areas were mentioned. The first is the law. The college has asked that there would be a specific law relating to children because they are different from adults and also the current Mental Health Act does not have a human rights approach to children in that they do not have the same protections as adults under the law. We feel that should change. My colleague already said how we did not have an opportunity to give direct feedback into the development of the recommendations for a new law. We hope we will get more of a chance in the future.

As regards recruitment for medicine, the MacCraith report which came out in 2014 gives very clear and practical guidelines on how to ensure the doctors we train here stay here and how the doctors we employ here continue to practise here rather than leaving the country. We have called on many occasions for the HSE to implement the report, which is a very good report, in several stages. It was recently backed up by the report of Professor Frank Keane and his group looking at recruitment and retention of the medical workforce in Ireland.

As my colleague, Professor Kelly, has said, medication has its place. We do not support its use when it should not be used. I could add to that though that we do see patients presenting with a need for medication because they did not get intervention at an earlier stage of the course of their illness, which might have prevented them reaching that stage.

As regards suicidality, we could have a whole week on that here. Obviously, people who are experiencing suicidal ideation and suicidal intent need appropriate psychiatric assessments, but we also know that for young people there is the issue of societal exclusion and how we deal with that. There are simple things that could be done through the Oireachtas to improve inclusion of young people. We have a lot of national organisations that are working very hard to do this. Some of them are subject to taxes, which take some of their money away. I speak of sporting organisations, for instance, and it should be quite simple for the Oireachtas to take steps to ensure our community organisations are not penalised financially for the work they are doing, often done by volunteers but they are still having to pay rates and other things for buildings where they try to bring young people and get them involved in things. The big issue, other than mental illness, is exclusion from society.

Mr. Paul Gilligan: I would like first to deal with the question asked by Senator Devine. One of the things that the independent sector can do that perhaps the statutory sector cannot is engage in different projects and fund things that may be difficult to fund. One of the biggest issues for young people is stigma. Presenting to a mental health service is very difficult. It is something we have not talked about today. There are many initiatives but St. Patrick's Mental Health Services has been able to develop initiatives, some directly focused on anti-stigma, one called Walk In My Shoes and another called #MindYourSelfie, all appealing to the technology savvy generation. The Senator spoke a little bit about Mission Possible, which is a school-based initiative that has been very successful. It is very important to acknowledge that if we

can deal with stigma and address awareness, we will increase the number of people who seek help earlier.

The second question was asked by Senator Freeman. Historically, there has been a disconnect between the independent private sector and the statutory sector. A Vision for Change did not envisage a role for the independent sector. While that has changed significantly in the past ten years, there is much more work to be done on that. At the moment there are many examples of co-operative work and working together, but it is not strategically planned and it tends to be demand-led. We would like to see a shift in that. If there is one thing I wish to emphasise it is that in the report it would be important to write in a role for and place an obligation on the independent private sector because we are up for this. We believe we must all work together - the voluntary sector, the independent sector and the statutory sector - to address what is a very serious problem.

I will finish by asking my colleague, Ms Gogarty to just give one example. It will be very brief.

Ms Orla Gogarty: I wish to cite an example of how we can work in a very functional and progressive way with our colleagues in the Health Service Executive. It is probably not a known fact that as an independently governed organisation, we probably have some freedoms that, as Mr. Gilligan mentioned, statutory services do not have.

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

Senator Keith Swanick: I thank all the contributors. I will be brief. It comes as no surprise to me that only 3% of the health budget is spent on general practice, which facilitates 25 million consultations per year with a satisfaction rating of greater than 95%. It also comes as no surprise to me but it saddens me that for the first time ever in the history of the State, GP training posts this year are unfilled. There are just 171 GP trainees embarking on a career in general practice. The training programme will take four years. I do not know how many of them will qualify or how many of them will stay in Ireland but what I do know is that 900 GPs will retire over the next five years. That will have a direct impact on the provision of mental health services in this country. General practitioners are excellent at diagnosing mental health problems in adults and young people. They are the first port of call. They are the foot soldiers in the community. That is why I believe the lack of GP trainees will have a direct impact on the provision of mental health services. The Minister and the HSE need to address the elephant in the room and to resource the sector adequately.

Chairman: An bhfuil aon cheist agat?

Senator Keith Swanick: I agree wholeheartedly that psychologists should be attached to

general practitioners. It would be a good idea to have one psychologist shared among three or four practices. Sometimes there is an overemphasis on the bricks and mortar of primary care centres rather than on the activity within those centres, and this needs to be addressed.

I call on the Minister to facilitate a rapid-access 24-hour CAMHS referral service for general practitioners. We heard stories from parents last week and the common theme was that every parent ended up in an emergency department with their child. That is improper. A 24-hour rapid access referral service to a CAMHS team would prevent children attending emergency departments unnecessarily. It would not be abused.

Chairman: When the report is complete there will be a chance for a debate with the Minister.

Senator Keith Swanick: Dr. Brendan Doody said that there were 12 inpatient beds in 2007 and there are 76 now, some of which are not always filled due to staffing problems. What is the number of beds filled in an average week?

Senator Frances Black: I appreciate the outstanding work the witnesses do. There seems to be a lot of firefighting and it must be very difficult without the supports. There will obviously be burnout and this is a particular problem when one works with children. I want to get the opinions of witnesses on what Dr. Geoffrey Shannon, the Government special rapporteur for child protection, said a couple of weeks ago.

Chairman: There is no time for opinions.

Senator Frances Black: I am looking for answers. The biggest challenge facing society is the adverse consequences for the welfare of many children posed by alcohol. Drug and alcohol abuse are key features in this report and they have a damaging effect on children. The failure by society to address alcohol as a fundamental problem places insurmountable problems on the child protection system. It is not just about Tusla and gardaí but society and our ambivalence to alcohol and substance abuse. One in four deaths of men aged between 15 and 39 in Ireland is due to alcohol and it is a factor in half of all suicides in Ireland and over one third of deliberate self-harm cases, peaking at weekends and public holidays. What are the answers to this issue? It plays a huge role and there is very little talk around it. The witnesses gave great presentations and I would like Dr. Eddie Murphy to talk a bit about this. Perhaps some of the GPs could also respond.

I work in this area with families impacted by alcohol. When one parent lives with another who is an alcoholic the stress, anxiety and mental health issues are off the Richter scale. They cannot be present to their children and their children end up looking after the other children in the family. It is devastating.

Senator John Dolan: I ask the witnesses to reflect on a couple of points. I appreciate what Senator Freeman has done in this area. I want to try to be present in these families where there is a disintegration of hope and I acknowledge the frustrations of staff working in the services. We are dealing with a crisis but we have to set up supports for people's health and well-being which are more than just health services. They must involve a community environment for children and young people. Tomorrow week the Government will launch a national disability strategy implementation plan to move forward the UN Convention on the Rights of Persons with Disabilities and this includes mental health. It will be interesting to see how well or otherwise it deals with this topic. I have seen many children and young people with chronic health

issues and life-threatening and life-limiting conditions. Co-morbidity, mental health and well-being issues come down like a cloud on top of children and their families.

Chairman: Does the Senator not have a question?

Senator John Dolan: I have put my question. I was at the launch of A Vision for Change and I felt the hope and optimism of all the people in the room. It is depressing. The Taoiseach, on returning from Áras an Uachtaráin, stated that this State would ratify the convention by the end of this year.

Chairman: I ask Senator McFadden to be as brief as she can and to put a question.

Senator Gabrielle McFadden: As the first person to speak from the Government party I feel bound to stand up for the Government. The Government does not wake up in the morning and decide to make people's lives miserable by cutting the budget for mental health services. We are coming out of a very severe recession and these discussions are about seeing how we can go forward as a group, rather than giving out about budgets. I regularly speak in the House on mental health issues and the rights of people with disabilities and I have regularly spoken on the need for CAMHS services in the midlands. I have a 21 year old with mental health issues who was sent to hospital in an ambulance and sent home again in a taxi 12 hours later, at 10 p.m., so I know what everybody else knows.

My father used to talk about there being too many chiefs and not enough Indians and there seems to be an awful lot of managers. There seems to be an enormous lack of procedure and of joined-up thinking in the services, which would have led to the 21 year old child of whom I spoke being sent home in a taxi. There are not enough front-line staff nor enough psychologists or primary care teams.

Dr. Hillery spoke about retention and salaries. Can he tell me how the salaries of a psychiatrist and a psychologist compare? What about psychiatrists here and their counterparts in the UK? Can he also tell me what the figures are for retention in the UK as compared to here?

Senator Paudie Coffey: I acknowledge the significant contribution and the expertise of the professionals who have spoken today, and their experience at the coal face. It is important that we, as policy makers and legislators, hear where the gaps and deficits are so that we can influence the real decision makers, who should be here to listen to the real-life stories and the frustrations I am hearing from those present. I am talking of the faceless bureaucrats and the decision makers.

Senator Keith Swanick: Hear, hear.

Senator Paudie Coffey: They are the number crunchers within the HSE and Tusla.

Senator Colette Kelleher: They are coming in this afternoon.

Senator Paudie Coffey: I know they are. Let me give my opinion because I wish to put my frustration on record. In 2011, I made my maiden speech to the Dáil on the issue of suicide. I lost six close friends over many years for different reasons. While some of them may never have been saved, the questions I want to ask today concern access to service. When somebody confides in a community leader, whether it is a chairperson of a GAA club or a Foróige leader, to where do those people turn to give that young person access to the supports and the services he or she so badly needs? I do not see it. I am very frustrated. I know that a large amount of

money is being spent on mental health services but we are not using it efficiently.

I want to focus on primary care. The general practitioner's practice is already a very busy environment and it can be hard to get an appointment. How can a resource be put into primary care to support the GPs and the practice nurses when a patient presents? If a local volunteer is struggling to deal with a young person with suicidal ideation, possibly over the weekend, how do such people access the service or refer someone? How can we specifically put a resource in there to assist those people? These are the resources and the supports we need. We can talk all day and all night but how can it be put in place at the coalface in order that people can access the services the witnesses provide and then try to link in and cross-cut the various Departments and supports?

Professor Fiona McNicholas: I cannot understand why the number of psychiatry admissions to the paediatric units is not on record anywhere. I mentioned only one hospital but there are three in Dublin. Liaison psychiatry provision is not mentioned in the recent national mental health document. Child psychiatry services in paediatric hospitals are not funded by the mental health division but from the acute hospital budget. They are piggybacking on other services. If I was cynical I would say that perhaps they are best left hidden.

There is a broader picture about collecting data on mental health cases in general. My colleague alluded to the idea that if we do not have the right facts we are not going to be able to find the solutions. Numbers are counted in respect of how many go through but no effort is made to look at complexity, the clinical treatment offered or the outcome. My larger concern is that the difficulty in understanding what is done by CAMHS is mirrored by the committee's concern about GP practices and other infrastructure and the need to provide more resources for those. All of that definitely needs to happen but we are talking about community services including alcohol use, societal issues and housing problems, which are indicative of the primary interventions that are needed to optimise mental health and well-being in order that the small number who actually have psychiatric illness and who require very specialist services will actually get them. Our understanding was that today the committee's focus was to be on the issue at the top of the pyramid. We would, of course, like both to be resourced and consequently it is new and separate funding that should be considered by the Government.

Dr. Yvonne Begley: A Senator who I believe has left the room asked why the suicide rate is going up in 15 to 19 year olds. To echo what Professor McNicholas said, what we are dealing with is mental illness. When I became a doctor I wanted to answer the questions of why people get ill, why people get cancer, why one person might catch a cold and another does not. The fact is that illness exists. I am a doctor and I treat people who are ill, and some of the people who complete suicide are ill and need to see a doctor or access a medical service. If I asked a consultant surgeon to look after children with appendicitis and I would not give them an anaesthetist, an operating theatre or any theatre nurses but a room in the hospital somewhere in which to provide care for their patient he or she would resign on the spot. If we take away what little access to beds we have when we are on call - many of my colleagues will not cover the on-call rota anymore because they will be left looking after someone who is ill - to answer that question, there is no way to treat them and no resources. I agree with Professor McNicholas that everybody in the country knows how to do my job better than I do. Everybody talks about what is required to stop people getting mentally ill. I was a general practitioner and was looking for an inoculation that stopped people from getting mental illness. After 25 years as a psychiatrist I actually take my hat off to mental illness. It exists, it is real and it needs treatment. It does not need counselling or play therapy. Those things are very important for other kinds of problems.

Mental illness needs medical treatment and psychiatric treatment in the right place with the correct staff and the correct resources.

Dr. Brendan Doody: There are 76 beds which are either HSE beds or HSE-funded. The number has dropped with the Linn Dara unit having to reduce its capacity. The number of currently available beds is less than 50. On the issue of staffing and being obliged to close beds, I want to reassure the committee that everything that could possibly have been done within the service to ensure that those beds were kept open was done. They were kept open for as long as it was feasible to do so, and it is hoped that the closure will be for the shortest time possible. It is hoped the beds will reopen in October. While the unit was operational after it opened on schedule in December 2015, its bed occupancy was between 90% and 100%. That is also the current rate of occupancy.

I was asked about the range of inpatient services. All the 76 beds that are currently available are what would be called generic or open units. Inpatient services require not just those units, but also low and medium-secure units. This was acknowledged within A Vision for Change. A specialist eating disorder unit is also required. Those units are in development. The eating disorder unit will be part of the new paediatrics hospital and it will be a number of years before that will be available. The hospital will also have an eight bedded generic inpatient unit. There will be 20 additional beds on stream with the completion of the new national paediatric hospital. In the interim, a particular challenge has been that we are seeing increasing numbers of children with eating disorders being admitted into the generic units. On average, one third of our beds in our unit are occupied by young people with very severe eating disorders at any time.

I was asked what the consequences of the absence of these units are. It means that some young people have to access medium-secure psychiatric services or specialist inpatient eating disorder services outside of the State. That number is lower but it will remain the case until those services are available. A secure inpatient facility is being developed in Portrane as part of the redevelopment of the national forensic services. There is a ten-bed adolescent secure unit to be developed. We are looking at a timeline of about three years before that unit is open. There are plans to develop these units.

To increase the capacity to support children with eating disorders, a clinical treatment programme was recently launched with a plan to roll out specialist community eating disorder services, which will be quite intensive and will have both outpatient and intensive day-patient components. That is what is happening in the interim but the absence of secure beds also means that some young people will be admitted or remain in adult units. One must remember that to admit a young person onto an open unit we must bear in mind the therapeutic milieu of the unit. We may have young people on that unit who are 13 and 14 with anxiety disorders and eating disorders. We have to remember the impact of admitting a very unwell, disturbed young person onto that and we have to think about the impact on other young people. Other young people on the unit may feel quite threatened by that and feel unsafe, which might have an impact on their own treatment programme. When we are looking at admitting, the whole issue of placements must be considered.

Dr. Elisabetta Petitbon: Senator Kelleher mentioned my presentation. It was about being more on the side of going for the medical model, which is actually a trend that is quite provable lately in Europe, and going towards using talk therapy. In fact, our clients ask for it. In particular, when working with children we cannot not use such therapies. There are alternatives such as art therapy or pet therapy which are completely non-existent here in Ireland. To answer Senator Kelleher's question, when she asks what one thing should be reported in the document,

I would say that if psychiatrists feel that they are not being heard by the State, and psychologists less so, psychotherapists feel they are completely non-existent. Therefore, please include our voice.

Dr. Eddie Murphy: It is not that psychology and psychiatry are mutually exclusive. It is important that there is a requirement for one-to-one and day-hospital visits in the step-care model; children do get mentally ill, but there is also a focus on those services in primary care. I support the provision of psychology services in primary care and not at the network level service.

Approximately 70 psychologists, from the three branches of clinical, educational and counselling psychology, are trained in this country every year. It takes approximately eight years to be trained as a clinical psychologist. That is three years of undergraduate study, two years of master's study and then a three year professional doctorate programme. One of the ways to look at the provision of psychology services is in primary care or at children's centres of excellence, which include all our other colleagues such as physiotherapists and occupational therapists, where we can capture children with disabilities, autism spectrum disorder etc. coming through as well as those with mental health issues.

There has been a creeping casualisation of the alcohol culture in Ireland over the past 20 to 30 years, and it has a significant impact on youth suicide, self-harm and mental health. Some specific proposals on this would concern advertising, purchase price and having specific areas for its purchase that would nudge people rather than it being in their faces when they are in shopping centres. For example, a person can buy alcohol when getting fuel for the car now. This casualisation is really inappropriate and I support the Public Health (Alcohol) Bill.

Dr. John O'Brien: I am answering on behalf of the Irish College of General Practitioners, ICGP. First, I reiterate what was just said about alcohol. It is clear that we have a national psychopathology around alcohol. If I say that when I was a medical student I drank Lough Erne and that I met my wife in a pub with a whole load of pints on me, everyone would smile indulgently. However, that needs to stop. We need to stop smiling indulgently. We have to get to grips with this because it is an avenue to mental health that is staring us in the face, and it is most particularly the case with vulnerable people in vulnerable communities. It is one of the great scandals that we have not addressed as a community.

Another speaker asked what They a GP needs at the point of presentations. need time. The usual GP consultation takes ten to 15 minutes. More often, in poorer areas, it is ten minutes. What does anyone think a GP could address in ten minutes? It is very little. A specific time needs to be aside. People do this. There are heroic efforts to which they go to provide the time to people. As Mi Angelo used to say, people will forget what you said. People will forget what you did. But no one will ever forget how you made them feel. This is the essence and the kernel of a good general practice service. We need more GPs, practice nurses and psychologists.

Another speaker asked what GPs need at the point of presentations. They need time. The usual GP consultation takes ten to 15 minutes. In poorer areas it is more often ten minutes. What does anyone think could be addressed in ten minutes? It is very little. A specific time needs to be set aside, and people do this. The efforts to which some people go to provide the time to people are heroic. As Maya Angelou said, "...people will forget what you said, people will forget what you did, but people will never forget how you made them feel." This is the essence and the kernel of a good general practice service. For that, we need more GPs, practice nurses and psychologists.

There is one last point that I need to make. It concerns entry to general practice and the disappointment voiced at the fact that we did fill our quota of GP training places this year. The ICGP is in charge of the interview process for it. We interviewed more than the allotted numbers and we offered more places than the allotted numbers but the acceptances were less than the allotted numbers.

Senator Paudie Coffey: Would a shared psychological service among GP practices be a solution?

Dr. John O'Brien: It would, but the challenge would be that it would be swamped. If an individual psychologist was working in an individual practice, over time there would be burnout. They need to work in a clustering with other members and teams.

Chairman: I appreciate the Senator's important question-----

Senator Paudie Coffey: We are getting to the nuts and bolts of it.

Chairman: -----but time is of the essence as lunch beckons. However, the Senator will have the chance shortly for a private chat. I ask Mr. Gareth Noble for a final comment or answer to questions to him.

Mr. Gareth Noble: Today we have heard many observations from professionals about having their voices heard. The challenge moving forward, however, is to ensure that the voices of the children who are at the centre of these difficulties are also heard. My biggest frustration as a legal practitioner is that children and young people do not feel heard. It is time for us to deliver on that.

Senator Gabrielle McFadden: My question on salaries and the comparisons was not answered.

Chairman: To whom did you direct the question?

Senator Gabrielle McFadden: Dr. Hillery.

Chairman: Will Dr. Hillery give a very brief answer to that question?

Dr. John Hillery: I will answer two questions, if I could. I tell Senator Black that the College of Psychiatrists of Ireland, like the College of General Practitioners, welcomes the Taoiseach's statement that the Public Health (Alcohol) Bill will be passed by the end of the year. That would be a major step forward from the point of view of mental health.

As regards Senator McFadden's question, the NHS has the same problems as we have about recruiting consultants. What is happening here and in the NHS is that agency staff are being used to fill long-term gaps, and agency staff get paid more than the consultant salary. I really cannot speak to how psychologists negotiate their pay. That is totally separate from my remit. The consultant's salary is based on many years of negotiation before she or I entered-----

Chairman: Dr. Hillery did tell us how long he was in training. I was astounded.

Dr. John Hillery: Then there are many issues about which there probably is not time to go into here. However, I cannot speak to why psychologists get paid the way they do.

Chairman: I appreciate that.

Dr. Elisabetta Petitbon: I have the figures if the House would like to hear them.

Chairman: I would love to but in view of the time-----

Dr. Elisabetta Petitbon: On the salaries, I will answer the question from the point of view of psychologists. The salary for a psychologist, basic grade, ranges between €54,000 and €84,000. A senior psychologist can earn up to €90,000. The salary scale for a psychotherapist is approximately €35,000.

Chairman: I am very grateful to the witnesses. Does Senator Joan Freeman wish to make a brief closing remark?

Senator Joan Freeman: Yes. I promise I will be brief. Two things came out of this morning's session. One is the witnesses' obvious passion for the children of our nation and that they really want to get this sorted. I promise that in my role as a Senator I will ensure that we will continue with this today. Second, this afternoon we will be speaking to the Minister of State with responsibility for mental health, Deputy Jim Daly, and a representative from the HSE. I will probably hear a little of what was reflected by Dr. Doody and that there are lots of things in development, especially with the new hospital. This will take approximately four years, however. What will happen to the children today?

Chairman: On behalf of the Seanad Public Consultation Committee, I thank all the witnesses who contributed this morning. It has been an informative and productive session. We all learned a lot from their insights and observations. Full account will be taken of today's discussions when a draft report is being prepared and copies of the final report will be sent to all who contributed.

Sitting suspended at 12.50 p.m. and resumed at 2.p.m.

Chairman: We are back in public session and will resume our public hearing on children's mental health services in Ireland. In the afternoon session, we will hear from representatives of State and official bodies. On behalf of the committee, I welcome from the Office of the Ombudsman for Children, Dr. Niall Muldoon, and Ms Naomi Kennan, policy adviser. From the Department of Health, we have the recently appointed Minister of State with special responsibility for mental health and older people, Deputy Jim Daly. From the HSE's mental health division, we have Mr. Jim Ryan, acting national director, and Dr. Philip Dodd, national clinical adviser and clinical programmes group lead on mental health. From the Mental Health Commission, we have Ms Patricia Gilheaney, chief executive, and Dr. Susan Finnerty, inspector of mental health services. From the Irish Medical Organisation, IMO, we have Dr. Matthew Sadlier, consultant psychiatrist, and Mr. Cian O'Dowd, policy and international affairs officer. From Tusla, we have Mr. Jim Gibson, the chief operations officer, who is present in his capacity as acting chief executive in place of Mr. Fred McBride, who is on leave, and Ms Patricia Finlay, service director for Dublin and mid-Leinster. We also have Professor Joyce O'Connor, chairperson of the expert group on mental health policy, which produced the policy A Vision for Change. The witnesses are most welcome and I thank them for engaging with the committee in its consideration of this important and sensitive topic.

Before we begin, I must draw witnesses' attention to the following procedural matters. This is housekeeping, so to speak. I advise witnesses that, by virtue of 17(2)(*l*) of the Defamation Act 2009, they are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by the Chair to cease giving evidence on a particular matter

and they continue to do so, 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 and are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. I also advise the witnesses that the opening statements that they have submitted to the committee will be published on its website after the meeting.

To commence proceedings, I invite Senator Freeman to make a few introductory remarks. I will then invite each witness to make a short presentation to the committee. Witnesses may share their time with a colleague if they so wish. They should please indicate this when they are invited to speak. Given the large number of witnesses attending this session, I ask that presenters keep their opening statements as brief as possible. I suggest five minutes. When the presentations have finished, there will be time for questions and comments from the Senators and responses from the witnesses.

Senator Joan Freeman: I welcome the Minister of State, Deputy Jim Daly. I am delighted that he has been appointed and I congratulate him on that. I hope that he comes to this position with fresh ears and that he will not listen to all of the previous arguments that have been plied to questions on mental health services for children.

I also wish to say "hello" to Mr. Jim Ryan, whom I have met several times. I admire his dedication and hard work and that he is committed to working in this area. Last week and this week, however, we have tried to paint a picture of the reality of what mental health services for children are like. The only analogy that I could come up with was to describe the people present - the Ombudsman, the CEO from the Mental Health Commission, the parents who are in the Public Gallery and those who provide our services - as a body and the HSE as the doctor. We are dying. It is not that this does not matter to the HSE witnesses on a personal level, but they do not seem to hear us. Mental health services are dying. Until the HSE witnesses and everyone else who is present today can tell the truth, then we cannot fix the problem facing us. This morning, I asked for truth. I am asking for the same this afternoon. Then we can work together. There is no need for anyone to be defensive. We are all trying to make this work. I am asking the witnesses to help us by telling the truth about what the services, the HSE and the Department of Health can and cannot do.

Chairman: I now call Dr. Niall Muldoon from the Office of the Ombudsman for Children.

Dr. Niall Muldoon: I thank the Chairman for the invitation to speak at today's committee meeting. I wish to start by acknowledging the moving contributions made last week by parents and young people, including Ms Arianna Gallagher, who are clearly struggling with their mental health issues and the impact of them. What it clearly showed to me was how we are failing these families and children who are in so much pain. The first principle of medicine is to make sure one does no harm, and I wonder whether we are doing harm even with the services we are providing. We know, as a community, that we really need to take stock when we are allowing more than 60 of our children, our adolescents, to go into adult units in the psychiatric services. Anyone visiting these units would know there is an environment and an atmosphere in them that can be tense and incline towards violence and which is just uncomfortable for anyone. For children already at their wits' end and suffering from serious illness, it is not a good place to be. The average stay is about four weeks, which is a long time for a person in the wrong place, and we really need to start moving on from that.

I commend Senator Freeman on the introduction of her Mental Health (Amendment) Bill. We very much welcome it and look forward to its passage through the Houses. We must acknowledge that it will not be the cure to all our problems but we will certainly support it. The conversation Members started last week in the Seanad and earlier today is very much needed, and I am very hopeful it will lead to real and significant change for children and their best interests.

We have made a submission to the committee on the key areas we feel need attention and we will not go back over them today but we want to highlight a few key issues. When we got together to prepare this presentation, we felt that our recommendations all rolled into one key recommendation: if we can put the child at the centre of children's services and, every time a decision is made, base that decision on such an approach, we will improve our system no end. The services provided for children need to go to the children who need them when they are needed and in the way in which they need them. This is not what is happening at present. At present, the child must take what the system can offer him or her and make do with what is available. This all depends on where the child lives, the primary care support systems available and whether there is a psychiatrist in the area and it can depend on a range of other factors. However, the last thing it depends on is the child's needs, and this is where we have gone wrong and what we need to get back to. The child is doing all the adapting and all the compromising, the family is driving hither and thither and it is just not working. We need to change it as quickly as possible. Children should not have to wait until they reach breaking point, self-harm or suicide attempts, generating physical manifestations of their mental ill health, before they get some kind of help. That is just cruel.

As a nation, we committed to the UN Convention on the Rights of the Child 25 years ago to promote and protect children's rights and we followed this up with a very strong statement when we put children's rights into the Constitution in 2012. This means that the vindication of these rights is not just something we would like to do, but also something we are obliged to do as a State. Children's rights and children's perspectives should have been protected much more when the economic crisis hit. That is what children's rights mean. The Government, when the economic recovery came about, should have protected and raised children's services much more quickly than it did, and the fact that it did not do so is to its eternal shame. Children have not been prioritised in a way that would lead one to believe that children's rights are at the heart of Government decision-making.

As I have already mentioned, putting children at the centre of mental health services is vital. We need to talk to them, consult with them and get their views. This is a basic, fundamental change that needs to come about in any new legislation that derives from this work. When one hears a child in the mental health services, one is doing more than just hearing the child's views; one is also promoting them at a time when they feel at a low ebb and feel no one is listening to them or hearing what they are going through. One is giving them an opportunity to feed into their service and change the service. In this regard, we recommend, as part of the review of the A Vision for Change policy, the creation of a new A Vision for Change for children alone. We need it to be more than chapter 10 of a large work; we need it to be a stand-alone piece of work in order that it has a specific timeframe and a specific implementation plan.

The role of consent is an issue we have come across regularly in our office. Even last week, we saw that professionals at the national youth task force consultation were not able to agree as to whether consent from one parent or two parents is needed when a child is under the age of 16. The interpretation of the Non-Fatal Offences Against the Person Act also needs to be clari-

fied because there is still uncertainty as to whether a child of 16 or 17 can consent to treatment. Some will allow this; some will not. Again, it is clarity that is needed, and these are crucial matters, especially for children with eating disorders or children who may have to get care outside of the State. The issue of consent is crucial in these areas.

The issue of children with mental health issues has been a strategic objective for my office since I entered my position. I spend much of my time going around the country meeting children, whether going to Pieta House events or Cycle Against Suicide events, children's well-being weeks in schools or mental health weeks. I am passionate about raising awareness of mental health and supporting young people to come forward when they need help. I think we are getting there. As a society, we are talking about mental health more, encouraging our children more and getting further down the line in allowing them to open up. However, we are also in danger of calling them out of the shadows only to leave them exposed in the sunlight because we do not provide the services they need.

As a psychologist, I am acutely aware of the positive work that can come with early intervention and with work with children in even the darkest places as a result of mental ill health. I have worked with children who have suffered serious damage and am always inspired by the power of the human spirit to flourish and heal from even the greatest traumas once children are supported correctly. It is even more amazing to behold a child or young person who begins to blossom and emerge from a deep darkness caused by damage to his or her mental health. We very much need early detection and intervention to improve our children's service. I suggest we need universal, accessible, evidence-based prevention and early intervention services, and they need to be provided at primary care level and across all communities in order that there is no inequality depending on the area in which one finds oneself living.

Communication and collaboration is another issue we have had, and I will give the committee examples of this. We have had numerous complaints about CAMHS teams refusing to take referrals from other CAMHS teams when a child moves house. This is a systems issue. We have had numerous complaints about children being referred by one psychiatrist to an adolescent bed in a residential unit and being sent back because there is a disagreement over the diagnosis. This is a systems issue. We have had numerous complaints to the effect that children are attending one accident and emergency unit and spending a number of hours there only to be told they are too young to be there. The committee heard about this last week. They are told they are too old in one hospital and told they are too young in another. This is a systems issue. This is a matter of adults worried about their criteria, diagnoses and rules, and the child is forgotten about. This can be changed immediately. It does not need money but a cultural change. Individual areas, regions and units often have separate priorities and guard their patch with little or no thought to the child affected. I suggest that putting the child front and centre in the decision-making would not lead to any cost increases in many cases but would be more a cultural change and put respect for the child in a paramount position. I believe that the majority of energy and resources should go into primary care services to help children as early as possible. However, CAMHS is still a vital part of the solution and needs to work much better.

I met with the previous Minister of State with responsibility for mental health and older people, Deputy McEntee, and we discussed this issue. She highlighted to me that there are 15 so called "unfillable" psychiatrist posts around the country, some of which have been vacant for over five years or are hard to fill on an ongoing basis. Any proposed legislation or policy ideas must take on this issue, must find a new way of doing things and must be creative. Some of the questions I would ask are as follows. Is it only about pay and conditions? Is it about

involving other professionals earlier in the process? If we cannot recruit child psychiatrists to these "unfillable posts", should we consider having other professionals lead the teams? In other countries, some categories of nurses and psychologists have prescription rights. Could this assist us in building up our teams? Could paediatricians stand in for psychiatrists on occasion, perhaps to cover accident and emergency situations or during leave? We should not need our young people to be at breaking point before they can access help.

We know from all the statistics the committee has heard that we have a huge job of work to do, and this consultation could not be more timely. Nelson Mandela said: "There can be no keener revelation of a society's soul than the way in which it treats its children." This should be our mantra in all the work we do for these children. These are some of the most vulnerable children, the most vulnerable people, in society. How they are treated and the experiences they have now will have massive implications for their future and, consequently, massive implications for our society. They will become our teachers, politicians and policymakers. They have much to offer our society and how we treat them now is vital.

I again commend those parents and young people who came forward last week bravely to tell their stories. I hope they will be vindicated by decisive action on behalf of the Government to make real changes in this area.

I commend Senator Freeman and the committee on tackling this extremely important issue. Please be aware that the Ombudsman for Children and the Office of the Ombudsman for Children are totally committed to supporting the committee in any way we can.

Chairman: The Minister of State at the Department of Health, Deputy Jim Daly, is next. I again congratulate the Minister of State on his well-deserved appointment. The floor is his.

Minister of State at the Department of Health (Deputy Jim Daly): Fáiltím an deis a bheith anseo chun labhairt agus a bheith páirteach san ócáid iontach speisialta seo. I welcome the opportunity to contribute to this important public consultation. We all share a common desire to have the best possible mental health policies and services for children and adolescents nationally, while taking account at the same time of the practical realities involved to effect further improvements.

There is no doubt that mental health remains a priority for the parties, organisations and individuals that have participated in this consultation process. I understand that advances to mental health care in recent years as well as improvements still called for have been highlighted in the presentations and discussions of the committee. I fully appreciate the genuinely held concerns raised here. I assure those present that their considered views will be heard and that I, the Department of Health and the HSE will take heed of the outcome of the work of the committee.

A cornerstone of this Government's overall health policy is to enhance all aspects of mental health care. This is reflected in the programme for Government and is high on my agenda as Minister of State. I wish to take this opportunity to acknowledge the progressive roles played by my various predecessors and, notwithstanding the obvious challenges remaining, to build upon their achievements. Despite severe pressures on our public finances over recent years, steady and measurable progress has been made to develop mental health services. Significant investment has been undertaken thereby allowing a fundamental shift away from a static institutionalised and hidden care system to realising a modern and responsive service. Change is taking place spanning all fronts and across all age groups from enhanced community-based care to forensic mental health care for children to psychiatry of old age.

A core difficulty we now face is not funding availability *per se* but, rather, wider issues surrounding the recruitment and retention of mental health professionals. This can lead to the temporary closure of children and adult mental health services beds, such as occurred recently at Linn Dara in Dublin, especially given the need in such circumstances to balance safety and quality issues against staff availability.

Overcoming staff retention difficulties is obviously core to improving care and access to care. We also need to clearly plan and deliver services in a better way to meet evolving demands and circumstances. This includes better prevention, early intervention and inter-agency approaches in future, thus ensuring the best use of either specialist or wider care resources. We cannot take advances for granted and, therefore, we need to refine policies, legislation and services.

Since 2012, approximately €140 million has been added to the HSE mental health budget, which, this year, totals close to €853 million. This is a significant funding commitment by any standard and the Government intends to increase the mental health budget annually as wider circumstances allow. Core to implementing A Vision for Change has been the approval of over 1,500 new posts since 2012, including those approved for CAMHS. A balance has been struck between acute and community-based care and the pace of change has gradually gathered momentum at local level. In particular, all efforts have been made to ensure that new posts are of the type required to transform our mental health system in the light of increasing and future demands.

The mental health priorities for 2017, as agreed in the HSE service plan, spans much-needed improvement across counselling services, enhanced community mental health teams and improved 24-7 response and liaison services. Work is also ongoing in the areas such as psychiatry of later life, perinatal mental health, attention deficit hyperactivity disorder in adults and children and dual diagnosis of those with mental illness and substances misuse. Again, this reflects many of the issues raised with the committee. The HSE is also addressing other key issues highlighted, such as age-appropriate placements, reducing waiting lists and a more standardised approach to service delivery nationally.

It should be noted that the placement of those under 18 years of age in adult units has reduced considerably over recent years. Where this arises various factors such as geographic location, expected length of stay and age and wishes of the young person and their families all play a role. In addition, the HSE takes special measures to ensure the safety of the young person in such placements.

Other developments designed to relieve system pressures include 60 additional student psychiatric nurse places coming on stream during the period 2016-2017, along with a further 70 to follow in 2017-2018. In addition, the HSE is offering all graduating nurses permanent contracts. In line with a Government commitment to develop early intervention mental health services for those aged under 18 years, approximately €5 million has been allocated to HSE primary care, of which €3.4 million will fund 114 new assistant psychologists. This will enhance response at that level and help to address CAMHS pressures overall.

A significant development in the mental health sphere is the recent commencement of construction by the HSE on the new multimillion national forensic health service capital project at Portrane to replace the Central Mental Hospital at Dundrum. This long-overdue initiative comprises a 130-bed new main hospital along with a new ten-bed forensic CAMHS unit and a new 30-bed intensive care rehabilitation unit. The main development includes ten beds specifi-

cally catering for mental health intellectual disability. The new modern complex will greatly transform our forensic mental health services when it opens in early 2020. A new intensive care rehabilitation in particular will be key to alleviating pressure across the wider mental health and judicial care systems.

A priority for me is to progress the work of the national task force on youth mental health established by my predecessor as Minister of State, Deputy McEntee. This is focused on changes to improve communities working together at a local level and services working together at national level. It has been designed to draw on the experience of many quarters to enhance supports for young people and to otherwise promote resilience and emotional well-being. The task force has undertaken a recently completed series of youth consultations and a national consultative forum has convened in June. Many of the participants who have come before the committee had an input in some way to the task force reflecting at least some of the issues raised here. Above all I want the outcome of the task force to be realistically based resulting in real improvements.

Mental health services are obviously shaped by factors beyond pure funding, including prevailing legislation and policy. The recent strategic direction in Ireland has been underpinned by A Vision for Change, complemented on the suicide front by Connecting for Life. I am progressing the context we are focused on today, that is, a review of A Vision for Change, in tandem with changes to the Mental Health Act 2001.

While fundamental principles and approaches will broadly remain unchanged, various aspects of legislation policy and services arguably need to be re-nuanced in light of experience and identified future challenges. In refining policies and services I will advocate strongly for better prevention and early intervention, improved access, more person-centred care and recovery orientation.

Senator Freeman recently introduced the Mental Health (Amendment) Bill 2016, the aim of which is to limit the admissions of children to adult psychiatry units by allowing them to take place only in emergency circumstances. As I said when I spoke on Second Stage of the Bill in the Seanad, the issue is not about whether we need to reduce these admissions but rather about how we go about the change to best effect. A change in legislation certainly has a role to play in this regard and I look forward to working with Senator Freeman and others on exactly how we should frame the terms of such amending legislation. Deputy James Browne has introduced a Bill in the Dáil that seeks to improve the circumstances for children who require inpatient psychiatric treatment. While it is not ideal to amend the same legislation in two Bills at the same time I hope that, with goodwill on all sides, we can reach an accommodation that we can all live with. It is clear that collectively we still face many challenges irrespective of our political grouping or individual view and notwithstanding recent significant progress realised over a relatively short time.

In the interests of one of the most vulnerable groups in our society, the work of this committee is a valuable contribution to the immediate and longer-term priorities required to improve mental health care for young people. As I indicated already, I will give full consideration to the outcome of this process such that we can minimise differences, maximise progress and continue in a responsible and effective way to achieve what needs to be done.

Chairman: Next we will hear from Mr. Jim Ryan, acting national director of mental health, and Dr. Philip Dodd, national clinical adviser and clinical progress group lead for mental health. I take it they are sharing time. Is that correct?

Mr. Jim Ryan: We are, Chairman. On behalf of the HSE mental health division, I thank the committee for the opportunity to appear. I wish to pass on apologies from Ms Anne O'Connor who is on annual leave. My colleague, Dr. Dodd, will read the opening statement on behalf of the mental health division.

Dr. Philip Dodd: As outlined in the 2017 HSE mental health division operational plan, the division remains focused on developing CAMHS throughout the country. The division acknowledges that a broad range of services support the mental health and well-being of children and adolescents. The term "CAMHS" - or "child and adolescent mental health services" - is applied specifically to services that provide specialist mental health treatment and care to young people up to 18 years of age through an approach involving multidisciplinary teams treating moderate to severe mental health disorders. CAMHS is only one part of a larger health system that addresses the mental health and well-being of young people. The system includes services at primary, secondary and tertiary care levels. As a specialist service, CAMHS sits within the secondary and tertiary care levels. The mental health division is committed to working with its partners and stakeholders, in primary care and social care in particular, to develop a comprehensive range of services to support the mental health of children and adolescents. Actions in this regard include the continued investment in and development of Jigsaw Youth Mental Health Services across the country; the HSE mental health division has allocated resources at primary care level to recruit 120 assistant psychologists to develop early intervention services for young people, with the likely impact of reducing inappropriate CAMHS referrals; working collaboratively with the SpunOut youth website to improve information on understanding and accessing CAMHS; joint working protocols between key HSE services are being developed to assist teams in collaboratively supporting young people with complex needs who require an input from a variety of specialist teams across mental health, primary care and social care services, as well as services for people with disabilities; and contributing positively to the national task force on youth mental health in readiness to implement the HSE's mental health division's specific final recommendations

It is generally accepted that, although A Vision for Change made clear recommendations for the provision of resources for CAMHS, they have not yet been fully realised and current capacity falls short of what is required. Despite a net increase in CAMHS staffing, from 622 in 2010 to 842 in 2015, most community CAMHS teams across the country are operating at 50% of the level recommended in A Vision for Change, this despite significant investment in CAMHS in recent years and intensive staff recruitment efforts. Mirroring the position across the health service in general, staff recruitment is a significant challenge, in particular nursing and medical recruitment. Attracting consultant psychiatrists to work in CAMHS is especially challenging, with many citing pay and conditions as a reason for seeking employment in other speciality areas or jurisdictions. The underdevelopment of CAMHS teams and staff recruitment problems together significantly contribute to the development of long waiting lists for assessment, inadequate out-of-hours CAMHS services and inappropriate use of acute admission services. This is in the context of significantly increased referral rates. Between 2010 and 2016, referral rates to CAMHS increased by 63%, while the referrals accepted by CAMHS also increased by 66%.

On the availability of CAMHS out-of-hours services varies across the country, currently they are available in about 73% of the country. This is a service improvement priority for the division. There is inadequate provision of CAMHS acute admission services. A Vision for Change recommends a total of 106 in-patient CAMHS beds, with ten secure beds and eight beds to support the treatment of patients with eating disorders. There are four CAMHS acute admission services in Ireland, with a maximum capacity of 76 beds available. If beds provided

by private health care providers are included, there is a national provision of 102 beds. However, within the public system there are currently 48 beds operational. The remaining 28 are closed due to staff shortages. There is a specific staff recruitment campaign under way to address this particular staffing issue, with improved service availability expected by September 2017.

On service development, plans are in place to provide an additional 30 beds, including secure beds and beds to provide specialist eating disorder treatment, but they are not due to be online until 2021. Even within the service development plan, there remains a lack of further specialist CAMHS acute admission services such as for the specialist treatment of children with an intellectual disability and a significant mental health problem. As a result, the existing generic CAMHS acute admission services are sometimes tasked with providing highly specialist care in a generic service setting which can result in further service pressure associated with potentially delayed discharges.

A direct consequence of these challenges is children being admitted to adult acute admission units. The decision to admit a young person to an adult unit is not taken lightly and it is always done as an absolute last resort when no other option is available. In making the decision to admit, the safety of the young person is paramount and the decision follows a clinical risk assessment of the young person concerned. There can be a number of factors that influence the decision, including an acute illness and failed attempts to secure a bed in a CAMHS acute admissions centre. A decision to admit a young person to an adult unit must be notified to the Mental Health Commission and be in accordance with its code of practice. In addition, the HSE mental health division is also notified of all such admissions in order to assist in expediting a transfer or discharge from the adult unit as soon as practicable.

On admission, the young person concerned is allocated a qualified mental health nurse on a one-to-one basis whose sole responsibility is to support the young person during his or her admission. Where possible, he or she is supported in a quiet area of the adult ward away from other patients. The priority of the treating team on the adult unit is to support him or her in having access to the appropriate CAMHS team as soon as possible in order that an appropriate care plan can be developed, possibly involving transfer to appropriate CAMHS or children's services.

On the characteristics of these admissions, the numbers are falling; admissions are becoming shorter and mainly made up of young adolescents. In 2010 there were 163 admissions of young people to adult units, compared to 68 in 2016. Of the admissions in 2016, 88% were of young people aged 16 or 17 years, while 62% of all young people admitted to adult units were discharged within three days of admission. This compares to a figure of 41% in 2015 and 34% in 2014.

While the HSE mental health division is tasked with developing and providing CAMHS in a difficult operating environment, as I have outlined, it remains committed to supporting the development of high quality integrated mental health services for young people in a spirit of partnership with key stakeholders and as part of a whole system approach to supporting young people's mental health and well-being. Specifically, the division is committed to achieving a further reduction in the number of admissions of young people to adult acute admission units, although it acknowledges that, in exceptional circumstances, the practice may be required to continue in the absence of appropriate CAMHS acute admission capacity and in the context of less than optimal CAMHS provision.

Ms Patricia Gilheaney: I thank the Chairman and committee members for their kind invitation. The Mental Health Commission welcomes the spotlight the committee is placing on children's mental health. I am joined by my colleague, Dr. Susan Finnerty, Inspector of Mental Health Services. We intend to share the time available to us. I intend to address the submission from the Mental Health Commission to the committee on the Mental Health (Amendment) Bill 2016. However, I do not intend to detain the committee by going through the detail of some of our technical suggestions.

The Mental Health Commission is an independent statutory body established pursuant to the Mental Health Act 2001. Its principal functions are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and take all reasonable steps to protect the interest of persons detained in approved centres. The commission regulates the provision of inpatient mental health services through inspections carried out by the Inspector of Mental Health Services and her team and registration, ongoing monitoring and enforcement.

Since its establishment, the commission has been unwavering in its view that children should be admitted to age-appropriate facilities. Certain provisions of the 2001 Act apply to children and it is in that context that the commission welcomes the invitation to comment on the Mental Health (Amendment) Bill 2016. The principles underpinning the Act are enshrined in section 4 which refers to a person and, as such, is applicable to a child. Section 4 relates to the making of a decision under the Act concerning care and treatment. Section 4(1) states the best interests of the person shall be the principal consideration, with due regard being had to the interests of other persons who may be at risk of serious harm if a decision is not made. Section 4(2) provides for the statutory duty in relation to any proposal to administer treatment to a person to properly notify such person of that proposal and take due account of his or her representations before making any decision in that regard. Section 4(3) further states that in making a decision concerning care and treatment of a patient, due regard shall be had to the need to respect the right of the person concerned to dignity, bodily integrity, privacy and autonomy. Section 23 of the Act makes provision for the detention of a child who is a voluntary patient in an approved centre but whose parents, or those acting *in loco parentis*, indicate a wish to remove the child but the child is still suffering from a mental disorder.

The sole section of the Act that relates exclusively to children is section 25, which makes provision for the involuntary admission in certain circumstances of children suffering from a mental disorder. Involuntary admission of a child is only possible by way of a District Court order pursuant to section 25 of the 2001 Act. Section 25(14) of the Act refers to provisions of the Child Care Act 1991 that apply to proceedings under section 25 of the Act. Such sections relate to procedural matters that are taken into consideration when an application under section 25 of the Act is made to the District Court.

Section 26 relates to the granting of leave and section 27 provides for the voluntary admission of a person, including a child, to an approved centre. In summary, the sections of the 2001 Act that relate to the admission of a child are sections 23(2), 23(3), 23(4), 25, 26, 27 and 29.

The commission actively engaged in the review of the Mental Health Act 2001. It was represented on the steering group established in August 2012. In addition, members of the commission's legislation committee met the chair of the expert group. Following publication of the expert group report, the commission submitted its views. The report contains 165 recommendations. Recommendations 111 to 123, inclusive, relate specifically to children and are as follows.

Provisions relating to children should be included in a stand-alone part of the Act and any provisions of the Child Care Act which apply should be expressly included rather than cross-referenced. A child should be defined as a person under 18 and thus brought into line with the Children Act 2001. A dedicated children's part of the Act should stipulate the following guiding principles that every child should have access to health services that aim to deliver the highest attainable standard of child mental health; the autonomy and self-determination of the child should be respected in so far as practicable in conjunction with parents or persons as required acting *in loco parentis*; and there must be consultation with the child at each and every stage of diagnosis and treatment with due weight given to his or her views consistent with his or her age, evolving capacity and maturity and with due regard to his or her will and preferences. Services should be provided in an age-appropriate environment, and services should be provided in close proximity to family and-or carers wherever possible. The child must receive the least intrusive treatment possible in the least restrictive environment possible.

Where there is an intervention on behalf of the child, his or her best interests must be taken into account, and "best interests" must be defined in a way that is informed by the views of the child, bearing in mind that those views should be given due weight in accordance with his or her age, evolving capacity and maturity, and with due regard to his or her will and preferences. Children aged 16 or 17 should be presumed to have capacity to consent or refuse treatment. For admission of a 16 or 17 year old to proceed on a voluntary basis, the child must also consent or at least must not object to his or her voluntary admission. Where a 16 or 17 year old objects, the case should be referred to a child-friendly family district law court which can determine whether the child has the necessary maturity or capacity to make an informed decision. The group acknowledges that there should be no automatic presumption of capacity for children under the age of 16. However, in such cases, the views of the child must be heard and service providers must give them due consideration and weight.

The commission, in its submission on the report to the Department of Health, indicated its support of the recommendations relating to children, many of which place the child or young person in a more central position in the process of admission, care and treatment. However, the commission also stated that further attention needs to be paid in revised mental health legislation to the human rights of children.

It also made reference to the response of the Committee for the Convention on the Rights of the Child, which, in its response to Ireland in its report in February 2016, referred to the following: the lack of comprehensive legislation on children's consent to and refusal of medical treatment, in particular mental health care services; children being admitted to adult psychiatric wards owing to inadequate availability of mental health care facilities for children and long waiting lists for access to mental health support and insufficient out-of-hours services for children and adolescents with mental health needs, in particular eating disorders; and the lack of a child-focused advocacy and information service for children with mental health difficulties.

The committee recommended that Ireland must enact legislation that explicitly and comprehensively provides for children's consent to and refusal of medical treatment, and ensure that this legislation is in line with the objectives of the convention and encompass clear recognition of children's evolving capacities. It also recommended that Ireland undertake measures to improve the capacity and quality of its mental health services for children and adolescents. In doing so, Ireland should prioritise strengthening the capacity of its mental health services for inpatient treatment, out-of-hours facilities and facilities for treating eating disorders. It also recommended that Ireland consider establishing a mental health advocacy and information ser-

vice that is specifically for children, and accordingly accessible and child friendly.

The Mental Health Commission is of the view that while improving the capacity and delivery of mental health services is appropriately placed in revised national mental health policy, it is clear that an opportunity is presented in the drafting of revised mental health legislation to incorporate the points raised by the commission. The commission notes that the Title introducing the Mental Health (Amendment) Bill 2016 states: "Bill entitled an Act to provide that all children must be admitted to child appropriate inpatient psychiatric units and providing that no child shall be admitted to an adult psychiatric inpatient unit (voluntarily or involuntarily) save in exceptional circumstances where such admission is in the child's best interests."

The commission welcomes the policy intent of the Bill as it places in primary legislation the commission's view as specified in the code of practice relating to the admission of children that was issued pursuant to section 33(3)(e) of the 2001 Act in 2009. Section 2.5 of the aforementioned code of practice specifies provisions that should be in place if approved centres for adults are used of necessity in exceptional circumstances. It is suggested that provisions akin to those specified in the code should be considered for elevation to primary legislation.

Sections 4.3 to 4.7 of the commission's submission are technical in nature and I will not detain the committee with those at this time. I will now pass over to my colleague, Dr. Finnerty.

Dr. Susan Finnerty: I thank the committee for inviting us. As inspectors of mental health services, my team and I inspect approved centres under regulations, rules and codes of practice. This includes both adult and child approved centres. I will give some feedback on the 2016 inspections regarding children.

In 2016, there were 509 admissions of children to approved centres. A total of 441 of these were to CAMHS units and 68 were to adult approved centres. There are four HSE CAMHS approved centres, one in Galway, one in Cork and two in Dublin. In total, these were registered in 2016 to accommodate 76 beds. However, at the end of 2016, there were only 66 operational HSE beds in CAMHS units. There are also 26 independent beds in St. Patrick's Hospital and in St. John of God Hospital. As of the 31 May 2017, there were 59 HSE-registered beds and 51 of these are operational.

As stated previously, there were 68 admissions of children to adult approved centres in 2016, which represents one in seven of all admissions of children. This had decreased from 96 in 2015. However, the number of preliminary notifications received by the Mental Health Commission of admissions of children to adult units from 1 January 2017 to 31 May 2017 was 44, an increase of eight compared with the same period in 2016, when there were 36 admissions of children to adult units.

In 2016, there were 19 adult approved centres admitting children. The age range of children admitted to adult approved centres was between 13 and 17. Some 66% were 17, some 23% were 16 years of age and 12% were 15 or under. The average length of stay was six days and 35% of children admitted to adult units were moved to a CAMHS unit. Two of those admissions to adult units were detained under section 25 of the Mental Health Act.

We inspect approved centres under the code of practice relating to the admission of children. Section 2.5 of the code of practice states that if adult approved centres are used for the admission of children, the following should apply: policies and protocols are in place for admission, family liaison, parental consent and confidentiality; age-appropriate facilities; age-appropriate

therapeutic programmes; child protection provisions; training for staff relating to the care of children; age appropriate advocacy; advice from the CAMHS. HSE policy is that the child has a single room and one-to-one nursing observation and this was noted to be in place. All adult units that admit children were non-compliant with section 2.5 of the code of practice, leading to the conclusion that adult approved centres are not suitable for the admission of children.

With regard to CAMHS teams, A Vision for Change recommends that there should be two fully staffed CAMHS teams for a population of 100,000. During 2016, I met with the area management teams in each of the nine CHOs. There were a total of 58 CAMHS teams nationally at the end of 2016. No CHO had the required two teams per 100,000. Four CHOs did not have an out-of-hours service at the end of 2016. Children who present to the emergency department out of hours with a mental health difficulty are assessed and treated by non-specialist non-consultant hospital doctors and consultant psychiatrists in the emergency department and it appears that they have no other option but to admit children because of their risk and due to the lack of appropriate services and beds.

Dr. Matthew Sadlier: I am Dr. Matthew Sadlier and I am a consultant adult psychiatrist. I am here to represent the Irish Medical Organisation, IMO, and to set out the views of doctors in Ireland on the problems facing child and adolescent mental health services. The IMO is the representative body and trade union for the medical profession and represents all doctors across all grades.

Through written submissions made to the committee and those made to it during last week's hearing, the committee will be aware that mental health services for children and adolescents in Ireland fall far short of what is needed and that we are failing young people and their families. In many ways mental health awareness has never had a higher profile, with sufferers encouraged to seek help. However, while as a society we might encourage our young people to access the help they need, at present we have neither the capacity nor the staffing in place to adequately respond to those requests.

Funding for mental health care in Ireland remains low. In the HSE's service plan for 2017, funding for mental health services made up just 6.1% of the HSE's total operational budget. This is a far cry from the 8.24% of total health fund spending that should be directed to mental health services, as set out in A Vision for Change in 2006. We have seen the percentage of total health budget for mental health decrease from 13% in 1984 to 7.3% in 2004 and to the current 6.1%. By way of contrast, many other western European health systems, such as those in France, Germany and the United Kingdom, spend approximately 10% to 11% of their health budgets on mental health services. This chronic underfunding has manifested in a failure of State agencies to build the necessary capacity to provide adequate mental health services to children and adolescents.

The IMO recognises that good patient outcomes are most likely if patients have timely access to advice, assessment and treatment, but the latest figures available show that CAMHS are still far below the level of capacity recommended. Just 67 child and adolescent mental health teams are in existence out of the 95 teams recommended in A Vision for Change for the population of the country. This means that each team is forced to serve a larger population, creating additional pressures on staff and, inevitably, longer waiting lists. Just 66 CAMHS inpatient beds are in place, which is far less than the 100 beds which were required in 2006. Since 2006, there has been a population increase of approximately 216,000 in the age group of less than 18 years of age. This is a rise of 21%, so the need for beds is even greater than it was in 2006.

Furthermore, inpatient beds are available only in the major urban centres of Cork, Dublin and Galway, often placing treatment options far from the homes of patients in other areas of the country. For example, no inpatient beds exist in the country's north west, south west or midlands, nor are there beds in the country's third most populated city, Limerick. Where referrals are required for patients in these regions, they travel to Dublin, Cork or Galway, which puts additional strain on both patients and families. Our membership has reported that facilities are often unsuitable for the provision of care to children and adolescents.

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

In the absence of adequate primary care teams with allied mental health professionals, such as psychologists and speech and language therapists, general practitioners, GPs, often have no option but to refer patients to secondary specialist services instead of being able to manage some patients in the community setting. Chronic under-staffing and a lack of capacity, despite the recommendations of the Mental Health Commission, have resulted in 68 children being admitted to adult psychiatric units in 2016, representing approximately 18% of all child admissions. At the end of March 2017, some 51% of referrals to CAMHS were waiting over three months for an appointment, demonstrating the inability of the existing staff to treat patients in a timely manner.

Mental health services, indeed most health services in Ireland, encounter major difficulties when attempting to recruit personnel, leaving many health services in Ireland critically understaffed. Recently, the IMO has heard complaints from doctors being forced to work hours far above legal limits, due to severe under-staffing. This problem has been particularly identified in the CAHMS in north Cork, where three non-consultant hospital doctors have been forced to provide 16 hours each of on-call cover each week day and 24 hours of on-call cover each weekend on top of their 39 hours of weekly commitment. In responding to calls from the IMO that this practice cease and that correct staffing levels be attained, the HSE stated that it did not believe it would be possible to alter the current work practices within the service. It referred to "significant difficulties recruiting suitably trained personnel, at local and international level, which is having a significant impact on the quality and timeliness of service provision".

Problems such as these are not restricted to services in Cork, however. Waterford, for example, has funding for three child and adolescent consultant psychiatrists but has only been able to fill one and a half of these posts. In north Tipperary and west Limerick there are no non-consultant hospital doctors and no consultants in training on the CAMHS teams. It is little wonder that the health services in Ireland experience pronounced difficulties recruiting and retaining medical staff when both remuneration and working conditions lag significantly behind those available elsewhere in the English-speaking world, with which we largely compete for medical staffing. Independent research on the emigration of health professionals from Ireland has found

that "much recent emigration has been driven by dissatisfaction with working conditions in the health system and uncertain career progression opportunities, aggravated by austerity-related staff reductions, salary reductions and taxation increases". This research has also indicated that the overwhelming majority of those who leave do not plan to return to Ireland and experience superior working conditions, training and professional opportunities abroad. Simply put, no solution can be found to the staffing issues within the mental health services unless action is taken to resolve the current recruitment and retention crisis among health professionals.

Additionally, structural issues must be addressed. Sufficient CAMHS inpatient bed capacity must be provided, in appropriate locations, to ensure that all children who require such care can receive it and thus end the practice of the inappropriate admission of children to adult psychiatric units. General practitioners must also be provided with the necessary resources in their primary care teams to manage patients presenting with mental health problems, without recourse to secondary care. Finally, the confusion regarding discrepancies in the definition of a child between physical and mental health services, which leads to the confusion we have heard about today, should be resolved. The IMO calls on the committee to recognise these issues as central to remedying the problems facing child and adolescent mental health services and to recommend that immediate remedial action is taken to address these issues.

I thank the committee for its time this afternoon and both Mr. O'Dowd and I will be happy to answer any questions.

Mr. Jim Gibson: Tusla welcomes the opportunity to make a submission on this. In many ways, as chief operations officer I can empathise very clearly with parents whose children have mental illness episodes. I am a corporate parent for over 6,300 children in State care. Last year, we lost five children to suicide. That causes me great grief as a public servant. I listened to all the submissions today. We made a written submission. I would prefer to talk about some of the key points about which we need to be mindful.

A child and adolescent mental health service of very high calibre makes an extremely good impression and makes a difference to the well-being of a child or young person who accesses it. We strive, as a State agency, to have good working relationships with other State agencies. We recently signed off on a joint protocol for children in care to have priority access to disability services and mental health services. Having said that, as a State agency we receive over 43,000 referrals per annum. Many of the young people who present at our service do so with mental illness episodes. It is very difficult, when they have access to a child and adolescent psychiatrist, to obtain a diagnosis. I am talking about adolescents heading into adulthood. Our experience on following the affected children and young people is that when they enter young adulthood and engage with adult mental health services, they seem to get a diagnosis quite quickly and, therefore, get a medical treatment plan and medication to resolve their issues. In the case of personality disorder, for example, the diagnosis seems to come quickly in adulthood. I am not a medic and acknowledge there may be very good reasons diagnosis is not as quick for adolescents. This is a theme we see regularly. When those affected receive a diagnosis and treatment plan from a mental health perspective, their behaviours de-escalate in all walks of life in the community. That is an important point.

What parents and staff in Tusla require when young people or children present with mental health difficulties is an accessible and immediate service. I am very much aware that CAMHS operates at the acute end of the spectrum and that many times when we do have access to that service, it reaffirms the professional's assessment of the child's needs. Therefore, it reduces much of the anxiety experienced by other professionals in trying to manage children and ado-

lescents who present with mental health issues. Interagency collaboration is easy to talk about but much harder to make happen. There are developments within Tusla in this regard. The Government has invested heavily in the children and young people services committees. Many of those committees have sub-groups for children and adolescent mental health and they do very good work on awareness, early support and family support across all agencies and within the non-Government sector. I ask the committee to consider this model a vehicle of investment to ensure we have good programmes on information-sharing, early intervention and supports for children or adolescents experiencing mental health difficulties and their families. The committees have been running for several years and their meetings are well attended by an interagency forum and well supported. They are a good vehicle. A good example is in Kerry, where there was a serious rate of youth suicide. The committee got together and put together very good programmes with information on accessing immediate support. It works well. With the acute service, it is a matter of accessibility and timeliness.

May I use a case example to show how we were able, along with other agencies, to provide an immediate, assessable support to a family with a single mother? Coming up to Christmas, her daughter experienced suicidal ideation and had carried out many attempts on her life. The mother found her daughter hanging in the landing one night and was able to rescue her. She was admitted to the general hospital. The out-of-hours CAMHS assessed her. In the professional opinion of the assessors, she required an inpatient bed in a child and adolescent psychiatry setting. That young person remained in the general hospital for three weeks. Tusla was contacted at an early stage on the grounds of there being a child protection issue. We responded to that and made our assessment, namely, that it was not a child protection issue but a mental health issue. The mother was a good mother, a very concerned mother who loved her daughter but felt she could not manage to ensure her daughter's safety. Therefore, the young person remained in hospital. Unfortunately, the adult psychiatrist attached to the hospital reassessed the child and made a professional decision that she was fit for discharge. The hospital telephoned us and said the matter was for Tusla. We said we would be part of an overall plan of intervention and support but we asked it not to expect Tusla to have the capacity to look after the matter on its own.

The immediate response from a social work perspective was that we needed a residential service. As a manager, and with a management team, we disagreed. We said we need to put a service in the family home of the mother and daughter if they are willing to accept that. We put a social care team in with the mother's consent because her main concern was that she could not ensure her daughter's safety at night. We said we could remedy that and that we could, with her consent, put a team into the family home for a period of three months. One social care worker in that team was given a brief to develop a relationship with the young person that would remain on an ongoing basis thereafter. That young person is well and safe and living at home in her community with her family. She does have mental illness episodes but they are well managed. The point for us was that CAMHS was very agreeable to being involved in the integrated response, which was immediate, timely and proportionate to the need of the young person and her mother. If there is anything we can do as a State agency today, it is to state the need for an integrated, timely response characterised by togetherness, true collaboration and working together to ensure the well-being of children and young people.

Professor Joyce O'Connor: I thank the committee for giving me the opportunity to attend today. I have a written submission but will not read it. I just want to make one proposal, which is on addressing excessive and unacceptable waiting lists. Before I make it, I must congratulate Senator Joan Freeman and her colleagues on putting a spotlight on the issue of mental health. It is very much needed. All the submissions have very clearly defined what the problems are.

What comes across to me is the determination of Senator Freeman, the Minister, the HSE representatives and all the others who presented in positing the high priority of children. They have defined the issues very clearly. In the spirit of Mr. Gibson, I ask that the case study he gave on a particular child be used in drawing attention to the immediate priority of addressing waiting lists. Through Senator Freeman, I ask the Minister to establish, through his office, a national task force to address this issue as a matter of priority.

Waiting lists create enormous problems for parents. Last week, I was very moved when I heard what parents had to say and the issues they addressed. We know that the longer young people and adolescents wait to be assessed, the greater their problems and the more difficulties are created for families.

The acting national director of mental health services, Mr. Jim Ryan, is here today. He could give leadership and organise a response. He could do exactly what Mr. Jim Gibson and the Ombudsman for Children, Dr. Muldoon, talked about and adopt a child centred approach and respond in an integrated and co-ordinated manner. How can it be done? A structure already exists because there are nine community health care organisations that lead in mental health. We should avail of all of the services that are available. Myriad services are available and not only ones that are statutory to the HSE. We also have the Jigsaw and SpunOut organisations in the voluntary sector. A whole range of services is available but I will not list them. There is also the independent sector of which the Dean Clinics are an example. The National Treatment Purchase Fund should be used to address this issue, if necessary. I ask that all of these resources are brought together in a way that will address the issues created by waiting lists.

I do not underestimate the funding, recruitment and staff retention issues as they have been well documented. They are issues for the future. They will not be solved immediately and will take a long time to be resolved. As Dr. Muldoon has said, there are cultural issues involved. We need to know how the services work and not just focus on additional resources. We also need to know the process of referral, triage, assessment and intervention.

It is important to note, and for Senator Freeman and her committee to see, that there is a suitable model available for review and possible modification. I hate to say it but the Gordan Lynch and Elma Hedderman study was conducted as long ago as 2006. It clearly showed that more streamlined triage practices can significantly speed up triage and assessment, and reduce waiting times from a year to just a few weeks. As suggested earlier, triage can be undertaken by nurse practitioners and other experienced members of a multidisciplinary team. As we know, mental health issues cover a wide span and triage is a very good way to address the issues quickly.

Other researchers called Aisling Ní Shiothcháin and Michael Byrne carried out a review on best practice and analysed waiting list management and initiatives in 2009. They have produced a 14-point plan on how to do so and they would say, as I would, that managing the waiting list is key. Waiting lists are unacceptable. Young people and their families are suffering on a daily basis and their situation can deteriorate. Early intervention could help alleviate the problem. We know that early intervention is important in so many areas, particularly young people's potential in their future lives.

I suggest that we address the problem in an immediate fashion. The Minister of State may be shocked to hear that this issue could be resolved by Christmas if we adopted a focused approach. I believe we can do it because there is a structure already in place, we have limited resources in the community, we have community care organisations that operate under the

director of mental health services, we have evidence-based research in how to address the problem through referral, triage and interventions, and we have a 14-point plan. I sense here today, and having heard the submissions this morning and watched proceedings last week, that people want this issue to be resolved. We have the belief but in this case we need the focus, we need the use of evidence-based practice and we need good leadership. I think we should celebrate this and give a plan to the HSE to see how this can be done in the future in a cost-effective manner but, more importantly, in a way that addresses the needs of young children, adolescents and their families.

Chairman: I thank the professor. She had me worried for a minute. Her questions made me think she should have sat on this side of the House. Well done. I propose that we move on to questions that will be short and brief as ever. I call on Senator Freeman to commence.

Senator Joan Freeman: I will avoid asking the Minister of State too many questions this afternoon as he was only appointed a little over two weeks ago but I will get on his case in the autumn.

Chairman: He is on the case already.

Senator Joan Freeman: I hope so.

Senator Martin Conway: Very much so.

Senator Joan Freeman: I will direct my questions at the mental health division. I have heard the presentation that Mr. Dodd has made a dozen times. The first time was by the previous Minister of State who was responsible for the mental health brief, the Minister of State, Deputy Helen McEntee. The current Minister of State has said something similar and I have heard the same from the mental health division many times. At best the presentation can be described as defensive and at worst it is fantasy. It has been said that when a child is put into a mental health unit that he or she has one-to-one support but, in contrast, Dr. Finnerty said that not one of the units were compliant. Where did Mr. Dodd get his information from?

There seems to be a shrugging attitude about the recruitment and retention of staff. There is an attitude of it is not our fault, we just cannot get the staff. As Dr. John Hillery said this morning, any major company would ask itself why do people not want to work with us and why can we not retain staff. Has the HSE ever asked itself those questions? The staff in the HSE have changed. If the HSE cannot retain staff or they choose to move around all of time then how can there be continuity when it comes to dealing with the issues that affect this country?

"Task force" are the worst two words in our language. A task force sounds good but in reality it is just kicking the can down the road. As many as 12,000 reports have been written on our services and 12,000 tonnes of dust have accumulated. What is the point of these reports? Today, I had great hope until I heard Mr. Dodd's presentation. I had hope because I had listened to the men and women who work so hard in this country to make good services available to the children of our nation but then I heard the HSE utter the same platitudes again. Unfortunately, nothing had changed. When will the HSE change its tone?

Senator Colette Kelleher: I welcome all of the presenters and the Minister of State. I also welcome back Ms Lauren Keogh and Ms Sinéad McGee who were part of a group of mothers who gave powerful testimonies of their lived experiences. It is great that both of them are here again today. It is great that they keep us on track when it comes to asking the right questions.

I have questions for the Minister of State, the HSE, Tusla, the Ombudsman and everyone else. The Minister of State is newly appointed. I would be interested to know how the Minister of State, Deputy Daly, rates the child mental health services in Ireland, his priorities for his first 100 days in office, if he believes his budget is big enough and, if not, what he would like it to be and what percentage of that budget he would like to be spent on child mental health. I would be interested in also hearing the Minister of State's response to Professor O'Connor's suggestion on how to tackle the waiting lists, which is very interesting. We can do many things, including host the Rugby World Cup. We could do this if we put our minds to it.

My question to the HSE is when will the 24 hour cover for child mental health be in place? I would like to read into the record the testimony of a mother, named Louise, to the committee last week, in which she describes her son's breakdown following the death of his father. She states:

> We went to accident and emergency that night when the ambulance came. My son, a fit and healthy 17-year old who was supposed to line out and play a hurling match the following day was brought in on a stretcher and wheeled catatonic into accident and emergency from an ambulance that night but he was alive. We spent that night in accident and emergency. I sat in the waiting room watching all the ads, such as "It's ok not to be ok", "Ask for help" and "Tell someone". That is absolute rubbish. There was nothing there for us when we went looking for it. It is a complete and utter contradiction and it is hypocritical. There was nothing there. We had been everywhere looking for help.

Following on from that, what is the HSE reaction to public health campaigns that have great messages but no substance in terms of backup?

Dr. Geoffrey Shannon gave powerful testimony to the committee about the importance of interagency work. I was glad to hear Mr. Gibson speak so well about that work. What is the HSE view on it? Dr. Shannon, who produced an audit and reviewed several models of inter-agency co-operation, pointed out that he has emphasised throughout the audit report that notification is not communication. In other words, it is not good enough to send on a letter. What is important is communication and working around the child. There is a tendency among State agencies to accept that if they fill in a form and push an issue the problem is solved. It does not work that way for the child. I would be interested if the HSE and Tusla could rate out of ten the inter-agency work. I understand the Minister of State, Deputy Daly, is a former teacher and so I would also be interested to hear his rating of the service.

My final question is to Dr. Muldoon. What innovative proposals does he have to fulfil the unfillable posts? As he raised that as an issue I would be interested in hearing his views on it. I would also like if Ms Gilheaney could reiterate her proposals on strengthening consent for the under 18s in terms of treatment, including detention, involuntary detention and medication. Children have fewer protections than adults and I would like if Ms Gilheaney could remind us of the position in this regard.

Chairman: I call the Minister of State to respond first.

Deputy Jim Daly: I thank both Senators for their enthusiasm and their contributions to this worthwhile exercise. There is a lot of learning in this for all of us. Nobody has the monopoly of wisdom on any of the solutions. However, through our shared knowledge we may find the solutions to progress this issue.

On Senator Kelleher's question of whether I am happy with the CAMHS and how I would rate it, it is not good enough and, of course, I am not happy with it. I do not accept that this is the best we can do on behalf of the children that are availing of these services. I am familiar with these services as a parent and a public representative, and as a Minister I have an added responsibility for these services. I do not rate them fit for purpose or as the best we can do. We must do better.

Senator Colette Kelleher: How would the Minister of State rate the services?

Deputy Jim Daly: I do not want to rate them. It is immaterial and it would not be fair of me to rate any service.

Chairman: This is not a quiz show.

Deputy Jim Daly: It is immaterial. It would be a subjective view. My view in that regard is not important.

Senator Martin Conway: The fact that the Minister of State is not happy with it is enough.

Deputy Jim Daly: On my priorities for the first 100 days, I am only two weeks in the job and I will try to answer every question as honestly and ably as I can but it would appear that the biggest issue in the mental health area is CAMHS. Following on from the contribution of Professor O'Connor I am hopeful that there is something we can do in this area. I do not know yet how much I can do but I will give it my all. My first priority is to get my ahead around the issue. My second priority will be to give my all to address of the issue and third, to make progress. I am determined to do that and I will work with all involved and do all that is possible to that end.

In regard to Senator Kelleher's question regarding Professor O'Connor's suggestion, I am willing take it on board. I look forward to having a conversation with the professor to tease out further what she is proposing. Notwithstanding the Senator's allergy to the words "task force" that is what Professor O'Connor has proposed. We already have a task force on youth mental health, the final meeting of which I will chair next Tuesday in Dublin. I look forward to receiving the report of the task force to see what tangible steps we can from it. As a task force, it did not run too long. During my first week as Minister of State I attended a task force consultation in Farmleigh. I hope that this task force will guide some of the steps I will take in my time as Minister. I would not be allergic to any task force in respect of which a time limit is put in place. A task force is effectively a group of people with expertise in a certain field. We all have views and opinions but we need experts to feed into areas in order to arrive at solutions. I appreciate Professor O'Connor's style. I support solution-led politics. We can talk all day today and tomorrow about what is wrong and we can continue to list all that is wrong in eloquent style but what I want to hear are solutions and I will welcome solutions from all contributors. I am particularly enthused by Professor O'Connor's solution-led submission today.

In regard to whether my budget is big enough, budgets are never big enough. The budget for this area is approximately €1 billion. I am more interested in what can be done, how we do that with what we have and in ensuring we get value for money. Perpetually looking for more resources and money to be thrown at the problem is not the solution. That is not the politics I subscribe to. How we do what we do must be held up to close scrutiny, which is tough. It is easy as a politician to look for more money and resources but it is a lot more difficult to scrutinise how we do what we do and that is what I will be championing during my tenure as Minister in this area, however long that will be. I hope I have answered the Senators' questions. I also

thank Senator Freeman for the hospital pass to allow me some time to settle into my role.

Chairman: I now invite Mr. Ryan of the HSE to respond.

Mr. Jim Ryan: There were two issues raised in regard to 24-7 cover. As mentioned earlier by Dr. Dodd, 73% of our services provide 24-7 cover. Where that cover is not available, the issue is staff recruitment and retention, which has been well rehearsed over the last two days. It is not the case that the HSE is not trying to recruit staff or that it does not have the resources to recruit staff rather it is that between nursing and consultants cover in particular it is proving extremely difficult to recruit in some parts of the country and in some of the roles. We have done recruitment internationally and a group will shortly go to Geneva for a conference on recruitment. We will work everybody and anybody on this issue. We have engaged with a number of different international recruitment companies. The problem is often that as staff numbers decrease, teams feel disempowered and disengaged and it becomes difficult to recruit. Our job, as part of the leadership that has been spoken about, is to rectify this. As mentioned earlier, there have been increases in the number of staff and likewise the number of referrals over the last five or six years. We are dealing with an increasing population, an increasing number of referrals and there are times when we have to try to ensure that the services we are delivering are being provided in a robust way 9 to 5, 7 over 7 and 24-7. In regard to a young person arriving at an accident and emergency department in the early hours of the morning, we accept that this is not ideal from the point of view of any young person's mental health. We do try immediately to have an assessment done by a CAMHS team to ensure the appropriate treatment is provided as quickly as possible. The committee has seen from the figures that the numbers admitted to adult units have been reduced. There was an increase in the month of January of which we were aware. There was a particular reason for that. Some of the cases involved were quite difficult to manage and we and our colleagues in Tusla were working hard to try to provide solutions which were appropriate to the young person's needs.

Dr. Dodd may wish to address a number of the points that were raised. I would like to address the issue of the waiting lists. Two years ago, we had in excess of 400 young people on a waiting list for more than 12 months. A colleague and I literally went down through each of the 400 and identified whether he or she was appropriate to mental health, primary care, social care, or potentially the National Educational Psychological Service, NEPS, in education. As a result of that exercise and through the redeployment of some our staff who are in current CAMHS positions, we reduced the number to less than 200. Unfortunately, we have lost certain key posts and as a result those numbers have gone up again.

In respect of legislation, the Mental Health Act provides that each young person attending a child and adolescent mental health service has to have a named consultant psychiatrist. That is in the Act. It is different from other jurisdictions where they have what is called an accountable clinician, who can be someone other than a consultant psychiatrist. That has implications for the ability of other professionals to see, assess and treat young people. If the young person has to have a named psychiatrist, then in fairness that psychiatrist has to have an overview of the case. It is simply a fact. We have to work within the legislation.

On admissions to adult units, we have already gone through the protocols that have to be put in place. A point was raised about the acute units not being in compliance. When a young person is admitted to an adult unit, the unit is not in compliance. However, this does not mean the protocol we have in place for the occasions on which a young person is admitted are not followed. They are followed.

Senator Colette Kelleher: Sitting on a chair for 24 hours is compliant?

Mr. Jim Ryan: No.

Senator Colette Kelleher: Okay.

Mr. Jim Ryan: To be clear, the division is not saying it is the right thing to happen to the young person. It certainly is not in that situation. When a young person is admitted, however, I get a fax immediately into my office that says a young person has been admitted to an adult unit. A similar fax goes to the Mental Health Commission. We know every day how many young people are admitted. We have a weekly bed meeting at which all the referrals that are being made in that week are assessed clinically by our four CAMHS services. They do not work in isolation but in tandem to ensure we can provide a service. I accept there is a distance involved but I have to work within the service we are funded for to try to be able to provide the best service we can.

On retention and recruitment, we have looked at many different ways of going about things. Part of it is about terms and conditions, which were mentioned earlier. Much of it has to do with trying to create a modern service. The last question put to me concerned what is new. Part of this is about sticking at what we are doing and trying to do it better. That is what we are fully focused on and I am fully committed to it in my role today and in my role as head of operations.

Senator Colette Kelleher: There was a question about interagency work.

Mr. Jim Ryan: As I think Mr. Gibson mentioned earlier, a protocol has been published in the past six weeks which outlines the interagency workings between the HSE and Tusla. Within the HSE, that means mental health, social care and primary care. We were aware that there were some young people who could fall between the various bureaucratic cracks. Trying to put the young person at the centre of decision-making can sometimes be difficult because of different legislative requirements. I take the point on board, however. We have to put the young person at the centre of the decision-making.

Dr. Philip Dodd: With regard to interagency work, there are two protocols. One has been completed with Tusla. The second is not fully complete. It addresses those children with complex needs who potentially have needs across disability services, social care, mental health services and Tusla. What is proposed in this protocol is adjudication at a central agreed point whereby the needs of the child are placed at the centre of the decision as to what agency should take a lead, given the child's presentation. That protocol is near to completion. I am a member of the protocol working group. My experience currently is that there is a significant level of enthusiasm to try to get that agreed way of working across agencies in place as soon as possible.

Chairman: I think Dr. Niall Muldoon was asked a question.

Dr. Niall Muldoon: I was asked what innovative ideas I might have for helping with recruitment efforts, which have been ongoing for numerous years. I see two issues. One, which the Minister of State touched on, is how we do what we do. We have heard a number of relevant examples, including some in my presentation. Even when a child gets into CAMHS there is sometimes no sense that it is a safe place to be. When we have psychiatrists differing over a diagnosis and children not being admitted into residential units as a result, that is not safe. Those things can be sorted out as they are systems issues. We need to take things in hand and make sure there is some level of consistency. We have had complaints about this. A child who has been diagnosed as needing a residential bed by a properly trained child psychiatrist is sent

off and referred, and then the residential unit says no, it is different, changes the diagnosis and sends the child back. That is not safe. We need to produce a safe situation for the people working there and for the children who get into the system.

Mr. Ryan spoke about legislation allowing for an accountable person. Have we thought about the need to change the legislation if that helps us? As far as I am concerned, the child has no care for who the boss is. It does not matter as long as the child gets the service that is necessary. Is there a possibility of making exemptions in certain situations? Could other people lead teams if necessary? I do not mind who they are and, most importantly, neither does the child. We can be imaginative and creative. The Senator asked one of the psychiatrists last week if there was any possibility of changing teams and the answer was that it is tradition. That tradition has always been there but we are trying to look forward. We are trying to be imaginative with waiting list priorities and changing things around. Can we do that? What Mr. Gibson highlighted was imaginative in that it involved things that have not been done before and are different and new. People will be discombobulated by that but let it be the professionals, not the children. I think we can move forward in that way.

Chairman: I invite Ms Patricia Gilheaney to answer whatever questions are relevant to her.

Ms Patricia Gilheaney: I thank the Senator for her question about consent and children. It is an issue about which the Mental Health Commission is quite concerned and has been for some time, as expressed in its views in respect of the expert group review. As it stands, the majority of children requiring care and treatment from a mental health service will do so on an outpatient basis. When inpatient care is required, the majority of children will receive that care and treatment in the approved centre with the consent of their parents. The legal status of the child is that he or she is a voluntary patient. Under the Act, a child is anyone under the age of 18 unless they have been married. We have the situation where we have a young person up to and including the age of 17 who can be a voluntary patient in an inpatient mental health facility if their parent provides consent. The young person's view as to whether he or she should be there is to some degree irrelevant.

It is the commission's view that there needs to be clarity in this regard. There are provisions under section 23 of the Non-Fatal Offences Against the Person Act, which provide for the consent of a 16 and 17 year old in respect of medical and surgical treatment. However, it is unclear as to whether that is pertinent to mental health care and treatment. Clarity in that regard certainly would be very welcome. It would be protective of the child's interests. Obviously, in respect of children under the age of 16, the commission is strongly of the view that their views should also be heard and taken into consideration in respect of any intervention that would be taken on their behalf.

The second question concerned equivalence of protections for children and adults. A key provision for adults detained under the Mental Health Act 2001 is that they have an automatic right to have an advocate appointed. Under the Act it is a legal advocate. The commission endeavours on receipt of notification of such admissions to ensure an advocate is appointed within two working days. There is no similar provision in section 25 of the Act in respect of children. While under section 25(14) there is a provision for the District Court to take into consideration section 26 of the Child Care Act 1991 for the provision of a guardian *ad litem*, that is a discretionary power of the court and is not mandatory. It is the commission's view that the child should have access to an advocate. Particularly in the case of a very young child, a guardian *ad litem* might be the most appropriate advocate. For an older child, the appropriate advocate may be a legal representative.

Chairman: I thank Ms. Gilheaney. I believe there was a question for Mr. Gibson. I hope his answer will be as brief as he can make it.

Mr. Jim Gibson: I will answer the question on interagency collaboration and co-operation and where I would rate Tusla in that regard. There was some reference to Dr. Shannon's report which was on a totally different area. It was also a look back at 2014. This is 2017. I would like to make that distinction. Notifications which were referred to in the report were about An Garda Síochána. We have agreed with the recommendations of that report.

With regard to our collaborative approach, I would like to speak from an evidence-based position and outline some things which Tusla has established and which have gathered momentum. In every county in Ireland there is a children and young people's services committee. Area managers within Tusla are the chairpersons of these committees and Tusla pushed for their establishment. They are multidisciplinary and interagency by their very nature. They have worked up plans for each county which have been submitted to the Department of Children and Youth Affairs. These plans are worked on proactively. These committees connect with the local authorities and they plan to assist local authorities in submitting their local development and community plans to Government. We are very much involved.

More importantly, when we were established we said very clearly that there was a dearth of early intervention and family support initiatives throughout Ireland. From day one we have proactively bought into very strategic relationships with Atlantic Philanthropies and the National University of Ireland, Galway to build our prevention, partnership and family support. People would have heard of the Meitheal programme around Ireland. That is an excellent example of collaboration and interagency working because there are representatives from every discipline and every agency involved in the programme. The Meitheal programme is about a team around the child. I will give another example. There was a young boy whose uncle-----

Chairman: We are more interested in answers than examples.

Mr. Jim Gibson: I will just mention it quickly because it is very important. It demonstrates the collaboration and the commitment to interagency working. There was a young boy whose uncle died of suicide and shortly afterwards his father died of suicide. That young boy retreated into his bedroom. The school was very concerned about him and it made a referral to our agency. We used the prevention, partnership and family support, not the child protection system, to offer assistance to that family. We engaged with his mother. Collaboration with parents, children and young people is also very important in respect of what they see as their needs and what services should be developed for them. That young person got a team around him. He went back to school and was supported by a variety of professionals, not only from statutory agencies but also from sporting agencies, youth clubs and so forth. That makes a big difference.

Where would I rate Tusla? Not ten out of ten, but we are halfway there. We have a lot of work to do but we will get there.

Chairman: I thank Mr. Gibson. I am coming back to the Senators. I will take three and I would like the Senators to make their questions brief.

Senator Pádraig Ó Céidigh: I give the Minister of State my heartiest congratulations. I wish him every success. We have known each other for a short period. I know he is a man of his word and will give it 110%. I am delighted he is in the role. If I may say so, when the Minister of State spoke with papers in front of him, he was a different man from when he was

speaking from the heart. He should keep speaking from the heart.

Senator Joan Freeman: Hear, hear.

Senator Pádraig Ó Céidigh: He turned to Professor O'Connor and said he was with her and would meet her. That is the man I know and that is the person we need leading this critical area. I will move on to questions.

Chairman: The Senator should fire them out quickly.

Senator Pádraig Ó Céidigh: I will, very quickly. The key term for me was "child-centred". Dr. Muldoon mentioned the child-centred approach. How dysfunctional are we in terms of achieving a child-centred approach? To me there seems to be a big chasm or gap there. We are not there at all. We are not fit for purpose by a long shot, to use Dr. Muldoon's terminology. I would like to hear how Mr. Muldoon could see us making our system child-centred.

I am sure the witnesses are all good people of integrity. I do not doubt that. However, I do not know how many of them, if any, were here last week to listen to the parents and I will not ask the question. I do not know how many of them were here this morning listening to the practitioners. I do not know how often they do it but I plead with them to start because they are the people at the coalface. They are the people who make it happen.

Do the Minister of State and Mr. Ryan accept that we have failed? It is only when we accept that we have failed that we can decide to start afresh and do something new. I said that last week. I said that both Houses have failed young people.

Senator Joan Freeman: Hear, hear.

Senator Pádraig Ó Céidigh: I believe we have. Do the Minister of State and Mr. Ryan believe we have failed? That is not blaming anyone but accepting facts as they were. We will go on science-based facts. Let us clear the deck. I am with Senator Freeman. I have a problem with having great numbers of committees. We have to be a bit more business-like. Last week, Ms Lauren Keogh twice mentioned something critically important. She mentioned lean methodology. I do not know if the witnesses know what lean methodology is. It is fundamental in business. It is not a matter of throwing money at something. It is about how that money is spent. We are dysfunctional and disjointed. If we were *Titanic*, we would not get out of Cobh.

Chairman: Is there a question?

Senator Pádraig Ó Céidigh: I have asked two questions.

Chairman: Very good. Will Senator Boyhan ask his question or questions quickly?

Senator Victor Boyhan: I will make my points and then I will ask my questions.

Chairman: We are not interested in raising points. We are interested in brief questions.

Senator Victor Boyhan: I thank the panel for coming here today. I welcome the Minister of State. I echo what my colleague, Senator Ó Céidigh, said because I heard the Minister of State on radio twice in the past week. I pulled my car in when he was speaking on "Morning Ireland". I thought that this was a man who was full of conviction and enthusiasm. I sincerely wish him well. He is in the right place and he is the right man for the job. That is clearly something which the Taoiseach recognised in him. That is why he was appointed and it was a good

appointment.

To ask a few questions, we heard about resources in today's session and last week's. We heard about the people who experience mental health issues trying to access resources. The mental health situation and services in this country are in crisis. One might as well be talking to two groups of people. Practitioners, and administrators in particular, in the health service say one thing and come up with various excuses. Another group of people experience something very different on the ground. These groups must be connected. This morning we had very professional people who believed and had professional values before the committee. Those values were clear from every one of them who spoke and shared with us today in what is a listening Parliament and a listening exercise.

I will direct all my questions to the Minister of State. He will not get a honeymoon period from me because I believe he can answer my questions and I would be delighted if he did. I believe in the suggestion that we should have a task force. Let us hear from one. We do not want an open task force, and I believe the Minister of State made that point, but what is his view on that issue? How are we going to address the waiting lists? How are we going to have early intervention, because that is the crisis? The time for excuses is over. The time for blaming resources, other people, the administrators, the HSE or Tusla is over. People are sick of it. The people outside this bubble called Leinster House are fed up with it. They are sick of it and they want answers.

Will the Minister of State clearly set out how he is going to address the issue of retention and recruitment of staff into the mental health services? How will he go about minimising the length of waiting times? Will the Minister of State give this body a categorical assurance that not one single designated bed will close this summer? If there are any closed today, will he commit to reopening them? These are designated beds for child psychiatry. I do not want any excuses about staff or other beds. No child should be in an adult psychiatric service. I want the Minister of State to assure us today that if there are any closed, we will reopen them. I want him to give another undertaking that summer holidays will not be used as an excuse, because mental health issues do not stop when the sun shines. That is the message.

Chairman: I invite Senator Devine and I would appreciate her putting her question quickly.

Senator Máire Devine: I will not give the Minister of State a bye-ball today. I am sorry but on most days in the Chamber I start by saying two words; "Linn Dara". We talk about it every day, day in and day out. It is indicative of the mental health services for our children in Ireland that, in the face of an emergency, we went and closed 11 beds, half of the unit. It just does not make any sense. Along with Senator Boyhan, I call for those beds in Linn Dara to be reopened as soon as possible. This is in the gift of the Minister for State, Deputy Jim Daly. It is not rocket science. It seems that most of the difficulty is around retention and recruitment of staff. I like Professor O'Connor's idea that it must be community led and come from within and be of our communities. Perhaps I will not be popular for saying this but maybe we should begin to deprofessionalise a lot of what we offer to our children within our communities. This is where we are born and, hopefully, where we will die. Last month the Children's Rights Alliance gave us a "D". Heartbroken parents appeared before the committee last week and told us what is happening in their world. We need to respect them and I wonder whether the HSE is taking into account the independent survey of parents' views that came out two days ago. It is fairly mindblowing and it tells us what we need to give to them. The cost of mental health problems to the economy is €3 billion, which is 2% of GNP, according to the 2011 Mental Health Commission report, The Human Cost. It shows that it is a growing problem. As the population grows, the

number of referrals grows. As the elders, legislators and policymakers, what have we done that we have so wrecked our children's lives? That is a big question and I do not expect any answers. There are ideas on it but we must take responsibility and we must act.

Chairman: Will I throw the Minister of State into the deep end or does he wish to first respond to that barrage?

Deputy Jim Daly: I thank the Senators for their kind comments, their good wishes and their passionate contributions and statements that preceded their statements. They are difficult to answer. Senator Ó Céidigh asked me about specific cases. I do not know enough in that regard. I was one week in the job last Thursday and I am ashamed to say that I was not aware of what was going on here and the significance and import of it. Being appointed on a Tuesday, trying to find my feet and catch up, I was genuinely not aware that I was invited to be here last week. I explained this to Senator Freeman yesterday. It happens when one goes into an incredibly busy Department. I was just playing catch-up and it was a timing issue that caught up with me last Thursday. I assure the committee that it was not from any disrespect, lack of regard or lack of interest towards the families who presented to the committee. I will catch up and read all the blacks of the reports and presentations to and by the families. My officials have told me about some of them and I have met with people in the corridors of Leinster House who have told me of the powerful testimonies that were given here. I have not physically had the time to read them prior to coming to the Chamber today but I can assure the committee that I will read them and take on board the presentations. I thank people for their honesty in sharing such difficult stories on their part.

Senator Ó Céidigh asked me to specifically comment on one case. I would prefer not to, with the indulgence of the committee, because I do not believe it would be fair to do so unless I had heard the testimony in full myself. I thank the Senator for his kind comments. He also asked some specific questions about a task force. I shall look forward to speaking to the professor after the meeting. After this meeting I am rushing to another meeting with the Secretary General, but I will request the professor's mobile phone number before I leave. I will pursue the issue of a task force. I believe it is a good way to go, provided that it is clearly driven and clearly defined with a clear end. If it is sharply focused then it is the right way to go. I do not have the kind of wisdom required. There is a lot of expectation of a Minister of State but he or she has only so many qualities and so many qualifications to bring to any role. We do need to rely on the experts. They need to be brought around the table. One needs to keep the number as small as one can and to get everybody contributing to be engaged in solution-led politics and to be as effective as possible.

I am trying to read my own writing. On recruitment and retention of staff, I do not have the magic solution to this matter. It is clearly an issue of which all of us are aware. I honestly do not know how we are going to get around that. It is a big issue and I am informed by the HSE that it is not just a problem in Ireland; it is an issue also in Europe. The retention aspect worries me just as much as the recruitment, if not more. Why are we not retaining the staff we need in the services? I do not have a solution for the Senator, other than a commitment to doing my best to find a solution for it. I do not have that just yet.

Senator Victor Boyhan: What about the bed closures?

Deputy Jim Daly: I am afraid that I would be disingenuous if I gave a commitment that no bed would close under my watch as the Minister of State or that I could reopen beds because I do not have that power. I cannot tell people to reopen beds immediately. The health and safety

and the security of the patients must be considered. I am one person. I cannot dictate that any bed is opened or closed. I can work as hard as I can with the HSE to ensure beds do not close and to make sure adequate funding is there but as addressed by Senators, including Senator Ó Céidigh, it is not all about funding. There also are other issues. I am particularly interested in how we do what we do. It would be disingenuous of me to give a commitment because it is not in my gift to give a commitment that no bed will close under my watch as the Minister of State. I sincerely hope that it will not close-----

Senator Victor Boyhan: That is the problem.

Deputy Jim Daly: -----but no Minister could give that commitment.

Chairman: That is understandable.

Senator Máire Devine: What about emergency legislation?

Chairman: Order please.

Deputy Jim Daly: That is a fact of life and I can only do what is within my role, functions and powers as a Minister of State. There are limitations to that so I cannot give the Senator that assurance. I do not believe Senator Devine had a specific question for me.

Senator Máire Devine: I asked about Linn Dara.

Deputy Jim Daly: I will allow my colleagues here from the HSE to address that.

Chairman: I now call on the representatives from the HSE to respond to the questions addressed to them.

Mr. Jim Ryan: I will deal specifically with Linn Dara. There are 11 beds, from the 22 beds, closed at the moment because we were not able to staff the nursing side of the unit. The other staff were in place. We had consultants and we had the multidisciplinary team. We have a plan in place to reopen that at the end of September.

Senator Máire Devine: That is a token.

Mr. Jim Ryan: The Senator asked me earlier on for a personal commitment. I am talking about trying to do the very best we can. The Senator asked me about what is new and I am trying to do what we can in order to do that. This morning I had a report about the recruitment process being in place for new graduates, for those who are coming from a graduate programme, and people who we recruit internationally. We are doing everything we can to try to reopen the 11 beds that are currently closed in Linn Dara. Six beds are closed at the moment in St. Vincent's Psychiatric Hospital in Fairview. We have consultants starting there in the next weeks, which we expect will bring the number of beds back up to 12. We are recruiting non-consultant hospital doctors for the Aislinn centre in Cork, which we would hope will bring the beds available from 12 to 18. All those efforts are being made. It is not through lack of effort; it is simply that it takes time. That is all I can say.

Chairman: Would Dr. Dodd like to add to that?

Dr. Philip Dodd: I refer to Senator Ó Céidigh's query on whether we in the HSE have failed young people. Based on the testimony I heard last week from those individual cases - I read and followed some of the proceedings - the HSE did fail those young people. The HSE cannot

justify that. The lived experience of some aspects of CAMHS is not acceptable. I accept this but to suggest that all staff members working in CAMHS need to hear and live such a negative narrative about the services they try to deliver is not a positive suggestion. We are trying to develop a recovery-oriented mental health service for children and adults in Ireland. This is a difficult job to do given all the constraints I have outlined. It is not accurate to suggest that senior management in the HSE is somehow so disconnected from the front line. I am on the senior management team of the mental health division. I work part time as a consultant psychiatrist. I try to support adults who have an intellectual disability and a mental health problem. I am absolutely familiar with the lived experience of trying to access better services. I am new to the mental health division in the HSE and since I have joined the senior management team, I see a group of people who are trying to their best to come up with solutions and to remain as positive as possible in coming up with the best outcomes for our service users as they access our services.

Senator Catherine Noone: I thank all the representatives for attending the committee today. I missed most of the contributions due to other commitments. I have a brief question for the witnesses from Tusla and, perhaps, some of the medical professionals present. Dr. Geoffrey Shannon's report is very topical at the moment, and I note Mr. Jim Gibson's comments that the sections 12 and 13 aspect of the report is not necessarily relevant to this. I believe there is a relevancy. I am interested in knowing what is recommended from a psychological-psychiatric point of view for children who are in section 12 and section 13 situations where there is a mental health issue. Is it sufficient that they get that type of help after the event and once they have met a social care worker or a social worker? What is the current position on the extra workers throughout the country and the out of hours service, and what is required from the point of view of a medical professional? I know there is a review going on. In respect of our interagency conversation, it may not be relevant, but does the protocol apply to the Garda Síochána as well? I have been looking into this lately in respect of sections 12 and 13, which are quite topical.

Senator Pádraig Ó Céidigh: One of the parents handed me this question. I am told there are many temporary and locum staff in the HSE. Would the Minister of State consider making them permanent, which would at least stop the rot? If he could commit to making every effort to ensure this takes place, we will have done a good day's work.

Senator Joan Freeman: While it may sound as if I am attacking Dr. Dodd and Mr. Ryan, I am attacking the system. I presume Mr. Ryan works in the administrative part of the HSE. He mentioned going through 400 cases. How was he able to determine who should be seen and who should not and who should go where? There seems to be a good relationship between Tusla and the HSE, which has not always been the case. Tusla is fully behind the Bill that I am proposing, yet the HSE is not. Where is the disconnect? The previous Minister of State, the HSE and the Government keep talking about the wonderful budget of €850 million, or whatever the figure is, but only 6% of that is for children, that is, €50 million to provide the services for children, or maybe my mathematics are very bad.

Dr. Dodd said he is in that world of mental health services but he is an adult psychiatrist, not a child psychiatrist, which is a very different world. This is not a criticism of the Mental Health Commission but there is no child psychiatrist on its board. How do we get the true picture if there are not people who represent the front line talking about our children on these issues?

Senator Martin Conway: I have great faith in this new Minister of State. I have known him for many years. I believe he is totally committed to this and that we will see change. I have spoken to him privately on this issue and the work we are doing.

An Leas-Chathaoirleach: I invite the HSE to respond.

Mr. Jim Ryan: In respect of the waiting list, I asked that each team would identify in a template those waiting over 12 months. Each team told me where its issues were. I did not take a bureaucratic view. The clinicians told me. That is how I understood that. In respect of the Bill, the HSE and Tusla can work with each other but that does not mean we always agree with each other. In respect of CAMHS, 6% would be closer to €50 million.

Senator Joan Freeman: That is what I said.

Mr. Jim Ryan: I thought the Senator said €15 million. We allocate the budget according to what is allocated yearly. Each year over recent years CAMHS has been prioritised for additional resources. Most of the time the difficulty is not about getting the budgets but about being able to spend it appropriately when we cannot recruit some of the staff we require.

Dr. Philip Dodd: In response to Senator Ó Céidigh's question from a member of the public about making consultant psychiatrists permanent, one of the priorities in the mental health division is to advance any consultants on the specialist register who go through a fair public process to be permanently appointed. Consultant psychiatrists have the best rate of full approval, from the point of budgetary sanction to advertisement for the post on the Public Appointments Service website, than anyone in other areas of the health service. We are doing our absolute best through the rapid recruitment of consultants for that to be achieved.

The health budget of 6% for mental health, by international standards, is low in general. A paper considering the national spend on mental health services in several countries was published this week in the *British Journal of Psychiatry*. It shows, as we would expect, that the percentage investment in mental health services links directly to health and well-being. Do we need literature to prove that? Maybe not, but we now have a very robust study that would suggest that investment in mental health results in good outcomes for members of our population.

With regard to child psychiatry representation, I am an adult psychiatrist and work with people with intellectual disability. I trained in child psychiatry as well. I am not on the specialist register for child psychiatry but several consultant child psychiatrists work with me. I am absolutely familiar with the challenges in CAMHS. I regularly link with clinical directors in children's services throughout the country. I spoke to Dr. Doody this morning.

Senator Joan Freeman: Dr. Dodd is not dealing with the parents of children.

Dr. Philip Dodd: I deal with the parents in my own service along with members of the mental health team in my own clinical practice. I do not have the full spectrum of experience but I have enough experience to speak with some conviction on what it is like to negotiate with services.

Senator Colette Kelleher: I asked about the protocol and about 24-hour cover, which came up in almost all the submissions, and all day last week. Dr. Dodd said there is a percentage coverage of 73% or 75%, but that does not seem to reach people. The GPs this morning put forward a very good solution to build the 24-hour cover around the GP co-ops, for example, South Doc in Cork. Will the HSE and the Minister of State consider that? We are trying to come up with answers. The GPs' seven point plan was well worth considering. They also spoke about the deprivation weighting, but one would not need to be a psychiatrist to work out that in poorer communities there are higher levels of mental ill health. Will Dr. Dodd consider the proposals for that? I do not think he answered the question about the 24-hour cover, which

is an important issue that has come up in the course of this consultation with families, young people and their mothers.

Mr. Jim Ryan: I genuinely do not know the answer to the question about the Garda. I can find out.

Chairman: Mr. Ryan can come back on that. Mr. Gibson from Tusla can answer the question he was asked very briefly.

Mr. Jim Gibson: The Chairman cannot really put the clampers on me. The first thing I want to say is we were invited here today to represent a State agency and to speak about mental health issues. I am quite happy to meet any representative about the current out-of-hours service in Ireland from the Child and Family Agency. I do not want to get into the Dr. Shannon thing at all. I am here to speak about mental health, which is the real issue. If a child or young person presents to An Garda Síochána out of hours and Tusla out-of-hours services are involved, we respond. Ms Finlay, service director, can outline what happens. I hope that will go some way to answering the question.

Ms Patricia Finlay: I have been a practitioner and I have been in homes where gardaí have had to remove children. I emphasise very much that the majority of our social workers have five years of training to prepare for these events in supporting children and their parents for the trauma, separation and loss being brought to any child. It is an extremely delicate balancing act and, unfortunately, we must make those difficult decisions every day and work closely with gardaí on that. There was a question on protocol. The specific protocol we spoke about today relates to one that exists between the HSE and Tusla. We work very closely with the HSE on those cases. Does it need to be better? Perhaps we need more formal structures and this protocol will support such structures.

With regard to the Garda, Tusla has almost completed a protocol on working with gardaí. It is there. We have mentioned the children and young people services committee a number of times. Under the prevention, partnership and family support programme that Tusla has, the principle is to have everyone around the table. The practice of working is described as meitheal. It is not for child protection cases but rather where a family and child are in need. As people know, meitheal means bringing people together to bring home the harvest. That is really what meitheal is about. It is a team around the child to support that child and the parents. It is really important as central to that is the young person and child is asked to be at the meeting and it is conducted in a way that is child-centred. We cannot even have a meeting unless parents are part of the process. That is the ethos and approach we are taking in Tusla of very much having children and parents participating in the plan.

Chairman: We are saving the best wine until last.

Deputy Jim Daly: Senator Ó Céidigh asked the very direct question as to whether I would give a commitment to take on that particular challenge regarding temporary and locum staff and if I would see if it is possible to make those staff full-time as part of a solution to the overall recruitment problem. I alluded earlier that my next meeting is with the Secretary General of the Department and the staffing issue is top of my list of matters to discuss with him in any event. I will specifically include that topic and revert to the committee with a comprehensive response. Priorities were mentioned earlier. The top priority for me is the waiting lists relating to CAMHS. The staffing matter is a central kernel to it, and it is the reason given to us time and again for the delays. We need to deal with the staffing issue. The ombudsman spoke

about changing legislation and we will consider whether that is the solution. I have discussed tentatively with the HSE about putting somebody else at the head of the team with CAMHS. There are so many protocols and systems in place, it is not straightforward. We are examining this already.

I will give people an assurance from a political perspective. We are all politicians and there is so much we can do, although we cannot do everything. I have been in the job for two weeks and to be fair to the Fianna Fáil Party, there has been a priority for them for some time to get a special committee on mental health up and running. I hope to bring it to the Dáil tomorrow. The terms of reference have been agreed and they are gone today to the officials. I hope we can get it to the Dáil and it can be passed there before coming through this House so we can get the committee up and running without delay. There is a timeline for ending around June next year and it will be dedicated to mental health. It should be solutions-led and politics should be cohesive and collective. I hope we will make good progress on the committee and I look forward to working on it.

Mental health issues are a top priority and today's meeting is another example of it, with the Seanad devoting energy, time and effort to the issue. It is further confirmation that politics will continue to work on this as a top priority. That is one assurance I can give to the people present today. There is not much more for me to say other than to thank everybody for their contributions. I thank the organisers of this initiative. We look forward to further engagements and I hope to make progress in this vital area.

Chairman: Does the representative of the Irish Medical Organisation wish to add anything?

Dr. Matthew Sadlier: There are so many issues, it would be hard to focus on an individual example.

Chairman: Is there anything that could be briefly put on the record?

Dr. Matthew Sadlier: Our membership is medical rather than from other professions. We would be willing to engage with any group on the issues of doctor recruitment and retention. Where we feel missteps have been made in the past, we have been very open and vocal about it and they are definitely on the public record. It would be the main focus of our organisation.

Dr. Niall Muldoon: I was asked a question by Senator Ó Céidigh about the child-centred approach. We are not so far from it within the service. We can start here. We can bring in children and young people. We heard from parents last week. We could have a closed session here. I am delighted to hear the Minister of State will set up a new committee. I have heard from children and young people on numerous occasions, including those going to paediatric wards and not just the adult unit. I listened to a young girl who self-harmed - under her bedclothes - while she was in a ward . These are real stories and how we would become child-centred. We would get the benefit of their experience in trying to improve the service. These are small contributions and not about big matters such as protocols; they are about how it can be improved for individual service users. We need to get child-centred. The UN Convention on the Rights of the Child is very clear on what can be done as well.

Ms Naomi Kennan: I have a brief comment on auditing our system to see how child-centred it is. At a basic level, we must ground it in the general principles of the UN Convention on the Rights of the Child. Article 2 deals with non-discrimination so are we providing equity of access to services in reality? This is irrespective of the location of the child, particular medical

needs or whether it is part of an especially vulnerable group, which needs additional measures in order to be able to access services equally, along with other children or young people. Article 3 asks if the best interests of all children and young people are at the centre of every decision and action taken on their behalf or are we getting bogged down with administrative issues, resources, procedures and policies? Article 6 deals with right to life, survival and development, so are we meeting that standard or are delays preventing children access to services they need in order to enjoy that right? As the ombudsman noted, in terms of Article 12, dealing with children's participation, are we treating them as co-partners in the development of this process and services and having views about decisions taken that affect them? Are we making those decisions without hearing from children? From the evidence being presented here, which is followed closely by our team, we have a very long way to go.

Professor Joyce O'Connor: I am pleased the Minister of State will examine the waiting lists issue. This is something very practical that can be done and which will address many of the matters of co-operation and focus. It would address issues in a speedy fashion. It can be done, which is important. It is not impossible.

Senator Joan Freeman: I thank everybody who was here today, particularly those from the mental health division who were subjected to a really strong attack from us. Again, it is not personal, but we must do it - we must ask those questions.

The Minister of State has been handed, according to some, a poisoned chalice. Let us hope it does not infect him. I say to him publicly that I will pursue the matter of waiting lists because there is a lady, a mum, here today whose daughter developed an eating disorder while she was on the waiting list, so it is crucial. Today is 6 July, and we are about to go into recess. Before we do so, I will ask him publicly again what has been achieved on waiting lists. From working with him before, I believe he can achieve the goal of handling this.

To the other people present I say they have probably served on numerous task forces or committees and have had their hopes raised so high, thinking that we would do something positive. I am sorry those hopes have been dashed most of the time. However, I promise them that after today, I and the committee will ensure that whatever the report, which will be ready by autumn, shows, we will ensure it is considered, adhered to and will not gather dust.

Chairman: Finally, on behalf of the Seanad Public Consultation Committee, I thank all who have contributed so much to this afternoon's session. I believe it has been very informative and productive and I think we have learned much from their insight and observations. Full account will be taken of today's discussions when a draft report has been prepared, and copies of the final report will be sent to all. As this is our final public hearing on this topic, I wish to put on record my gratitude to all members of the committee - that is, all our Senators - for their hard work over recent months. In particular, I thank Senator Freeman, who proposed this topic for discussion and who has worked extremely hard in the background in preparation for these hearings. I also thank sincerely all those who sent in submissions to the committee and the witnesses who appeared before the committee. I particularly wish to thank the parents for telling us about their experiences, which can be most distressing and difficult for the families, of seeking mental health services. Last week, the committee heard some powerful and moving accounts from parents of their experiences of youth mental health services in Ireland today. To that end, I acknowledge the presence in the Public Gallery today of Lauren Keogh and Sinéad McGee, both of whom presented at one of last week's sessions. I also express my gratitude to the secretariat of the Seanad office, particularly Bridget Doody, who, so to speak, has been my right arm, and the Library and Research Service for its valuable input into this public consulta-

tion.

The select committee adjourned at 4.25 p.m. until 10 a.m. on Tuesday, 5 December 2017.