DÁIL ÉIREANN

AN COMHCHOISTE UM CHÚRAM MEABHAIRSHLÁINTE SA TODHCHAÍ

JOINT COMMITTEE ON FUTURE OF MENTAL HEALTH CARE

Dé Céadaoin, 20 Meitheamh 2018

Wednesday, 20 June 2018

The Joint Committee met at 1.30 p.m.

MEMBERS PRESENT:

Deputy John Brassil,	Senator Jennifer Murnane O'Connor.
Deputy James Browne,	
Deputy Pat Buckley,	
Deputy Joe Carey,	
Deputy Marcella Corcoran Kennedy,	
Deputy Seán Crowe,	
Deputy Michael Harty,	
Deputy Catherine Martin,	
Deputy Tony McLoughlin,	
Deputy Tom Neville,	

In attendance: Deputy Michael Collins and Senator Máire Devine.

SENATOR JOAN FREEMAN IN THE CHAIR.

Business of Joint Committee

Chairman: We have received apologies from Deputy Gino Kenny. Members are asked to ensure their mobile phones are turned off for the duration of the meeting because such devices can interfere with the sound system. I propose that we go into private session to deal with housekeeping matters. Is that agreed? Agreed.

The joint committee went into private session at 1.38 p.m. and resumed in public session at 1.42 p.m.

Deficiencies in Mental Health Services: Discussion

Chairman: I welcome to the meeting from the Mental Health Commission Mr. John Saunders, chairman, Ms Rosemary Smyth, interim chief executive, and Dr. Margo Wrigley; and from the Ombudsman for Children's Office Dr. Niall Muldoon, Ombudsman for Children, Dr. Karen McAuley, head of policy, and Ms Margaret Brennan. On behalf of the committee I thank the witnesses for their attendance here today. The format of the meeting is that they will be invited to make a brief opening statement, which will be followed by a question and answer session.

I wish to draw the attention of our witnesses to the situation on privilege. Please note that witnesses are protected by absolute privilege in respect of the evidence they give to the committee. However, if witnesses are directed by the committee to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to a qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise nor make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable.

Members should be aware that under the salient rulings of the Chair they should not comment on, criticise or make charges against a person outside the Houses, or an official either by name in such a way as to make him or her identifiable.

I remind members and witnesses to turn off their mobile phones. If possible, switch them to airplane mode because it causes havoc if they are left on. I advise witnesses that any submission or opening statement made to the committee will be published on the committee website after this meeting.

I invite the witnesses to make their opening statements. We will start with Mr. John Saunders.

Mr. John Saunders: The Mental Health Commission welcomes the invitation to discuss deficiencies in mental health services. However, as the organisation with statutory responsibility to regulate, promote, encourage and foster the maintenance of high standards and good practice in the delivery of mental health services, we are disappointed that it has taken so long for this opportunity to meet with the committee.

The principal function of the commission is to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved

centres under the Act.

Recently, the Assisted Decision-Making (Capacity) Act 2015 provided for the establishment of the decision support service, DSS, within the commission as part of a new legal framework that reforms the law relating to the treatment of people who require or who may shortly require assistance in exercising their decision- making capacity, therefore, it expands the functions of the commission beyond mental health. The DSS forms a key part of the new legal framework for both the provision of information and the regulation of the diverse forms of assisted decision making arrangements.

In the past couple of years, the commission has continued to emphasise the human rights of mental health service users across all of its core functions. All service users should be involved in decisions about their care and be supported to exercise their legal capacity. Mental health service users should not be subjected to undue restrictions and should have access to basic general health services. Residents should have access to adequate living standards in inpatient settings where their privacy and dignity is respected at all times. These basic rights should be assumed in any modern mental health service and is a minimum we would expect for ourselves, our family and our loved ones. Furthermore, people who use mental health services need to be afforded the same rights as those who use general health services.

The commission registers, inspects and regulates mental health services delivered through approved centres. Over many years of activity, a number of core issues have emerged. These include the inappropriate admission of children into adult mental health inpatient services; inadequate staffing and variable funding in community child and adolescent mental health services, leading to unacceptable waiting times and forcing young people into emergency services; the continuing inability of some services to put in place an individualised care plan and therapeutic programme, which are the corner stones of a recovery focused, person centred service as per our national policy; the widespread use of restrictive practices such as seclusion and physical restraint as a normalised behaviour in services, which lack sufficient numbers of staff and-or appropriately trained staff; the fundamental and careless lack of attention to basic issues such as dirty and dilapidated premises, which do not ensure adequate privacy and where there has been a disappointing drop in compliance from already low levels; and the provision of services to vulnerable people with long-term mental illness who are accommodated in 24-hour community residences that are not subject to regulatory oversight.

In the view of the commission there is a glaring and inconsistent pattern of standards in service provision. The lack of any real progress and commitment on these matters undermines the fundamental human rights of those people who use mental healthcare services.

Due to a failure of Government to update the statutory powers of the commission, more people are now using unregulated mental healthcare services, that is, services outside the approved centres, which leads to a significant risk of neglect and abusive incidents occurring.

The commission is calling on the Government, with the Health Service Executive as the statutory provider of services, to initiate a major transformation programme to deal with the service issues highlighted by the commission.

Reform of the 2001 Mental Health Act is urgently needed and the commission urges the Department of Health to take heed of our commentary in this area to ensure that the provision and regulation of a modern mental health service in Ireland is the norm. If that does not happen, Ireland will continue to provide a level of unsafe and substandard services which are not

aligned to best practice and, as stated, breach the fundamental rights of vulnerable people who require such services.

The commission notes the continued endeavours of the Government, the statutory and independent service providers and the voluntary sector in the implementation of A Vision for Change. The commission has repeatedly indicated that much needs to be done to ensure the delivery of consistent, timely and high-quality services in all geographic regions and across the full range of clinical programmes and age groups.

The Commission is aware of a review group established to consider progress in the implementation of *A Vision for Change*. However, the Mental Health Commission has not received any formal communication from the Department of Health in this matter. This is a grave cause of concern, given the statutory role of the Mental Health Commission in overseeing quality in mental health care services.

The Commission welcomes the almost annual €35 million budget allocation for spending on additional mental health care services. The Commission is cognisant that the current level of expenditure on mental health as a proportion of overall health expenditure is still less than the 8.24% target envisaged in *A Vision for Change*.

The Commission is also conscious of the continued difficulties in maintaining and increasing staffing levels in mental health care services. From its inspections, it is aware that this has a significant effect on the quality and quantity of services that can be provided. Given the labour-intensive nature of mental health care, it is imperative that this matter is addressed urgently to achieve full staffing across the mental health care services.

Since its establishment, the Commission has seen significant changes in the provision of services, but challenges remain in the delivery of high quality recovery-oriented services. Although the Commission believes that staff understand the concept of recovery, it is not evident that this translates into recovery-focused care, particularly in the development of individual care plans. It is concerning that while compliance has increased, just a small minority of approved centres had individual care plans that were recovery-oriented, with strong service user involvement and multi-disciplinary inputs.

The Commission is of the view that there needs to be an emphasis on changing the corporate culture in the mental health services to bring about the required systematic shift towards recovery in service provision. In this regard, it will continue to focus on the need for individualised, recovery-oriented services that place service users and families at the centre of activity.

In respect of involuntary admissions, there were 2,337 involuntary admissions in 2017 compared to 2,414 in 2016, representing a slight decrease. We are pleased to note that over many years there has been a decline in the number of families involved in referring people to involuntary detention, and this is welcome. Their involvement still stands at 44% and we hope that in the future this figure will be driven down further.

In respect of community residences, the Commission continues to have concerns about 24-hour staffed community residences, which are providing care to a large cohort of vulnerable people with long-term mental illness. The residences have been found to be accommodating too many people, to have poor physical infrastructure, to be institutional in nature and to lack individual care plans. A major issue is that the residences are not regulated. Although the Mental Health Act permits the inspector to visit and inspect “any other premises where mental

health services are being provided", community residences are not subject to regulation by the Commission.

We are currently undertaking a three-year programme and the inspection of 43 residences in 2017 has already been published. Once again, this report highlighted glaring issues around the size of the residences, the limitation of staffing, the absence of privacy and space, the poor repair of buildings and the degree of institutional care provided in these homes.

Many of those living in 24-hour residences are ex-patients of the large institutions closed over the past 20 years. This is a vulnerable population, and the emerging patterns from the inspections is that they are a forgotten group of people who are living their lives in unsatisfactory conditions.

It is recommended in the Report of the Expert Group on the Review of the Mental Health Act 2001 that community services should be registered and inspected. The Commission is of the view that the regulation of 24-hour staffed community residences must be prioritised as a matter of urgency.

A most unsatisfactory situation still prevails, whereby children are being admitted to adult inpatient units. There were 82 such admissions to 19 units in 2017 compared to 68 in 2016. The admission of any child to an adult service is unsatisfactory. A contributory factor to the continued admission of children to adult units is a shortage of operational beds in dedicated child units. A significant influence is the inability of child and adolescent mental health service, CAMHS, units to admit children after hours thereby forcing admissions to adult care services. This trend has been prevalent for many years and is not only an unsatisfactory situation for the child and his or her family but a clear breach of the human rights and dignity of the child. This matter has been a concern to the Commission for many years. It needs to be urgently addressed by the Government, the Department of Health and the Health Service Executive, as the main provider.

In 2017, the Commission has also highlighted serious concerns in community child and adolescent mental health teams. The inspector found these teams to be inadequately staffed and to have considerable variation in funding depending on their geographic region. There was also a notable variation in waiting lists for CAMHS referrals and in the provision of emergency cover. While CAMHS should be focused on children and young adults with severe mental illness, the staffing deficits in primary care have meant that children and young adults with mild and moderate mental illness are also reliant on CAMHS services.

In conclusion, the Commission is concerned that there are serious human rights issues to be addressed in relation to the admission of children to adult services and the shortage of operational beds for young service users. Additionally, the Commission is concerned about the long waiting times for those children referred to child and adolescent mental health services. It is particularly concerned about the 1,300 vulnerable people with long-term mental illness who are accommodated in 24-hour community residences that are not subject to regulatory oversight.

Fundamentals in in-patient settings, such as individual care plans, privacy, the provision of therapeutic activities and staff training are also areas that require urgent attention. There continues to be fundamental shortfalls in compliance with basic hygiene, physical repair and space restrictions within many services.

The 2017 inspections have once again highlighted the inappropriate use of seclusion and

physical restraint in services which have become in many instances the normalised environment.

As the committee will be aware, there continues to be a chronic shortage of staff and appropriately trained staff. Notwithstanding this, the Commission is acutely aware that the front-line staff presently operating services are highly motivated and working under extreme pressure to meet the demands made on the service.

The Commission is aware of other issues of access to approved centres which warrant attention. These include, for example, policies of having to access mental health care services via accident and emergency units, which do not always have appropriately trained mental health staff, and difficulties in gaining admission to approved centres, as well as perceived early discharges.

Much work remains to be done to change service culture and to refocus on the full delivery of *A Vision for Change*. Services must be accessible, comprehensive, responsive and timely. Now more than ever, it is necessary to address systemic issues that hamper the delivery of services and the development of new, more appropriate, services.

Reform of the Mental Health Act 2001 is now a matter of urgency as a significant number of people are now using unregulated mental health care services, both day and residential. This situation dramatically increases the risk of abusive or neglectful incidents occurring.

The Commission is concerned that over the past five years there has been a consistent pattern in the operation of mental health services. Year-on-year similar issues such as individual care plans, the admission of children into adult units as well as issues of compliance with regulations, and privacy and medication issues, continue to be highlighted in inspection reports. This continuing trend is worrying and indicates for the Commission a lack of interest and motivation by both Government and services providers to make meaningful change. The Commission is strongly of the view that there is apparently little heed given to the commentary of the Commission by the Department of Health or Health Service Executive.

Nonetheless, the Commission will continue to work in supporting the rights of individuals and families who use mental health services and to seek to ensure that the service providers provide the highest quality of service provision in line with best practice, and to which they are entitled as a basic human right.

Chairman: I thank Mr. Saunders. Before I invite Dr. Muldoon to make his opening statement, I would like to respond to Mr. Saunder's statement that the Mental Health Commission was disappointed that it had taken so long to have the opportunity to meet the committee. The committee has had a lot of communication with Ms Patricia Gilheaney. We did not invite the commission to meet us until now because we thought it was important to meet service providers and users first. We have read all of the mental health reports thoroughly. As I said, we did not see a need until now to meet the commission.

I invite Dr. Muldoon to make his opening statement.

Dr. Niall Muldoon: I thank the joint committee for the invitation to present to it on a report prepared by my office entitled, Take My Hand: Young People's Experiences of Mental Health Services. As the committee will be aware, the Office of the Ombudsman for Children is an independent human rights institution which was established under the Ombudsman for Children Act 2002. My office has a unique combination of statutory functions. We examine and investi-

gate complaints made by or on behalf of children about the administrative actions, or inactions, of public bodies and promote the rights and welfare of children up to the age of 18 years.

One of the priorities of our strategic plan for the period 2016 to 2018 is to influence positive change for children with mental health difficulties. In the light of this priority, we decided in 2017 to undertake a consultation process with young people under 18 years receiving inpatient care and treatment for their mental health difficulties. The aim of the consultation was to facilitate young people in reflecting and sharing their views on mental health services based on their experiences from primary care through to inpatient services. I thank the 25 young people, aged between 14 and 17 years, who took part in the consultation process. We engaged with all six adolescent inpatient units in the country. I thank the management and staff of the five units who facilitated our work with the young people involved, including Linn Dara CAMHS inpatient unit, Dublin; Willow Grove adolescent unit, Dublin; Ginesa suite, Saint John of God Hospital, Dublin; CAMHS inpatient unit, Merlin Park Hospital, Galway; and Éist Linn CAMHS inpatient unit, Cork. I also thank Ms Lorna Walsh, a member of my staff, for her involvement. The young people involved were asked to consider three broad questions about their experiences of mental health services, namely, what they found helpful; what they found challenging and what changes they would like to see made.

Different methods were used by the young people concerned to express their views, namely, semi-structured interviews, painting, photography, collage and mind maps. Some of the images created by them can be viewed in the full report. On what they found helpful, many of them were positive about the support they received from professionals, family members and other young people in receipt of mental health services. According to them, professionals who engage and build trusting relationships with them have an important role to play in shaping their experiences of mental health services. They highlighted that medical professionals who used empathetic approaches and could relate to and communicate well with them and their families contributed to their feeling heard and understood. The knowledge and experience of teachers and school counsellors, as well as the arrangements put in place by schools to help them to cope, were commended by many of them. They spoke positively about the efforts family members made to help them, including by travelling long distances to visit inpatient units. Within the inpatient units, having a support group of peers who had experience and an understanding of the challenges in living with a mental health illness was identified as a valuable source of support. The benefit of programmes and activities such as music appreciation art, physical activity and life skills groups, was also noted by the young people concerned.

Despite these positives, the young people concerned highlighted a range of challenges that they had experienced, both as mental health services users and more generally. Many questioned the interpersonal and communication skills of the medical professionals with whom they had engaged. For example, the use of clinical language caused confusion for some young people and left them feeling they were not believed or understood. Some professionals were seen to be lacking in empathy and sensitivity, particularly when they made suggestions to "keep trying" and "keep working on it", even when the young people indicated that they felt "it wasn't working." The lack of opportunities to be heard was also raised as a significant challenge, both within the inpatient units and in wider services. It was noted that professionals often communicated directly with the parent or parents as opposed to the young people.

Several of the young people concerned spoke about and questioned what they regarded as a rush to medicate, with the use of medication being suggested very early on in their treatment. A small number said they had sometimes been physically restrained. They found this challenging

and frustrating and felt it should not be done. They also commented on the restrictions placed on them within inpatient units owing to low staffing levels and feeling institutionalised, with the main problem being a the lack of things to do.

Separation from family was a particularly significant challenge frequently mentioned by the young people concerned. Many spoke about the burden their mental health care had placed on their family and mentioned that it weighed heavily on them and was challenging in coming to terms with it.

With regard to school, some of the young people concerned felt their teachers and school counsellors lacked specialist knowledge of mental health and explained that their expectations of the supports available had not been met. They had also missed school owing to their mental health illness. As a result, their relationships with their friends had also been affected.

Many of the young people concerned spoke about the length of time it took to access CAMHS and the stark differences in the availability and consistency of the service throughout the country. They described these delays and inconsistencies as being very difficult. They also referenced the distance between the inpatient units and their homes, with one young person living an estimated six and a half hour drive from the unit. Another young person spoke about how the lack of adolescent inpatient places had previously resulted in him being placed in an adult psychiatric ward, an experience he described as traumatic.

The young people who took part in the consultation process recommended changes which they felt would improve mental health services and supports for young people in general. These recommendations can be found in section 2.3 of the report and include the following: increased supports and awareness raising initiatives in schools, including the availability of additional therapists or guidance counsellors; increased staffing levels in services, including community CAMHS services; the establishment of a youth advisory panel in each inpatient unit to ensure young people would be heard and have their views considered; greater autonomy being afforded to young people in inpatient units to self-regulate and manage their behaviour; and the availability of additional programmes and a less restrictive environment within inpatient units.

Following the consultation process and in the light of the complaints and investigations and policy work of my office, we have identified a number of key areas of concern and corresponding priorities for action. These are dealt with in detail in the report and include effective co-ordination and communication between those working in the area of children's mental health, as well as on a cross-sectoral basis, are central to delivering mental health services and supports that work for children. I welcome the recognition in the report of the national youth mental health task force that deficiencies in this area need to be addressed. The delay in making the youth mental health pathfinder project operational is unacceptable, given the commitment of the Government to it. The project will provide the vital structure to achieve greater co-ordination in the provision of mental health services for children and young people. It needs to be put in place urgently. Also, an independent mental health advocacy and information service specifically for children should be established without delay, as recommended by the UN Committee on the Rights of the Child and the national youth mental health task force.

I have serious concerns about the legislative framework for children's mental health services and the slow pace of reform in this area. I welcome the passage of the Mental Health (Amendment) Bill 2017 and its focus on inserting rights-based, guiding principles for children into the Mental Health Act 2001. While these legislative proposals are an important step forward, the Government's commitment to comprehensively revise the 2001 Act as a whole must

be progressed without further delay. To address deficits in policy implementation and provide a single point of focus for everyone who has a role to play in advancing provision for children's mental health, I am calling for the development of a dedicated A Vision for Change for children to provide a dedicated, cross-sectoral national policy framework for children's mental health services. The framework should set out what clearly the actions that will be taken and by whom, timelines for delivery and associated costs.

On financial and human resources, once allocated, resources should be ring-fenced. The lack of clear and accessible information on the amount of money being spent on mental health services for children also needs to be addressed. On human resources, consideration should be given to the appointment of experienced professionals, other than consultant psychiatrists, to roles such as clinical leads, with a view to ensuring children and young people will not be left waiting for the support they need owing to unfilled posts. I call for all primary and post-primary schools to have access to an independent therapist-counsellor to ensure early intervention will be available to all children when they need it.

I again thank the committee for giving me the opportunity to present my report which I hope will assist it in its work. I will be happy to answer questions members may have. The views and experiences of the young people expressed in the report must be brought centre stage and considered meaningfully by all State and non-State actors with responsibilities to develop and implement proposals for reform in this area.

Chairman: I thank Dr. Muldoon for his opening statement. The report is excellent. Before I invite Ms Brennan to make her opening statement, I advise her that the statement from her children will be included not only in our report but may also be included in the official transcript of the meeting. I ask that she provide it for the clerk after the meeting has concluded. She has used the services for her children in the south east. In the light of what happened last week, with three psychiatrists resigning in the south east, it is important that members hear about the impact it is having on her and all other families in the area.

Ms Margaret Brennan: I will read my statement, but I also have statements from my two older children who have experience of CAMHS in Wexford south district.

I live in south Wexford, but I am originally from Dublin. I am a trained primary school teacher, but I retired last September. I am married and we have four beautiful and much loved children, ranging in age from 20 years to ten.

I knew nothing or very little about children's mental health issues until our own children were involved. When I started teaching in 1990, there was little mention of children's mental health and I certainly never received any training in it. My husband and I were unprepared when our oldest child displayed signs of depression and other issues. Our oldest child first displayed low mood in second year at second level. We thought it was adolescence or the onset of puberty, but we were so wrong. After hearing him verbalise suicide ideation numerous times, we sought medical help. As the case was urgent, CAMHS saw him two days later. Of course, we were upset. We did not know how to help him and looked to CAMHS for support and medical help for our son. Over time, his diagnosis evolved and worsened. We saw every member of the CAMHS team in their various roles. He was assessed by all of them. My professional training informed me that there may have been more to his diagnosis than the initial diagnosis. Unfortunately. I was correct. Over the next five and a half years his diagnosis worsened significantly. As a result of all of his issues, he manifested the most awful behaviour. I have never seen ADHD manifest like this. At one stage we were paying €150 a month for his medication

and then I found out that every other county was allowing the cost of his ADHD medication under the long-term illness scheme but the area medical officer, AMO, in Wexford would not allow it. I appealed this decision and it was upheld. This is only a small thing, but many children benefited overnight.

At times I had to advocate to management for continuity of care and more appointments; however, my letters often went unanswered for many months, if they were answered at all. As the assessments were concluded, we got a better picture of his diagnosis. Dr. Kieran Moore, the clinical lead, left no stone unturned for our son. We had many difficult days; often there would be multiple appointments in a week and we only missed two in the whole five years. Our son was also an inpatient in a Dublin hospital unit for ten weeks. That was a horrible experience and a horrible Christmas, one I want to forget. He returned home for care to the CAMHS team. The social worker, the clinical nurse manager and the consultant in CAMHS south Wexford are beyond professional. They did everything they could for our son who was seen by Dr. Kieran Moore very often. Sometimes the appointments were very difficult, but he did everything he could, including sourcing an external specialist from the United Kingdom.

My personal opinion of the service is that the CAMHS team in Wexford is only a skeletal team. They offer a service that is barely addressing the huge issue of children's mental health. The professionals I have mentioned are highly qualified, very experienced and kind to both patients and their families, which makes a great deal of difference when one is so vulnerable, but, alas, other staff are part-time and can only offer appointments on a part-time basis. To say the least, the appointments they offer are patchy. At one stage, three staff were on maternity leave, none of whom was replaced. The consultant was on leave numerous times but no locum was ever provided. I queried this as it affected my child but to no avail.

The premises are totally inadequate. There are not enough consultation rooms and no therapies are offered. Our son was only offered two sessions of psychology in five and a half years. They did get a recent extension of a tiny portacabin, which is totally inappropriate. Knowing what I do now, depression and other mental health issues need more than tablets. There are many therapies that could be made available that work well with children and teenagers, but, alas, the children of County Wexford cannot get them. First, there are no staff to offer the therapies and, second, there is no accommodation available in the CAMHS premises.

My own experience of advocating for our child taught me many lessons. We were told that our son was the only pupil in his secondary school to have depression. That seems incredible in a school of 700 boys. The same deputy principal has since contacted me numerous times looking for information for other parents who are struggling, just as we did. If one does not advocate for one's child and speak up, or if you cannot speak up, you will not get the care you need. Depression is viewed as a disease. Even a child is considered to be faulty or a lesser person and this was said to us in a primary and a secondary school. There is huge stigma and shame around children with a mental health issue. CAMHS never blames parents but society and schools do. The gossip at pitches, on the sideline and within a small parish can be very hard to take. Many times we felt alone and had no idea what to do. We needed more than tablets. We needed therapy for our son and therapy for our family, but, alas, none was offered or available.

Eventually, on the school's insistence - the school was correct to do so - our child sourced counselling in it. No counselling was available in CAMHS. Our other child needed help from CAMHS after a mental health emergency. Alas, even after promising her help, our child was not seen for six weeks. They did not respond in a timely or an appropriate fashion. That made her issues much worse and compounded and exacerbated a fundamental issue of body image

and the impact of having a sibling with serious mental issues. The response of the person was that it was not possible to split in two. That is not fair.

Our overall opinion of the CAMHS service is that it is starved of resources. It is segregated from the general hospital, when it should be incorporated into it. Do we accept segregation of mental health patients away from the population? When will we learn that the mental health service deserves to be included in the hospital service, not separate from it? In my opinion, this echoes the discrimination we have seen in the past when children and older people were excluded from society and hidden in mental institutions.

The service is chronically understaffed. The staff who are there are of the highest calibre and so professional. They are kind to children and supportive of parents who are often under enormous strain. They are under incredible pressure. The waiting list is now four years long. Our youngest child is on it. He cannot fulfil his potential, either academically or otherwise, until he is assessed. Meanwhile we wait. He waits and many like him wait. Other children with critical and complicated issues also wait. Sometimes they are suicidal and wait; sometimes they need referrals and wait again. We were referred to three hospitals over the period of five years. Our son had to have multiple medical tests done elsewhere because CAMHS has nobody to take bloods or do an ECG. The service in Wexford has no consultant. His shoes are impossible to fill. The HSE in its statement stated they were actively recruiting psychiatrists abroad. That is not good enough. They just do not understand. They need to resource the service, employ professionals who are needed, put the CAMHS service into a hospital and offer a service that treats children holistically. Why would the HSE employ another consultant with no changes to working conditions? They are not listening.

I have written letters to management and politicians for years, all to the no avail. This level of service would not be tolerated in the provision of cancer treatment, or any other branch of medicine. Even the list for cardiac assessment in Crumlin was only 18 months long, the last time I checked. Would you bring a child with cancer to a unit without an oncologist and just hope for the best? No, you absolutely would not. Why should the parents of children from Wexford, north and south, and Waterford have a service with no consultant? That is an insult to our children and to our intelligence. There is also a very strong case of inequality and discrimination. Children are not receiving the care they need based on their address. It is clear that the political agenda seems to be to open the horrible historical chapters of our past. Is this done on purpose to divert attention away from the current waiting lists for children? In County Wexford a person who is in dire need is four years on a list. Will we have to wait 40 years to address the current crisis? I hope not. The Proclamation of 1916 urged us to treat all the children of Ireland equally. If I live in Wexford, I wait four years. If I live in Dublin or Galway, it seems I get a luxury of service. Both of our oldest children have written of their experiences. Our son does not mind his name being mentioned as he is in Barcelona but our second child very much minds her name being mentioned. I will not mention her name but will tell the committee about what happened. At the end of the day, society should protect the most vulnerable. Our children are so precious and when they are sick we bring them to the doctor. Now there is no doctor in a critical service. It is time to say "enough" and to stop and listen. Children matter and children's health matters. If a society is judged on how it cares for its youngest and most vulnerable citizens, then Ireland fails. I would like everybody here to understand the critical situation in Wexford. I am passionate about this because I know what can happen, not only to the patient but also to the siblings, family and parents. We as adults need to be the voice of those children. We need to change the system, which will not be easy but can be done.

Chairman: Thank you so much, Margaret. That was an extraordinary, focused, factual report of a lived experience of a parent. I really appreciate how it was delivered. It was inspiring. I reassure you that members are absolutely committed to improving services and we will make the HSE accountable for its lack of services. You have probably heard that before and have probably heard a million times about more reports coming out, more committees and kicking the can down the road.

Ms Margaret Brennan: Yes.

Chairman: Every member here is devoted to making this better. Thank you for your statement. It will go an awful long way in fighting our cause.

Ms Margaret Brennan: I hope so.

Chairman: I will now invite members to ask questions. Each member has seven minutes to ask questions and have them answered by the witnesses.

Deputy Marcella Corcoran Kennedy: I thank everyone for their presentations, particularly Ms Brennan. It takes a lot to waive one's anonymity and we genuinely appreciate that Ms Brennan has done so and is prioritising her children. I concur completely with the Chair's comments.

My first question is to the witnesses from the Mental Health Commission and concerns the key functions of the commission. What is the witnesses' view of how the commission has delivered on those functions since its establishment in 2002? Should the commission acquire any other functions?

Mr. John Saunders: When the commission was established and as the Act dictated, it was given the powers to inspect approved centres. These are residential units that are mostly attached to general hospitals now, where people reside for a period when they are acutely unwell. Those units have replaced the previous large institutions that we all know about. For the first number of years, the commission also inspected those services but they have been closed down since. The Act is very clear that the commission, through its inspectorate, can inspect the approved centres and can put into place changes to improve the quality of service in them. They are commonly called conditions and there are various other steps beyond them. The commission has been doing that since it initiated its inspection process in the early 2000s.

The issue to which I alluded briefly is that since that time, and quite rightly, more and more people are receiving mental healthcare services outside of approved centres. They are going to primary care - to their GP - or to community mental health teams, staffed teams that provide support to people in their local community. I mentioned the community residences, where people live in group homes in the community. As time goes on and in line with A Vision for Change, fewer people statistically and theoretically would use the approved centres while more and more people would receive mental healthcare services outside of them.

The Act allows us to inspect any place where mental health services are provided. However, it does not allow us to regulate or impose changes on those places. We can inspect any community mental health team in the country and if we find issues that need to be changed we can make recommendations. However, we cannot enforce them because the Act, which is now quite old, does not allow us to do so. That is one of the issues around the review of the Mental Health Act. Provisions are needed to allow the commission to regulate all services. In my statement, I said that the vast majority of those now using mental health services are using

services that are not regulated in the context of what the commission does. Time and progress have overtaken the original Act.

Deputy Marcella Corcoran Kennedy: The Act needs to be updated.

Mr. John Saunders: Correct. That was well flagged in the review that took place three years ago.

Deputy Marcella Corcoran Kennedy: Is amending the Act the best way to address the issue of unregulated services? Is that what Mr. Saunders is saying?

Mr. John Saunders: That is one issue. The Act is 18 years old. There was a major undertaking by government with all interested parties to review the Act in 2013 and 2014. That resulted in a review report which makes 160 recommendations. Everybody who contributed to it realised that the recommendations would bring the Act into the 21st century. Among them is the change to enforcement but there are also other issues around children's services and how they are managed. There is a whole range of recommendations that need to be put in place to bring about a more regulated mental healthcare service.

The Deputy asked if that is the way to do it. We have decided in this country to have a statute which regulates mental healthcare services. In my opinion, if we are to have a Statute, it needs to be fit for purpose and responsive to modern day services rather than being outdated in relative terms.

Deputy Marcella Corcoran Kennedy: Mr. Saunders states in his submission that little heed is given to the commentary of the commission by the Department of Health or the Health Service Executive. Does the commission have a formal process in place for engaging with the Department and HSE on a quarterly or weekly basis or whatever? I would have thought that would be crucial for the commission to be able to deliver on its functions effectively.

Mr. John Saunders: There are various pathways. The commission, through its inspectorate, obviously speaks to each of the services it inspects. There is a constant conversation about changes and improvements. To be fair to the mental healthcare services, where a need is pointed out and where it is possible for them to do so, they will make changes and improvements. The problem, as I suggested, is that the changes and improvements are often beyond the scope of a local service. There may be resource or policy issues that are national.

The mental healthcare services are unique in the sense that a mental health division was created in 2013. This was a highly visible structure through which the commission or anybody else could communicate on a national or corporate level with the mental healthcare services at what is called national director level, which is a very high level. That was quite effective for trying to push change within the system. However, that system has collapsed and there is no longer a mental health division because it was dismantled within the HSE structure at the end of last year. As we speak, we are not very clear about the overall corporate responsibility of mental health in the context of all the healthcare programmes that are in place. It is a constantly changing situation.

Deputy Marcella Corcoran Kennedy: What about the Department of Health?

Mr. John Saunders: We report to the Department of Health at a number of different levels. I again refer to my commentary on this. I was very careful in what I said. There is a sense that we constantly state the facts and realities as we see them. There is a sense that people listen

but also a sense that there is no immediate or long-term response to those issues, not always but sometimes. This is borne out for us by the fact that the same headlines come up year after year. The number of children admitted to adult units has been constant for the past five or six years. The numbers who do not have individualised programme plans are increasing year on year. The issues around seclusion are also difficult but none of these issues is new. They did not just arise this year or last year but have been coming up year after year. We are highlighting these issues but nothing is happening in terms of making a significant shift.

Deputy Marcella Corcoran Kennedy: I can hear the frustration in Mr. Saunders's voice. I am conscious of time and am probably fast running out.

Chairman: Yes.

Deputy Marcella Corcoran Kennedy: How long do I have left?

Chairman: The Deputy is one minute over her time.

Deputy Marcella Corcoran Kennedy: My apologies.

Chairman: That is fine. Does the Deputy have a very brief question?

Deputy Marcella Corcoran Kennedy: Yes, I have one for the Ombudsman for Children regarding the delay in making the mental health pathfinder project operational. What is causing that delay?

Dr. Niall Muldoon: According to the Minister of State, Deputy Jim Daly, a decision by the Department of Public Expenditure and Reform is awaited. As far as I am concerned that amounts to the bean counters saying that children do not deserve this project. It has been signalled within the Civil Service for the past two years that this would be a flagship project for mental health services. The pathfinder project aims to bring mental health services together, with increased collaboration, over a three-year period. We should be making it happen as opposed to delaying it for financial reasons. The committee has already heard about some of the consequences of missed steps when organisations and partners do not work together. We need to push forward with that as soon as possible.

Deputy Marcella Corcoran Kennedy: In terms of the universally accessible prevention measures that Mr. Muldoon mentioned, is there a role for Healthy Ireland in that context? Would Healthy Ireland fit in there in terms of the overarching policy? I do not remember people having mental health issues when I was a child but maybe they did and it was just not recognised. How can we empower young people and their families to help them to manage? Could Healthy Ireland fit in there?

Dr. Niall Muldoon: Absolutely, a whole range of good policies are outlined under Better Outcomes Brighter Futures and Healthy Ireland, which aim to improve the lives of children from a very early age. These policies deal with how to make children physically competent, resilient and emotionally aware, all of which is very positive. Parents today are also much more emotionally aware and those in the 25 to 30 years age bracket know how to help their children in that regard. However, we still need to provide services when something goes wrong. That is why I am suggesting that therapists or counsellors should be available at primary care level. A report is being launched at St. Patrick's hospital today which finds that some four year olds are displaying signs of anxiety but we can cut out some of the problems at source with very simple stuff. The aforementioned report is very clear that many of the issues for children are related

to marriage breakdown, difficult family relationships, blended families and so on. These are normal aspects of life now but if children do not sort them out in their heads when they are four or five years old, by the time they are 14 or 15 years old, they can have a real impact. If we can provide a six-month window of opportunity, we can prevent many problems. We have a lot of the right policies and thinking but we need the resources to match.

Chairman: Deputy Brassil is next.

Deputy John Brassil: I thank the witnesses for their submissions and Ms Brennan in particular for her very powerful contribution. The Mental Health Commission was established in 2002. Mr. Saunders outlined the principal functions of the commission in terms of ensuring high standards, good practice and so on. Under legislation, the commission "shall have such powers as are necessary" for the purposes of its functions. Given that in 2016, we had 68 instances of children being admitted to adult facilities, rising to 82 in 2017, is anybody listening to the commission? To use HIQA as a comparator, it seems to have the ability to bring about change but it appears the Mental Health Commission does not, to be blunt about it. This committee is trying to draw up a blueprint for the future so that we can improve matters. What is missing here?

Mr. John Saunders: The Deputy is correct in saying that there were 68 admissions of children to adult units in 2017. To put that in context, in 2012 there were 107 such admissions, in 2013 there were 98, in 2014 there were 92, in 2015 there were 96 and there were 68 such admissions in 2016. There has, therefore, been a shift. One of the roles performed by the commission is to carry out inspections. It sees what it sees, makes very clear statements as to whether what it sees is appropriate and makes recommendations for change. There is a dialogue with the service provider around that and, as I said earlier, in many cases small changes occur as a result of that dialogue. However, if that dialogue is not sufficient to bring about changes, the commission can impose conditions and timelines within which such conditions must be met. Compliance is monitored by the commission through the inspectorate. Inspections would take place on a monthly or three-monthly basis to ensure that the required changes take place. Again, if one looks through the thousands of pages of our reports, one will see changes brought about by that process.

We have the power to impose much more severe restrictions such as closure. However, one of the issues in mental healthcare, as everyone knows, is that the vast majority of services are provided by the statutory provider, that is, the HSE. If one of those services is closed, one is faced with the problem of where the people using that service will go and who will provide an alternative service to them. In many cases, there is no plan B because the statutory system is providing the services. We need to be very careful about using more draconian measures.

Having spoken to the inspectorate, I can say that people working on the ground often welcome the commentary of the inspectorate and the commission because it provides very clear direction to them in terms of the changes they can make to improve the services. When one talks to people across the system, many of them will say that bringing about change is a very co-operative process. It is not just about saying a service must close or do X or Y. It is about pointing out the changes that are needed and bringing people up to that change over time. When one looks at the position historically, one can see that improvements have taken place. The factors which mitigate against that are often down to the fact that people do not have the necessary resources or are working in buildings that are not fit for purpose. Often the issues are not localised but are national and, as such, they require a national response.

Deputy John Brassil: This committee is grappling with a complex and difficult area in an effort to bring about some positive change. Does Dr. Muldoon believe the system we are operating is workable or fixable? Can we get to a satisfactory level of service provision or should we dismantle what we have and start again? I know there is no silver bullet but I am interested in hearing Dr. Muldoon's views, based on his experience. Do we have something on which we can work or should we start from a completely different place?

Dr. Niall Muldoon: I think we have to do a bit of both, to be honest. Ms Brennan spoke earlier about the fact that some parts of the country have very good CAMHS and very good mental health services generally. Galway has been highlighted as one of the best in that regard. It can be done but it is generally done because of individual personalities who make things work. It is down to good decisions on who to bring in, what the contracts look like and making it work for an area. As a system, it is dependent on the individuals within it. That is why I am seeking a new A Vision for Change specifically for children. We keep referring to the original document but that was drafted in utopia, when we expected to be able to sell all of our old psychiatric hospitals for hundreds of millions of euro and reinvest that money in services. We are now in very different circumstances and the Minister of State at the Department of Health with responsibility for mental health has told me that at least 15 psychiatric consultant posts have been unfilled for the past five years. We are not producing enough psychiatrists to fill them. That is where we need to start thinking in a new way, such as how else we can fill those posts and whether there are other posts that could do the same job for a period of time. There is a bit of both. The system when it is fully resourced with the right people will work perfectly, but when one has a situation where only one type of professional can fill it and one cannot get that professional one needs to start thinking about who else can fill the post. That is one part of it, but it is also necessary to resource properly the earlier stage, which is the primary care, the early intervention, the GPs and the stages where young people are identified as quickly as possible. I would love to see people without their professional hats on discussing how one would set this up as new. It would be a conversation worth having if we put everyone in a room and asked: "What do we want for our children and grandchildren regardless of what our profession is and what would be the best way forward?" There are examples of good practice around the country that are not supported by the system but by individuals with real passion and emotion. That is where we need to get a mix.

Deputy John Brassil: That is a critical point. There are 15 unfillable posts. Let us move on and establish a system whereby posts can be filled with people who can be put into them. That is something we need to consider.

Chairman: I agree.

Deputy John Brassil: I have a question for Margaret Brennan. When dealing with her son's illness or her daughter's situation, was there any stage when she found something that worked for her?

Ms Margaret Brennan: Worked for me or worked for them?

Deputy John Brassil: Worked for the family. Was there any point where she could say that if she had been able to continue in that service the family would be in a far better place than they are now? I am trying to find something that operates well that the committee could examine and then build on. If there was none, that is fine. I am just curious.

Ms Margaret Brennan: The first thing that went well was that on his initial diagnosis of

depression he was seen after two days. That is not the norm any more. That is one thing that worked well. The primary thing to understand is that we do not have enough of a team. We do not have any other therapy. One cannot cure depression or alleviate its symptoms with medicines alone. It requires a three prong approach - counselling, activity and medication. My child could not get out of bed with the depression he had. No other therapy was offered. There was no counselling, psychology, art therapy or music therapy. There was nothing. We were left holding the can for long periods of time. I am not trained psychiatrically. I had to beg, plead and write: "Please help me. I do not know what I am doing and I need help for my child." I eventually sourced it but it was after many letters and calls to Dr. Niall Muldoon.

Chairman: Before calling Deputy Buckley, I wish to clarify something with Mr. Saunders. He mentioned that the number of admissions of children into adult psychiatric units has decreased over the years. He forgot to mention that it went up again last year.

Mr. John Saunders: Yes.

Chairman: Am I right in believing he is suggesting that the Mental Health Commission is taking credit for that decline?

Mr. John Saunders: No.

Chairman: Okay. It just sounded like that. I call Deputy Buckley.

Deputy Pat Buckley: My apologies for being late. I was meeting the Minister of State, Deputy Jim Daly. I have a few observations for Dr. Muldoon. I read the report. The children and service users were very open and honest in it. I compliment everybody involved with it because we need to get the truth out. However, there appears to be a repetitive issue here. On primary care, the committee has called for the development of a realistic plan and timeframe for the provision of 24-7 services, but that is not happening. Like Dr. Muldoon, we have called for everyone to sit down together and take off their professional hats and put on their thinking caps. We call it an outside-the-box and common sense approach to CAMHS. We know the incidence of suicide is higher in certain geographical areas than in others. My view is that if there is a restriction when it comes to staffing, and there is a diabolical situation at present, we can surely pinpoint geographical areas and get them fully staffed and working there.

Ms Brennan spoke about the lack of services even when one gets into them. There was just option A and no B or C in terms of treatment for her child, such as talk therapy and so forth. That is down to staffing. There is one issue that always aggrieves me. Why can we not fill the teams we have in CAMHS? If we cannot, can we not consider the geographical basis whereby if there is greater urgency in CHO areas 2 and 5 we try to staff those fully first? That decreases the pressure in one area. I realise it could exacerbate it in others, but the numbers are not as high.

Turning to the Mental Health Commission, we raised staffing here last week. If we cannot get the recruitment process right in any part of the sections, we have lost. I submitted a parliamentary question last January and the reply was that the Mental Health Commission recruitment process has 22 stages before there is an appointment. That is a bad indictment of good resourcing or good thinking. I have a question for Mr. Saunders on the allocation of funds. There was an under-drawdown of nearly €9 million in 2005, €5.5 million in 2006 and €3.1 million in 2007, but all the budget was spent in 2008. From 2009 to 2014 the moneys that were not drawn down amount to approximately €12 million. Where does that money go? Does it go

back into the system? Is it ring-fenced for something? It appears that across the entire area of mental health we cannot tie down a simple specific answer to a question, and when we cannot get answers we seem to go around in a revolving door all the time. I am very worried when we cannot get clarity on a matter.

With regard to the commission's powers and responsibilities, does it look over some of the Bills we produce? If we produce legislation is it part of the commission's remit to respond to it? One example is the Assisted Decision-Making Capacity Act. Does the Mental Health Commission look at that and agree or disagree with it?

Mr. John Saunders: Can the Deputy clarify that question?

Deputy Pat Buckley: Does the Mental Health Commission look at specific Bills that are brought to the Seanad or the Dáil?

Mr. John Saunders: Okay.

Deputy Pat Buckley: The retention issue is very frustrating. *The Irish Times* reported last Monday that 300 doctors have visas for Australia. There is something wrong. Surely if we can produce doctors, psychologists, psychiatrists and so forth we can retain them. Surely a structure could be put in place. Much of it is to do with the unions as well. Let us be honest and frank here. If we are not going to sort this out the committee will go around in circles. There will be departments for this, that and the other and a review of a review of a review. There are 47 or 48 reports now and an average of 500 people die by suicide each year, excluding accidental poisoning, possible filicides, single vehicle crashes and accidental drownings. We do not know what the numbers are. That does not even refer to the marginalised society, such as Travellers and so forth, where we have no records. I am very worried that we are going around in circles and I ask Mr. Saunders and Dr. Muldoon for their opinions on that. If we keep going the way we are going at present, will the whole mental health system implode, fall apart and fizzle out, because we seem to be losing every single ingredient to bake the cake in the pot?

Chairman: The Deputy will have to ask questions because he is running out of time.

Deputy Pat Buckley: I want an opinion on this. At the current rate, with the structures that are in place and the road we are going down - whether it is CAMHS, the whole mental health service or recruitment - if we do not do something drastic and immediate it will implode. Do the witnesses agree or disagree with that?

Chairman: I call Dr. Muldoon.

Dr. Niall Muldoon: I am not 100% sure if it will implode but we can certainly see the fall-out where it does not work. There are psychiatrists who have put 16 years of their lives into one area and then they decide that the only option they have left is to resign in order to force a change. That is a system imploding as far as I am concerned and that is the collateral damage.

Ms Margaret Brennan: It has collapsed in our area to the detriment of children on a four year waiting list. We have no specialists for our children.

Deputy Pat Buckley: It is a disgrace. It is ridiculous.

Dr. Niall Muldoon: From a business point of view I have consistently asked the Minister for Health and the Minister of State with responsibility for mental health and older people how much is spent in the area of children's mental health. We can tell that the mental health

budget is close to €1 billion in general but not how much is spent on children in particular. We know that 75% of all adult psychiatric issues start in childhood. No business is set up without knowing what is being spent, where it is being spent and where better resources can be allocated. When the Irish College of General Practitioners met in another committee with the Chair, they spoke about the need for demographic allocation and disadvantage needs to be considered there. There is a better way of doing that with the limited resources, namely to find out where the need is greatest and the south east seems to have jumped to the top of that queue but there are other areas that need better allocation. There is a way of improving the system but we need to start with the basic question of how much we spend on it. That needs to increase. We know it is only 6% of our national budget and the European average is around 12%. We are way behind on that. We know the money is not enough if the recruitment is not done properly. Other areas that Ms Brennan mentioned where we could recruit are play, art and drama therapists and other such people who are in professions that have only come on the scene in the last ten to 15 years. Many of them now have proper oversight and regulations. They could help us in the areas of primary care and we need to look at the more serious levels as well.

Chairman: I call Mr. Saunders and I ask him to be brief.

Mr. John Saunders: I agree with what Ms Brennan has said earlier on that we do not have enough people employed in the so called non-medical disciplines such as psychology and social work, not just in CAMHS but in all mental health teams across the country. That is part of the issue. The services are not providing what vision for change wants, namely a model based on doctors, nurses and a whole range of disciplines besides. The second issue is one of resources. One of the things we have been identifying is the fact that in CAMHS, for example, the amount of money available throughout the country ranges from a low of €40 to €92 per person per annum. It is a whole range of different figures depending on where one lives. That is evident in how services are being provided by other countries.

I refer to manpower. It is cold comfort to anybody here but A Vision for Change made four or five recommendations on increasing manpower for psychology, social work and other disciplines way back in 2006. It did not happen and now we are reaping the rewards of that if that is an appropriate phrase. We do not have enough people coming out of the training schools as are required in mental health. As has been said, some will emigrate.

Chairman: I will have to hurry Mr. Saunders up.

Mr. John Saunders: There is a severe supply problem which was not addressed back in 2006 and 2007 and of course the recession came into play in terms of public service expenditure.

Chairman: We will probably come back to Mr. Saunders and Deputy Buckley will come back to him if we have time at the end.

Senator Máire Devine: I thank the witnesses for their presentations. I give respect to Ms Brennan. It is great that her voice is here and more recently it has been proven in this country that ordinary voices such as hers are the catalyst for change. That is why we need to keep pushing this. It needs to change but it must come from our ordinary families and children who suffer in this country. I thank her for appearing before the committee. We are not that scary but sometimes it can be daunting.

I thank the Mental Health Commission also. What do they think about a prison becoming

an approved centre? I looked at their annual financial statements in depth for the last two or three years. I am concerned about how much they spend on their legal representation. I would like a written submission back to the committee on that. It seems to be a complete overspend. It feels like the lawyers are doing what they do best but maybe I am being condemnatory of them. It is to do with the due process in tribunals. Mental health tribunals are important and have become extremely important for people's rights in this country but they do not represent the patient in the tribunal as such. They are only there to make sure that due process occurs but that does not give voice to the patient. I have grave concerns about the lack of patients' voices in that process because lawyers and legal teams supposedly representing them only tick the box to say that due process has taken place.

Time and again, the Mental Health Commission has visited facilities that were very poor and unfit for habitation such as Portrane. I know that there are often no alternative facilities but how do they justify registering such facilities and allowing them to continue to offer services even though they are so far below par and unfit? I understand that we would have no other facilities but maybe that is the push that we need.

I have worked with mental health staff and represented them as a union representative. There have been several occasions where we have felt like calling the Health and Safety Authority because of situations within our hospitals or approved centres. That may seem like a last resort measure but perhaps it would send a signal out that something needs to be done.

I thank Dr. Muldoon. He produced a survey with input from young people. There were two private CAMHS units and three public. The committee has discussed this before. Were there any stark differences between the private and public responses? What did children find good, bad or indifferent in those? Some €400 million is spent on psychotropic drugs and €10 million is spent on talk therapies such as play, drama or art and counselling. He also mentioned the restraint of children, that it seems to have increased and seems to be more drug related, especially with the powerful, synthetic drugs that are out there now. Could he comment on that and the challenging behaviour that results from those drug induced psychoses? I agree with the comments on A Vision for Change which was also previously discussed. We need to have more of a community effort and to look at the appointment of experienced professionals to run the areas of our services that do not have any kind of order within them. We put that question to the College of Psychiatrists of Ireland and it was a definite no-no so maybe the witnesses might like to keep pressing that.

Chairman: I thank the Senator because we were running out of time there. I will ask Dr. Muldoon to answer first. Could Dr. Muldoon and Mr. Saunders remember that we are stuck for time?

Dr. Niall Muldoon: We did not look into the difference between public and private. The children gave their answers. We did not take heed of where it was happening in one place or another. We just wanted a general picture of where everybody was. That is why we were delighted to get five out of the six units so we could take a full picture around the country. As regards the €40 million versus €10 million, as far as we are concerned, this is something that will be important redress. Elements of counselling are happening alongside the use of medication. Four to one is not the right ratio with regard to that.

Senator Máire Devine: It is 400 or 40 to one.

Dr. Niall Muldoon: With regard to restraints relating to children, when we do these sort

of consultations, we take what the children say to us without any judgment, request or follow up. We then say that this is what we understand they have told us and check whether they are happy with how we are presenting it. In this case, we just took what they said, which was that there were a number of situations in which young people were physically restrained in order to administer an injection. They felt it was done in an inappropriate way, they could do without that happening and there would be other ways it should happen. They knew they were upset and needed help but they felt there were better ways of doing that.

From our experience with this case, consultation and presentation, nobody had any drug-related issues so I cannot really comment on that. The committee has discussed the difficulty surrounding dual diagnosis. That is another issue where a child with a drug addiction or any sort of addiction finds it difficult to access a mental health service. I would be very much aware of that but not in this particular report.

Mr. John Saunders: We have quite high legal costs that in the main relate to the other function of the commission around supporting the mental health tribunals. This is fundamentally a human right. People who are detained against their will have a right to have that detention questioned and that is what the mental health tribunals do. They give a "Yes" or "No" response to those issues. Of course, it could be improved but that is what the Mental Health Act demands and that is what the commission does under the Act.

In respect of the approved centres, thankfully, all the old unfit-for-purpose institutions are gone. We are now dealing with units that are attached to general hospitals. Some of them are quite old. In fact, most of them existed prior to the Mental Health Commission. Our brief under the Act is to inspect them and attach conditions and we do attach conditions. At any one time, a significant number of conditions are in place, which means there are things that people need to improve on. As I said earlier, the staff in those services at a local level bend over backwards to make those improvements because they know they are heading in the right direction if they do so. We must accept that they are there. Often it is the only unit in the county and we cannot just close it overnight because there is no plan B. The other thing to bear in mind around registration is that it is never simply a case of saying a place is providing a perfect service. There is always a dialogue around making changes and improvements. Anyone who works in the system will know that the commission through its inspectorate is very open to that dialogue to make those changes.

Chairman: The next round of questions will be in batches of three. We will call on three members, listen to all their questions and ask the witnesses to answer them.

Deputy Catherine Martin: I thank the witnesses for their presentations and all the invaluable work they do to advocate for our most vulnerable citizens. We share Dr. Muldoon's concerns about the lack of clarity and transparency when it comes to where the money is being spent. This committee has been hitting a brick wall for the past few months. In particular, I thank Ms Brennan. She was very courageous and I know she did that for her own child and the children in her own area and our country.I know how difficult that was for her and we really appreciate it. She hit the nail on the head. Fundamentally, it is a crucial test for society via politics and we are failing miserably. In the new politics that we talk about, mental health support should be top of the agenda.

Many of the questions I was going to ask about the Mental Health Commission have already been answered. Do we have any idea about the number of unregulated mental health care services outside approved centres or where they are located? What happens when they come to

the attention of the commission? Do we have any statistics in this area?

I will concentrate on education because that is my background. I was interested in Dr. Muldoon's recommendation for school-based counselling. It is something I would be keen to see. I know it is the norm in many countries so how can we do this? Does Dr. Muldoon believe that the Department of Education and Skills and the Department of Health are working together properly to address supports for our children? Is that interdepartmental collaboration close enough? Are the Departments working together in innovative ways to support them? Is the promotion of happiness and mental resilience among our children being addressed at all? In a recent survey, the majority of primary school principals said that they just do not know. Children are really stressed out and more anxious than ever before and principals do not know how to cope with it and how to help these children. Is that interdepartmental approach there?

There was a reference to some teachers doing some work. It is quite sporadic. What needs to be done there to ensure that it is not so sporadic and that we have the proper training for teachers before we reach the stage where we get those counsellors on site? What is the obstacle there because it cannot be sporadic and down to a post code? A lot of the time, children in the most vulnerable post codes are being let down so what can be done to ensure it is done across the board?

Chairman: I thank Deputy Martin for being so brief and to the point.

Deputy James Browne: I start by thanking Ms Brennan for her testimony. Breaking with anonymity was a very powerful, brave and difficult thing to do. One thing we have learned is that very often, personal experiences do the most in acting as catalysts for change. It should not have to be like this but very often, it is the thing that empowers some people to sit up, wake up and see exactly what is going on.

I thank Dr. Muldoon for his work in his report in terms of giving a voice to children. Very often, the most difficult thing we face is giving effect to that voice for obvious reasons such as data protection and access. Very often, it is the voice that is missing. There has been a history of too much focus on paternalism in this country that needs to be rebalanced so that our children's voices can be heard. I very much welcome that.

I thank Mr. Saunders and the Mental Health Commission for their work. I know Mr. Saunders does great work both inside and outside the commission. Very often, inspection reports are the launch pad for parliamentary questions I put and further work. My first question is for Mr. Saunders. I recently asked the Department of Health about the longest length of stay with regard to children in adult units. The Department told me that it does not keep that information or those records. I think this is quite unbelievable and unacceptable. It is outrageous that this is the case. I know the commission has had this information in past reports so I do not know why it is not available from the Department anymore. For the Department to say it does not know how long children are staying in adult units is outrageous. Dealing with Waterford, anecdotally, there seems to be a significant increase in the number of children staying in these units for four, five or six weeks. Perhaps the commission could address that. Is it just my interpretation of what I am seeing or is it a trend that is becoming more worrisome? From talking to parents, I have discovered it is happening because of the lack of alternative supports, which was addressed by Ms Brennan, such as activities or alternative therapies. Again, that is totally unacceptable.

Dr. Muldoon touched the most important finding of the commmittee, that being that we

do not know how much is being spent on child mental health services. I ask him to comment on another key finding, which is that €400 million is being spent on psychotropic drugs in our mental health services but only €10 million on talk therapies. Medication has an important role in treatment but a ratio of 40:1 in its favour over basic talk therapy support gives a very clear indication of the focus of and imbalance in our health services.

We know that people recover best when treated close to their family, friends and care network. Dr. Muldoon touched on that when he noted that separation from family is a particularly significant challenge frequently mentioned by young people. People with eating disorders or members of the deaf community who need specialised supports very often are sent to the United Kingdom for a long time to receive appropriate support. Those people are completely separated from their loved ones and care network. The same language may be spoken in the United Kingdom but it is a different jurisdiction and those people are completely alienated from their families, friends and support networks. I ask Dr. Muldoon to address the consequences of our young people being alienated by being sent out of the country to access medical supports.

Deputy Seán Crowe: The witnesses are very welcome. Ms Brennan mentioned that she was refused payment for medication. I ask her to expand on that because it shocked me.

Chairman: I ask Ms Brennan to wait until all questions have been asked before responding.

Deputy Seán Crowe: I ask Dr. Muldoon and Mr. Saunders to comment on that also. Is there an irregularity in terms of payment for medication being granted in some areas but not in others? Mr. Saunders mentioned that the Mental Health Commission has noted a considerable variation in funding depending on geographical area. How has that developed? Is it because of a Minister being from a particular area or is it due to a lack of services such that one area gets more funding than another?

The facility at Linn Dara was mentioned. I ask the witnesses to comment on the fact that beds are being closed there. Why is that being done? It does not make sense to do so if we wish to increase the number of beds available nationwide.

The witnesses addressed transitional services, in particular in regard to CAMHS. The transition of those aged 18 to 20 is a priority in that regard. What is being done for such people? What works and what does not in terms of other models in other jurisdictions? Are we learning from experiences elsewhere? Do the witnesses have any suggestions in that regard?

I have other queries but I am allowed to ask only three questions so I will leave it at that. My main queries regard transitional services, CAMHS and the difficulties which families encounter.

Ms Brennan addressed the difficulties she and her family have experienced. Is it a familiar pattern for families to wonder where to go, who to see and what happens if the services are not there? Those are the first things to strike families. Families have come to me whose son or daughter needs services and respite but refuses to go into respite or avail of services. What should families do in such circumstances, in particular if the child is violent, apart from sectioning the child? I am aware of a case involving a child who was eating off the ground, walking naked indoors and outdoors and had severe mental health problems. Many of the family members themselves end up on anti-depressants. I offer that as an example of families such as Margaret's who do not know where to go. They usually go to politicians but they are the wrong people to whom to go. Doctors probably do not know what to do, hospitals are too busy to

deal with them and the Garda can offer only limited advice. Where do such families go? I have asked that question before. It is probably monotonous for those at home watching or listening to the committee proceedings but these are the type of questions to which people need answers.

Chairman: I ask the witnesses to answer in sequence. Deputy Catherine Martin was the first to ask questions. I call on Mr. Saunders, to be followed by Dr. Muldoon.

Mr. John Saunders: I thank the Chair. I will give a brief response, given the time limits. On unregulated mental health care services, only approved residential centres across the country are currently regulated under the Act. We regulate those centres and impose conditions and changes. We can inspect other services but we cannot impose changes upon them. We have the power to inspect and to make suggestions to community residences, community mental health teams in adults' and children's services and every other type of service but we do not have the power under the Act to enforce those suggestions. That is the crucial issue and it is part of the review process to which I alluded much earlier in terms of the services. We know, and it is nothing new to say, that most mental health teams across the country are under-staffed because of supply and other issues.

Deputy Browne raised the issue of duration of stay. In 2011, the year in which the commission began to highlight the issue of children's admissions to adult units, the average duration in those units was approximately 11 days and children then went back to their families or on to appropriate children's services. That has now come down to approximately six to eight days per admission. It is important to understand the background to such admissions. Some children go into adult services because children's services sometimes will not receive people out of hours. Parents sometimes choose for their child, their loved one, to be served locally rather than travel 100 miles or more to a children's unit. There may be a clinical decision that it is the most appropriate location for a child. CAMHS may not be able to support people locally. We earlier mentioned that community mental health children's teams are not sufficiently staffed to provide the support a child might require while living in his or her own home and the last resort is often, therefore, for the child to go to a children's service or, in some cases, unfortunately, an adult service. That may not fully answer Deputy Browne but those are the headline issues.

Deputy Crowe raised a number of issues. There is a problem in regard to transitional services. Between the ages of 16 and 18 a person is constitutionally and legally a child but may be exhibiting adult-type behaviours and there is an issue in terms of who deals with such people. Traditionally in Ireland, the children's mental health service finishes at 18 and the adult mental healthcare service kicks in. There are logistical issues in regard to how teams co-operate with each other or not, depending on the situation. The commission and many others have highlighted inconsistencies across the country in that regard, some of which are partly historical. Some areas of the country historically have better financial resource allocations. If there was a very large institution in an area, a very large budget would have been provided to support it. When the institution closed, that budget may more or less stay in the area.

As mentioned by Dr. Muldoon, local clinical and administrative leadership is often the spark that drives change, such that change is promoted by personality or the dynamic of a team rather than having a national consistent change plan. There are pockets of brilliance and developments across the country. They are side by side with the more traditional, under-resourced lack of innovation, for want of a better word, in terms of the type of service they provide. We end up with the patchwork to which the Deputy alluded. That is the fact of Irish life in terms of how mental health care services have developed. I hope I have dealt with all of the questions.

Dr. Niall Muldoon: In regard to Deputy Martin's questions, I am part of what is called a well-being for teachers and learners group and I work very closely with the Irish Primary Principals Network, the National Association of Principals and Deputy Principals, the Teaching Council and the National Parents Council. The whole essence of that is to try to create co-ordination and encouragement so that well-being becomes part of the culture of every school. It is about emotional awareness across teachers, students and parents, so it is the school community that needs to have a well-being culture. We are trying to promote that all of the time.

Within that, changes are needed. The Deputy asked whether the Department of Health and the Department of Education and Skills are working closely together. They are not working together closely enough. They both have targets within a number of strategies, such as the Healthy Ireland strategy, Better Outcomes, Brighter Futures and various other strategies. However, with regard to co-operating with each other, it is not as good as it could be and this is something that can be encouraged. We need teachers to be valued more than they are at present for the work they do. We now have a well-being curriculum for junior certificate but we still find this is taken on board by certain teachers who might have fewer hours filled, and it might not always be encouraged as the most important part of the work they do. There is a lot of work to be done in both the Department of Education and Skills and the Department of Health. Co-operation is vital and that is where we need to have things like a counselling service available across the two Departments, and perhaps across other Departments. They are starting to work on issues such as speech and language therapists being provided in schools, which is a case of co-operation between the two Departments. If we can do the same with regard to a counselling service, that could work, but there is a lot of work to be done. Even during the early years in primary school, we can start to encourage children, teachers and any of the professionals working with them to work on the emotional well-being and emotional vocabulary of children. This would make a huge difference into the future and give them resilience.

Deputy Catherine Martin: I sit on the education committee, which prepared a report on promoting positive mental health. Within that, apart from looking after our children, it was referenced by the experts that, despite the need for teachers to be fully there to support their students, the mental health of teachers is often forgotten about. Is that something we can work on here?

Dr. Niall Muldoon: That is the essence. We deliberately named our group the "well-being for teachers and learners" group so that everybody can become a teacher, and the child can teach the adult and vice versa. We need well-being for both and that is where culture comes in. If someone knows the teacher is struggling, there is no point asking that teacher to help a child. We have to provide that service all the way through the school community.

Dr. Karen McAuley: We are glad the Deputy brought up the whole area of education. In terms of the work we did with the 25 people in the inpatient units at the time, at the outset we asked them about their journey through the mental health services but we did not ask them about anything other than the mental health services. What was very interesting was that, consistently, the young people included a focus in their comments on education, the importance of culture in schools and the professional and other supports, including peer supports, available in schools. In the area for ideas for improvement, they put a very strong emphasis on prevention in terms of work to promote well-being and good mental health, but also on supports being available at that level, informal and otherwise, to build young people's awareness and understanding of their own mental health, if they are experiencing difficulties, and to help them address those difficulties. It is a very important area to look at.

Deputy Seán Crowe: There was a question on Linn Dara.

Chairman: Dr. Muldoon will answer Deputy Browne's questions first.

Dr. Niall Muldoon: I have already commented on the difference between medication and counselling. With regard to geographic supports and the idea that young people have been taken away from their homes, the UN committee is very clear that the highest attainable standard of health care needs to include support and closeness to the highest possible level of support. The way I always describe it is that it needs to be accessible, appropriate and timely. The committee will see in our report that one young person was in an inpatient unit six and a half hours away from home and did not see the family for ten weeks. That is a difficult thing to do at the best of times and we are doing people a huge disservice if that is the best we can offer. International options are a huge problem, in my view. We have all sorts of concerns about children who are held in clinical centres in England. We find this happens with eating disorders because patients need to be PEG fed, for example. Again, it is an area where we can increase our professionalism in order to bring those young people home. From our perspective, this is a concern because it damages their rights to the best attainable health care within their own community. I would also have a question mark as to the clinical and governance system when people are sent across to another country.

Deputy Crowe asked about Linn Dara. I assume he is referring to last year's closure of 11 beds due to the difficulty in recruiting nurses. My understanding is that it was back up to full capacity from October or November of last year and I have not heard of any difficulties since then. However, it does show the vulnerability we have in that recruitment can be a difficulty for us and can lead to problems for children. An average stay there is about six weeks, which means some 60 young people may have lost out on that opportunity while those beds were closed. It is something for which we can plan.

Mr. Saunders talked about the 16 to 20 years age group. We still have CHO areas where CAMHS teams do not take anyone above 16 years of age, which is a disgrace. We have a centralised operating procedure which says they should do this but some of them are not. It is not even from 18 to 20 years but from 16 upwards that children are lost to a proper CAMHS service. We still have a lot of work to do in this regard.

The committee has heard perfectly today about the impact on families. If we had a service where they looked after our young people when they came in to us, the families would not have to fight, search, navigate, cajole and protest. None of those things would have to happen and they would still have a difficult time. If we were to do it properly, we would have a holistic service that provides support for everybody in that family that has an issue in regard to siblings, and parents would have some support. We have to start by giving the identified child every support possible and making it as easy as possible for the families. That is where an advocacy service and similar services can help, so they do not have to do all of the fighting.

Chairman: Deputy Crowe had some questions for Ms Brennan.

Ms Margaret Brennan: On the cost of medication, the area medical officer for the HSE area dictates what can be allowed on a long-term illness card. The area medical officers in Galway and Wexford decided that ADHD was not allowable on the long-term illness card for children, whereas every other county in Ireland was covered and all the other children in Ireland with ADHD were allowed the cost of their medication, which at the time was €150. I appealed this as I felt it was inequality and discrimination based on where we choose to live, and I won

the appeal.

On the question on the schools, the youngest child I ever had who expressed suicidal ideation was seven years old. We did not have a counsellor in that small rural school and we did not know what to do and had to get an external counsellor. Counselling in secondary schools has been cut and cut again. To get a slot for a teenager, one would have to be very lucky. I know the counsellors in three schools. One was brought in externally and the other two were on the school staff and teaching, so they were working their counselling around their teaching hours. It is very difficult, especially in a boys school, as they will not go to the counsellor.

There is one social care system working in the south-east called Hedge Schools Therapy, and I am sure all committee members are aware of it. It is very difficult to get and it can be accessed only through the HSE. My son was lucky and they changed his future. They brought him out cycling and rock climbing, and they took him on one half day from school. They are social care workers. All they do is outdoor therapy; they build fires in the woods and build resilience. Little by little, he began to disclose what had led to him being in CAMHS in the first place, which he has written down. He has also written an account of his time as an inpatient, which is horrific. Little by little, they changed his future and now he is doing well in college. The services and play therapists are there. There are therapists and psychologists but somebody is not funding the team.

Chairman: I thank Ms Brennan. I will speak to the clerk about inviting Hedge Schools to attend a meeting.

Ms Margaret Brennan: They are God.

Chairman: They sound amazing.

Ms Margaret Brennan: They are.

Chairman: The next batch of questions will be from me, Senator Murnane O'Connor and Deputy Michael Harty. I will start. I will address Mr. Saunders and then Ms Brennan. If there are questions that Mr. Saunders is not able to answer, I would be obliged if he could provide those answers at a later stage so that we can include them in the report.

Who does the Mental Health Commission report to? Who funds the Mental Health Commission? If it is the Department of Health, surely there is a conflict of interest? How can it tell the Department of Health that it is not doing a good job if it is paying the commission to do that? I am a little concerned about that. Will Mr. Saunders clarify that? He said the commission was established in 2002. As mentioned earlier by Deputy Brassil, the commission has written thousands of pages of reports and, 16 years on, we are still seeing the same problem. Do you have any power at all? When I say "you", I do not mean Mr. Saunders but the Mental Health Commission. Let us be very clear about that. Does the Mental Health Commission have any power at all? With all the reports and what it is finding, nothing is changing. When Mr. Saunders talks about how he thinks the commission should have the right to access external services, to measure, identify and investigate them, that would worry me a little. Since the commission has very little impact on mental health services, surely if it starts to focus the spotlight on external services, it will be taken away from the HSE? That worries me because we as a committee are trying to make the HSE accountable. I would like Mr. Saunders to comment on that.

My next questions are for Ms Brennan. I want a real, honest, basic answer to this question. What is she going to do now that the services are going to be removed or stopped? If they are

returned, the chances are that it could be in about a year's time. To recruit a psychiatrist in the south-east area would take at least a year. What is Ms Brennan going to do now? She mentioned the four year waiting list for her child. What was the waiting list for? Was it for initial assessment?

Ms Margaret Brennan: Initial assessment. A reassessment, actually.

Chairman: I will ask the others to put their questions and ask Ms Brennan to answer after that, please.

Senator Jennifer Murnane O'Connor: I compliment Ms Margaret Brennan too. I feel that parents are forgotten in this. The biggest role in a child's life is the parent's. Ms Brennan has fought for all these services and awareness. I see that in the different reports. That is unacceptable because the first port of call is the parent. The parent will notice signs. If one is not trained to notice these signs, it is a drawback, because timing is crucial with issues such as this. A programme should be put in place for parents such as Ms Brennan who need early intervention. She needs to know the signs. She has children and is not used to this. It is a whole new world to her. In my own area, I see people fighting for medical cards, not being able to afford the cost of doctors and waiting to go on a list for an appointment. That is unacceptable.

I will go back to Dr. Muldoon and his excellent report. It is crucial that we set up a national youth mental health taskforce. Dr. Muldoon's report states that many young people spoke of the length of time it took to access child and adolescent mental health services, CAMHS. When one gets to a certain age, one knows that there is an issue in the system. This system is broken. It is not fit for purpose. Families are affected. There are children and parents who are crying out for help. They are really stressed because they feel that their children need that help. There is no help there for them either. The whole system needs to be looked at, as do all these reports, whether they are worked on or money is put into them. We keep bringing up staffing and I know how crucial it is, particularly with teachers in schools but also with counsellors. It could start off with the small things, such as extra help in schools or for parents. It is not massive money and it boils down to funding. I do not care what anyone says. There is a massive rural and urban divide. One can see it. Different CHO areas all get different funding. Many will get more than others. That is unfair. We need to make sure that everybody gets equal treatment and it is not happening here.

I was reading Mr. Saunders' report on advising the Minister regarding regulations for approved centres. He has gone through all the different areas. He says he had inspected 43 residencies in 2017 details of which are published on the site. He has noticed massive issues. We know staffing is a massive issue. There is the absence of privacy, space, poor repairs to buildings and issues with institutional care. What are the HSE or the Minister doing about this? These reports are fine and we welcome them but what is being done? That is the issue today. It is not acceptable that 82 children were in adult units. That figure is going back up. It was 68 in 2016 and in 2017 it is up by 14. That is unacceptable. A Vision for Change is not working. Can everybody get together and start listening to Ms Brennan and the children who are crying out for help, put a programme together and start with the simple things such as getting school counsellors back and helping the teachers? Train teachers in the signs. Dr. Muldoon said that one can sometimes even see signs by the age of four. We all need to address these matters for the long term. We must develop a system, help and awareness; the Chairman would tell the witnesses that at every meeting I have attended I have stated awareness is the biggest issue. Parents are not aware and teachers are not aware. There is the awareness of what they are entitled to and the awareness of signs. There is such a lack of information and until that is sorted,

this system will not work.

Deputy Michael Harty: I apologise for having to leave. I missed the second presentation so some of my comments may have been dealt with. I will deal with three issues. The first relates to recruitment and retention. I heard a Minister this morning, when he was addressing this very issue, say that it was an international problem and that Ireland is no different from anywhere else. He proposed that tele-psychiatry would be the answer to recruitment and retention. I would like the witnesses' view on that. From my experience, the one-to-one personal contact that a patient has with his or her carer, whether a doctor or a nurse, is most important, particularly with regard to continuity of care. If one is trying to solve mental health issues over the Internet or Skype, it is a poor substitute for having a nurse, doctor or therapist to speak to a person.

The second issue relates to community care teams, specifically CAMHS. In my area in west Clare, we do not have a consultant psychiatrist. We have not had a psychologist for six years. We have half a social worker. The team is very understaffed. The problem with that is that those who are left standing are burning out. Not only do we not have the personnel to fill the gaps, but those who are there are under serious pressure. There seems to be a lack of urgency in addressing this issue.

The third issue relates to talk therapy and medication. Many quite serious mental health issues do not involve a biochemical imbalance but the treatment that is given is very potent medication. I do not think that is appropriate. I know we referred to €400 million for psychotropic drugs and €10 million for talk therapy but it is not as simple as that. Nevertheless, the tendency to reach for the prescription pad is very easy. If one does not have the top therapists, psychologists and cognitive behavioural therapy available that is the option. One is treating conditions which do not involve a biochemical imbalance with very potent drugs. Perhaps the witnesses might address those issues.

The amount of medication being prescribed for children with mental health issues is quite frightening. Quite often these medications are not addressing the issue at all, but rather are blunting symptoms instead of treating the underlying condition. I ask the witnesses to address those issues.

Chairman: I will invite the witnesses to speak in a sequential manner. I ask Mr. Saunders to answer my questions.

Mr. John Saunders: We report to the Minister of State with responsibility for mental health at the Department of Health and the Minister for Health. The issue around external-----

Chairman: Could Mr. Saunders expand on that? I said that surely there is a conflict of interest if he is reporting to the Minister and Minister of State who fund the service. Would Ms Smyth like to answer that?

Mr. John Saunders: Just to clarify, the Act is a health Act and is managed by the Department of Health and Minister of the day. That is who we report to as a health agency.

Chairman: Is there a conflict of interest?

Mr. John Saunders: There has not been so far. We report to the Minister and HSE. They listen. As I said in my report, often there is no immediate response to what has occurred.

Chairman: It seems pretty obvious why, if one delves into that.

Mr. John Saunders: I wish to be clear. The approved centres are run by the HSE in the main. There are also some independent services. The other unregulated services, that is, community mental health teams, are also run by the HSE. We are not talking about different providers. All mental health care services, with the exception of the independent private sector, are provided by the only statutory authority, that is, the HSE. That is how we work. Many people are using services which the commission cannot regulate forcefully.

Chairman: If you have no power over approved centres-----

Mr. John Saunders: We have power over approved centres but not the rest.

Chairman: Your powers do not seem to be working. I am talking about the Mental Health Commission.

Mr. John Saunders: That was another issue I wished to address. Over many years we have witnessed change such the closure of large institutions and improvements at local level. That change is inconsistent. That is the point of the discussion today. We cannot see consistent, timely and continual change year on year. There are changes here and there and improvements and disimprovements over time. That is because of the localised nature of provision in Ireland. We do not have a co-ordinated national drive to improve services across all counties in Ireland. On Senator-----

Chairman: Please answer my question for now. I will move on to Ms Brennan.

Mr. John Saunders: Okay.

Chairman: Mr. Saunders has not fully answered my questions. We will put them in a letter to him and he can respond promptly. I ask Ms Brennan to respond to my questions.

Ms Margaret Brennan: Absolutely. The first question concerns what we were going to do now. Tomorrow morning at 8.45 a.m. I will speak on local radio.

Chairman: Good.

Ms Margaret Brennan: I will speak in a slot as I have done here, armed some similar documents, to raise awareness. I have been told by the radio station that a campaign is about to take place, the details of which I do not know. After that, I do not know what to do for the betterment of my child but I know that some referrals have already been made to Dr. Kieran Moore in Crumlin. I do not know what to say about that. Parents do what they have to do.

Chairman: There was a four-year wait for assessment.

Ms Margaret Brennan: It is a reassessment because my child was assessed at the age of four as he was showing certain signs. CAMHS will not take any referral until a child is seven years of age. I had my child assessed at the age of four because I could see major signs, which cost me just under €1,000 and was not refunded by any organisation. He had to be reassessed after a number of years. The private psychiatrist left the country and we were left with CAMHS. It tried to assess him and that did not work. He went back on the list and was re-referred, and now sits at the bottom of the list. The reassessment is very quick, and all it does is assess whether he has the condition. We will not have an assessment. We do not have a specialist.

Chairman: That is absolutely shocking.

Ms Margaret Brennan: That is what is happening in the south east. Parents are in much worse situations than I am. There are parents whose children are suicidal. I know my child better than anybody else. I give him little concentration blocks and tasks at home which is costing me a fortune in Lego kits. That is the payment he likes. He gets rewards when he hits a target.

He is entitled to resource hours in school. As far as I can make out, the teacher has been on leave and there have been three substitutes for her, a situation which is not working. He has not improved as a result of the resource hours. It is down to me as his parent and I will do everything. If it costs me a fortune in Lego, that is fine. I will do everything to help my child as I have done for the others.

As regards teachers in schools, if one is interested one can opt into mental health care courses given by Professor Fiona McNicholas who provides them in teacher centres. Teachers have to opt in and get substitute cover. Those who are not interested do not opt in. I have been to one course and Professor McNicholas is absolutely brilliant. I met several secondary school teachers at the courses, some of whom are not trained counsellors but are taking on the role of counsellors in schools.

I would advise committee members to not be so quick to dismiss medication. It helps in a lot of cases. A doctor would not prescribe a medicine for a child if it was not needed. They are not that trigger happy with prescriptions. They will do what is needed at the time and start on a very low dose. I have never found a doctor who is prescription happy. They will do whatever the child needs. If he or she needs something for concentration, low mood or to calm him or her down, doctors will not give out medication willy-nilly.

I am at a loss. The CAMHS team will collapse without a specialist. We are not even in hospital, yet children with serious psychiatric problems are in a general hospital on a paediatric ward, where there are babies in cots. They are left there and parents are told staff cannot mind their children because they are not trained in psychiatric illness. On the two occasions I refer to nobody from the CAMHS team came to visit. I had to deal with the situation. I had to sleep on a chair or the floor and mind my child. That situation needs to be addressed. It happens quite often. As Deputy Browne said, children who need to be in a specialist unit are in wards with babies in cots for weeks. In University Hospital Waterford children are in a private room off an adult ward which is no bigger than a cupboard for weeks with no therapy and nothing to do all day. I cannot tell the committee what I have seen there.

Chairman: I thank Ms Brennan. To whom did Deputy Harty address his questions?

Deputy Michael Harty: Most were directed to the Mental Health Commission. Those relating to children were directed to the Ombudsman for Children. The first concerned recruitment and retention and tele-psychiatry.

Mr. John Saunders: I thank the Deputy. I agree tele-psychiatry is not a substitute. Mental health care services across all programmes are about people reacting with people and support far more than in general medicine and other forms of health. There is room for tele-mental health or e-mental health, but it has a very specific purpose. In general, one should never try to replace people with machinery in the area of mental health. I agree totally with Deputy Harty on that.

The second point to note to which the Deputy, and all of us, have alluded is that the com-

munity health teams are incomplete. People are working under pressure to provide a complete service with half the team. To use the analogy, how will a football team win a game if half its team members are not on the pitch? It is as simple as that. It is a complex problem to solve but it is simple. We do not have the right people in the right place to provide that service across the country.

On the issue of drugs, I respect all views around that. There is a history in mental health and in other parts of services of people relying on drugs because of the absence of something else. Equally, I am sure drugs work in certain cases. A number of years ago, the commission did a piece of research on benzodiazepines use in older populations and showed clearly that there is usually an over-prescribing of maximum doses in those cases. One rationale for that would be that there is no other way of managing people's behaviour, which is wrong. I have no doubt that in medicine generally, people sometimes resort to the prescription in the absence of other solutions.

Dr. Niall Muldoon: It is telling that when Dr. John Hillery highlighted the reason he was resigning from the Health Service Executive, HSE, position yesterday, he considered his medical ethics compromised and gave the example of having no respite for somebody with an intellectual disability and behavioural issues and therefore having to medicate them to keep them more relaxed and keep them down. That is where the system subtlety impacts enormously on people and if that is happening in the case of a child, we have got a serious problem. Again, it is forcing professionals into doing things they do not want to be doing.

Chairman: Deputy Buckley has literally one minute to ask a question.

Deputy Pat Buckley: We talk very fast in Cork. I have a question on age appropriate mental well-being classes in schools. We recently published a suicide training and prevention Bill. That was a small move but incoming public sector workers will get a minimum of a programme like SafeTALK, which will give them the coping skills to spot the signs. Would it be an advantage for that to be rolled out to schools? In that way, somebody who is working with children or with the public will have the skills to spot people who are in trouble. I know that is only one part of a bigger issue but as Mr. Saunders said, like the football team, if we do not have all the ingredients we will not be able to make the cake. This would be the first step to giving the people who are dealing with this area directly, namely, teachers, gardaí and Government officials, the coping skills to spot the signs and help people when they are in difficulty. In that way we would be nipping the issue in the bud and being proactive instead of being reactive in the future. Do the witnesses believe that would be a good idea? It is a simple question.

Chairman: To whom is the Deputy addressing that question?

Deputy Pat Buckley: To Mr. Saunders and Dr. Muldoon.

Mr. John Saunders: I thank the Deputy. I will defer to the Ombudsman in his capacity for advocating for children. However, there are many voluntary and statutory efforts around targeting children's health generally, in both primary schools and, more likely, in secondary schools. That is important for all the reasons we heard earlier. It is important because we know that if we get in early, we can inculcate attitudes and change ideas and behaviour. The issue is how to provide a consistent level of intervention for all children in schools. I am very aware that many issues in Ireland are addressed locally, again by this idea of some regional spark that has been developed. Many very good services are provided by voluntary organisations but they are inconsistent because of resource issues and geographical variations. There is a pattern in

Ireland where statutory mental health care services and educational services provided through the educational system are supported by voluntary effort. That is not a bad thing of itself but it leads to inconsistencies across the entire country. I will defer to the Ombudsman.

Dr. Niall Muldoon: Again, raising awareness and increasing the ability to spot issues has got to be a good thing but it must be consistent. Organisations like the GAA are taking initiatives like mental health first aid courses. People are queuing up for them because coaches and managers are dealing with this issue. It is coming into everybody's life and they are very aware it. Many parents are eager to understand it. It is a good development but we need to ensure that we do not leave it just to the voluntary sector to help us-----

Deputy Pat Buckley: I am sorry, Chairman, but it was not the voluntary sector. This was a Bill to put a statutory obligation on the Government to roll this out. Now is the time for future planning. There is no point in talking about it and doing review after review.

Ms Margaret Brennan: A lot is being done in schools.

Deputy Pat Buckley: Yes, but much of it is at the behest of the school principal, the club secretary or the GAA under-14 trainer. It should be universal, and everybody will benefit at the lowest point of entry.

Chairman: Thank you, Deputy. We will wind up the meeting now. My concerns have come to the fore today, in particular with the Mental Health Commission. I see the value and the necessity of the Mental Health Commission when it is investigating involuntary admissions. There has to be an adequate for people who have no voice. However, I do not see the point of the role of the Mental Health Commission going around to the child and adolescent mental health services, etc. when nothing is happening. I query strongly the relationship between the Mental Health Commission and the Department of Health and I would like to have some discussion about that at a later stage.

I thank Mr. Saunders, Ms Smyth, Dr. Wrigley, Dr. Niall Muldoon, Dr. Karen McAuley and, more than anybody else, Ms Margaret Brennan. I would say to her that when it comes to making changes, the only thing I have seen work in recent years is when the people are behind us. We need the entire public to get behind us on this issue and then we really will see changes.

Ms Margaret Brennan: I thank the Chairman.

Chairman: I thank everybody for attending today and giving assistance to the committee. This meeting of the joint committee is adjourned until 1.30 p.m. on Wednesday, 27 June 2017.

The joint committee adjourned at 4 p.m. until 1.30 p.m. on Wednesday, 27 June 2018.