CHILDREN'S MENTAL HEALTH COALITION

**5 July 2012**

# Submission from the Children's Mental Health Coalition to the National Children's Strategy consultation

## 1. Introduction

The Children's Mental Health Coalition (the Coalition) welcomes the opportunity to participate in the public consultation by the Department of Children and Youth Affairs in developing plans to improve the lives of children and young people over the next five years through a new National Children's Strategy. The Coalition was formed in 2009 to campaign and lobby Government for improvements in children's mental health in relation to mental health services, the education system, the justice system and the care system (www.childrensmentalhealth.ie). It comprises over 55 members representing groups from service providers, the education sector, human rights and children's rights organisations.[1] Our vision is that Ireland should be one of the best places in the world to be a child, where every child's right to mental health is realised. This submission is in response to the survey on: **http://www.childrensrights.ie/resources/dcya-public-consultation-new-national**. There is a need for the new National Children's Strategy to expressly address mental health. Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.[2] The Mental Health Commission estimated the costs of poor mental health to the labour market in Ireland to be €3 billion in 2006.[3] Although the costs associated with poor mental health are large, only 5.2 per cent of the overall health budget goes towards mental health despite a recommendation in *A Vision for Change,* the national mental health policy, that 8.2 per cent of the health budget be spent on mental health. The first National Children's Strategy did not adequately address the issue of mental health, despite some welcome initiatives such as the 2009 consultation by the then Junior Minister for Children and Youth Affairs entitled *Teenage Mental Health, what helps and what hurts*.[4]

## 2. Prevalence of mental health problems amongst children

The UN Convention on the Rights of the Child (CRC) defines a child as anyone below the age of 18, unless under the law, children attain majority earlier. In Ireland, the issue of who is considered a 'child' is treated differently in different contexts. Under the Mental Health Act 2001, a child is defined as anyone under the age of 18, however it is worth bearing in mind that Section 23 of the Non-fatal Offences Against the Person Act 1997 provides for children aged 16 and over to consent to surgical, medical and other treatment.

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[1] Alcohol Action Ireland, Amnesty International Ireland, ASTI, Barnardos, Bodywhys - The Eating Disorders Association of Ireland, Border Counties Childcare Network, CARI Foundation, Children in Hospital Ireland, Children's Rights Alliance, College of Psychiatry in Ireland, Dáil na nÓg, Educate Together, EPIC (Empowering Young People in Care), Foróige, Headstrong, ICTU, INCADDS, Inclusion Ireland, Inspire Ireland, Integrating Ireland, INTO, Irish Association of University & College Counsellors, Irish Branch of the Association for Child and Adolescent Mental Health, Irish Mental Health Coalition, Irish Penal Reform Trust, Irish Primary Principals Network, Irish Refugee Council, Irish Secondary Students' Union, ISPCC, Mater Child & Adolescent Mental Health Service, Miss Carr's Children's Services, Mothers Union, Mounttown Neighbourhood Youth and Family Project, National Association for Parents Support, National Association of Principals and Deputy Principals, National Parents Council, National Youth Council of Ireland, One in Four, Pavee Point, Psychiatric Nurses Association, Society of St. Vincent de Paul, Spunout, St. Patrick's Hospital, The Psychological Society of Ireland, Youth Advocate Programmes Ireland, Youth Health Programme, Base Youth Centre.

[2] http://www.who.int/features/factfiles/mental_health/en/index.html

[3] http://www.mhcirl.ie/documents/publications/The_Economics_of_Mental_Health_Care_in_Ireland%202008.pdf

[4] http://www.dcya.gov.ie/documents/publications/MentalHealthWhatHelpsAndWhatHurts.pdf

While it is important not to pathologise childhood, the World Health Organisation (WHO) suggests that worldwide up to 20 per cent of children and adolescents experience a disabling mental health problem. The range of childhood mental health diagnoses include depression, anxiety disorders, eating disorders, attention deficit hyperactivity disorders (ADHD/HKD); and more rarely, serious forms of mental distress can begin in childhood, such as schizophrenia and bipolar disorder. Mental health problems increase in severity and prevalence during adolescent years, with self-harm and attempted suicide also increasing throughout the adolescent phase.
In its annual reports, the HSE made a number of findings in relation to children and adolescents with mental health problems.[5] In the course of the month of November 2010 a total of 7,907 cases were seen, 7,136 (90.2 per cent) of these cases were returns and 771 (9.8 per cent) were new cases.

## 3. The current environment for children's mental health

*Mental health legislation*
The Mental Health Act 2001 is the main piece of Irish legislation relevant to children and mental health. It contains provisions in relation to the involuntary admission and detention of children as well as provisions relating to the administration of treatment to children. Unlike in the case of adults, Mental Health Tribunals, the review and appeals mechanism, do not review admission or renewal orders relating to children under the 2001 Act. Neither do Mental Health Tribunals have any role to play regarding the administration of treatment in the case of children. The Act gives little voice to children in their admission or treatment – consent is given or withheld by the parent in the case of all children up to the age of 18 years. Children in State care cannot enter an approved centre as a voluntary patient as social workers with the Health Service Executive cannot consent in *loco parentis* to psychiatric treatment. They must therefore be admitted as involuntary patients.

*Mental health services for children and young people*
The Coalition welcomes recent improvements in relation to children and adolescent mental health services, in particular the publication of the third Annual Report of Child and Adolescent Mental Health Services by the HSE. This type of data and analysis gives us a valuable insight into children's mental health. It is particularly encouraging to see an overall decrease in the waiting lists, an increase in the number of community mental health teams and the development of appropriate child and adolescent inpatient services. However it is critical this forward momentum is maintained and that any areas that are falling behind are addressed. In this regard, the Coalition welcomes the commitment in the HSE Service Plan 2012 to commit €7million to appoint an additional 150 staff to complete the multidisciplinary profile of the existing child and adolescent community mental health teams to include at least one from each profession. While this will represent a significant improvement, this is still below the staffing level for each multidisciplinary team set out by *A Vision for Change,* which recommends two psychologists, two social workers and two nurses per team. Furthermore, in a climate of mass retirements from the public service and a public recruitment freeze, the Coalition would like to ensure that this progress is not offset by the loss of existing staff from community teams.

[5] Health Service Executive [2011] 'Third Annual Child & Adolescent Mental Health Service Report 2010-2011' available at:
http://www.headstrong.ie/sites/default/files/My%20World%20Survey%202012%20Online.pdf

The HSE Third Annual CAMHS Report shows that 1,897 children and adolescents were waiting for an appointment at the end of September 2011. This does represent a decrease of 20 per cent from the total number waiting at the end of September 2010. Of these, 288 children had been waiting more than a year, down from 396 the previous year. While there has been an improvement, the numbers waiting for an appointment are still significant: there were 479 children waiting six to twelve months and 475 children waiting three to six months during that period.[6] In the context of a child's life, the passage of several months before receiving an appointment for a mental health problem is of serious concern. It is hoped that the additional staff promised under the 2012 service plans will lead to further improvements in this regard. While it is clear that significant efforts continue to be made to reduce waiting times, ideally, no child should be waiting more than six weeks for an appointment.

The Coalition is concerned that the recommendations in *A Vision for Change* of 13 child and adolescent mental health teams for children with an intellectual disability have not been met. Coalition members have reported that children with intellectual disabilities and children with autism currently have limited access to community mental health teams.

*Services for Young People of 16 and 17 years of age*

It is evident that the current level of service provision by the HSE in the community is inadequate to provide the full range of supports recommended in *A Vision for Change*. In particular there is a concern that the needs of 16-17 year olds are not being adequately catered for. The Coalition is concerned that these inadequate resources are impacting on teams being able to meet the needs of these young people age 16 to 18. There is also a need for better transition arrangements for children transferring to adult services. The HSE Third Annual CAMHS Report shows that of the 55 community teams, only 9 accepted referrals of young people up to and including 17 years, with a further 3 teams accepting young people up to and including 16 years. However, 39 of the 55 teams do not see new cases aged 16/17 years but do continue to see existing open cases beyond their 16th birthday where appropriate.[7]

*Inpatient facilities*

The Government must continue its work to end the practice of admitting children to adult wards, a practice described as 'counter-therapeutic' and 'almost purely custodial' by the Inspector of Mental Health Services. To this end, it is vital that the new inpatient facilities in Cork and Galway are fully operational as soon as possible and that the additional child and adolescent beds promised in the Third Annual CAMHS Report become fully operational during 2012.[8] The HSE has committed to increasing the number of beds available to 66 during 2012.[9] This will require not only the delivery of the promised infrastructure, but also the appropriate multi-disciplinary staff to be put in place. The Coalition is concerned about recent reports in relation to staff shortages in the new unit in Galway. The Coalition would like to emphasise the need for staff to receive adequate training in how to work with young people, including adequate training in how to manage challenging behaviour and the use of de-escalation techniques.

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[6] *Ibid,* section 3.1, page 16.
[7] *Ibid,* page 45
[8] The Third Annual Mental Health Service Report 2010 – 2011 outlines the planned development of child and adolescent inpatient units. Two additional units are expected to open in Dublin in 2012: a 12 bed adolescent unit in at St. Joseph's Adolescent Unit, St. Vincent's Hospital Fairview; an interim 8 bed unit at St. Loman's Hospital, Palmestown in Dublin, followed by a new 24 bed unit in Cherry Orchard, Dublin, which is currently at design stage
[9] *Ibid*, p. 35

The fact that nine of the 13 children admitted to adult psychiatric units during the first nine months of 2010 were admitted to an adult psychiatric unit in Limerick prompted the Mental Health Commission to initiate an investigation into the decisions[10]. The report found that the practice of admitting patients for an inpatient period of assessment and treatment is out of step with the rest of the country and carries significant risks[11]. This highlights the need for care plans for each child with mental health needs which have a family centred and multi-disciplinary approach.

*Early years*

The Coalition welcomes the development of the first early years strategy and believes it is crucial that this includes a strong focus on mental health and social and emotional well-being in the form of support for parents and to children in the pre-school phase of their life. This should include both universal policies that are relevant to all communities as well as more targeted support to communities affected by poverty or to families that are identified as being in need of additional support. Evidence shows that early years are a particularly decisive time and that early investment in parents during the first three years of a child's life can have a major impact on the child's mental well-being. This can be especially true for children at risk of poverty[12]. The most successful methods in preventing mental health problems for children are those that take place as early as possible, such as at the time of birth and even during pregnancy. Positive interventions are those "which improve and enhance the well-being of the mother and of the baby and promote the mother-infant bond, and which take into consideration the psychosocial aspects of pregnancy, promote good early parent-child interactions, attachment, support problem-solving skills of the parents, and underline the roles of fathers"[13].

Positive mental health and well-being amongst children can be greatly helped during these early years; childcare services can potentially play a very important role in this regard. Mental health difficulties that establish themselves during these years can bring about a greater propensity for mental ill health in later years[14]. Hence prevention from an early age is often key.

*Mental health in the education system*

There is no evidence that an appropriate level of services has been put in place to meet the needs of these children in a school setting. As a result of personnel constraints, the National Educational Psychological Service (NEPS) must concentrate most of its work on making assessments of educational need/difficulty/disability (which may or may not be linked with mental health difficulties) rather than focusing on working with schools for best outcomes for students who are so assessed. The NEPS remit does not focus on or support clinical mental health difficulties. Instead, the needs of children and young people with

[10] Dr. Sally E. Bonnar, Report for the Mental Health Commission on Admission of Young People to Adult Mental Health Wards in the Republic of Ireland, December 2010.
[11] Ibid, 4.6. The risks identified were as follows: The formal use of paediatric beds to care for children with mental illness is risky even with support from mental health services except for very short term care such as physical care of a severely ill anorexic patient. It is impossible to influence the ward milieu and the isolation inherent in being the only mental health patient in a ward is not conducive to good care. In addition, nursing staff seldom have mental health training and are unaccustomed to phenomenology in mental illness and the use of psychotropic medication.
[12] Childhood Development Initiative, Preparing for Life, Youngballymun, Joint Submission to Public Consultation on Improving the Lives of Children and Young People.
[13] The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care, http://www.scotland.gov.uk/Publications/2005/10/2191333/13337, p.26
[14] ibid

mental health difficulties are responded to via the local health services, which do not seem capable for similar reasons of providing speedy early interventions. Furthermore, implementation of the Education for Persons with Special Educational Needs Act 2004 has been deferred until further notice. The recent cuts announced by Government in relation to guidance counsellors are of concern, particularly in schools where they were qualified to provide counselling services, as this will lead to less opportunity for students to have one-to-one time with guidance counsellors, resulting in less support for students experiencing mental health problems.

From consultation with member organisations of the Coalition it is clear that schools and early years' providers are not currently equipped to adequately promote mental health or support children with mental health problems. Of central concern is that schools are not fully aware of the available supports and services. The Government should therefore establish a national directory with comprehensive information on the types of services available and what each service provides in each region, indicating contact and referral pathways to them.

Inter-departmental guidelines are currently being drafted on the "whole school approach" to mental health for schools. This approach attempts to change the ethos of the school in relation to mental health and includes all stakeholders. The Coalition strongly recommends that as well as addressing a whole school approach to mental health promotion, these guidelines must also address practical difficulties which schools experience in promoting, addressing and supporting the mental health needs of individual students. The guidelines should provide clear procedures on how teachers can raise concerns about individual students' mental health difficulties as well as training and supports for teachers in how to promote positive mental health both through the curriculum and through a whole school ethos, respond appropriately when mental health needs arise and support mental health needs once identified. The guidelines should also aim to improve linkages between schools and mental health services, including mechanisms for support and referral to NEPS and CAMHS.
The Coalition also welcomes the Minister for Education and Skills commitment to establishing a working group to tackle bullying. The Coalition hope that this working group will view the issue in the context of a whole school approach, not only to bullying, but also to mental health and well-being in schools, as the issues are very much inter-related. It would be regrettable if tackling bullying in our schools did not do so within the context of student's mental health and emotional well-being.

*The mental health needs of children in the care system*

Currently the mental health needs of children in care are not being adequately met. There is no framework for assessing the mental health or emotional and behavioural needs of a child when entering the care system. Many children in the care of the State end up in special care or secure care units where they are held in civil detention because the child's behaviour poses a real and substantial risk to the child's health, safety, development or welfare. In fact, the State does not have a sufficient number of places to cater for these children and currently operates a waiting list.[15] In some cases, the mental health needs of these children have not been addressed by the care system. A number of children in special care are sent out of the jurisdiction to secure care facilities in other countries such as Sweden, Scotland and even the United States as we do not have the facilities to address the mental health and other needs of these children in Ireland. In December 2011 there were 17 children in the care of the State that were in placements outside of Ireland,

15 According to Frances Fitzgerald, Minister for Children, Dáil Debates, 15/12/2011, Vol. 750, no. 2

with eight of these in secure care, due to the absence of sufficient appropriate therapeutic facilities to treat these children in Ireland.[16]

The Coalition has called on the Government to develop a national framework for mental health assessment for children in care and to ensure that the HSE delivers the necessary follow up services. Since the adoption of the Ryan Report Implementation Plan in summer 2009, there have been some improvements in the care system, including an increase in the numbers of social workers employed and in the provision of care plans to children in care. It is hoped that these measures will lead to improved care for the needs of children in care, including their mental health needs.[17] The Coalition welcomes the establishment of the Child and Family Support Agency which is under the remit of the Department of Children and hopes that this will mark a new departure in terms of meeting the mental health needs of children in the care system. The Coalition is concerned that a small number of children in the care system continue to be sent to secure care other jurisdictions as there are no facilities to meet their mental health and other needs in Ireland.

In October 2010, the HSE signed off on the development of a new service called the Assessment, Consultation and Therapy Service (ACTS) which seeks to address the mental health needs of children in detention and children in special care and high support units. The proposal also plans to meet the needs of children in the care system who are at risk of entering special care or high support units. While this is a welcome development, the proposal does not include a national assessment standard for all children in care with provision for all those with an identified need to follow-up support and treatment. It is essential that the mental health needs of children in care are identified at a much earlier stage, given the vulnerability of these children, and that supports are put in place before those needs reach a crisis point. Services should also be tailored to meet the mental health needs of children in need of aftercare services. This should include addressing the mental health needs of families whose children are at risk of entering the care system.

The Coalition is also concerned about the mental health needs of children in direct provision and separated children who have very particular mental health needs that need to be fully met. The direct provision system of institutional communal living is not well designed for, nor supportive, of childhood or parenting. In many cases parents and children are living in one room for extended periods, with little space for children to play or do their homework; parents are unable to engage in study and work; and many experience anxiety and depressing as they await a decision on your immigration status. The majority of separated children now live in foster families until they reach 18 years old and are then usually transferred to direct provision accommodation. A lack of aftercare support places this group at high risk. For separated children, the shift from Dublin-based accommodation to a system of foster placements throughout the country is challenging. Much expertise and supports have been developed in Dublin over the past decade to meet these needs. Access to similar supports, either at the community level or in Dublin, is critical to ensure that the mental health needs of these children are adequately met.

Specialised Child and adolescent community mental health services (Community CAHMS) should be resourced to provide outreach services to vulnerable children, such as separated children, homeless children, children in need of aftercare services

16 Ibid

17 The HSE's Performance Monitoring Report for September 2011 shows that the recruitment process to fill the 64 outstanding social worker posts approved in the National Service Plan 2010 is still ongoing, as is the 60 WTEs development posts set out in the National Service Plan 2011

and those living in local direct provision centres. It is important that such services are multi-disciplinary and are appropriately bedded into the existing community CAMHS. HSE CAMHS and the New Child and Family Support Agency should have joint responsibility for meeting the mental health needs of children in the care system. There is also a need to establish responsibility for identifying and meeting the mental health needs of mothers and families who may be in need of support. In addition, where reporting procedures are made under the new Children's First legislation, and where child protection concerns may be ruled out, it is important that responsibility is established and referral pathways identified to identify and meet the mental health needs of parents and children who were the subject of the report.

*The mental health needs of children in the youth justice system*

The Coalition has called on the Government to provide mental health services to children with mental health difficulties who come before the courts and for children in detention as envisaged in *A Vision for Change*. A system for addressing the mental health needs of these children is urgently needed. The Coalition welcomes the fact that the functions of the Irish Youth Justice Service (IYJS) that relate to detention schools for children transferred from the Department of Justice and Equality to the Department of Children and Youth Affairs. Many children with mental health issues may end up in the youth justice system because they have not been given adequate early intervention support. Currently neither the Courts Liaison nor Prison In-reach Service provides a nationwide service to children and adolescents, while services to young people in detention schools are lacking.[18] The Prison In-Reach and Courts Liaison Service should be extended nationwide and apply to children as well as adult prisoners, so that suitable children can be diverted to local in-patient services instead of being committed to detention centres. Children at particular risk are not being provided for. For instance, 83 per cent of children in a detention school were identified by a 2007 UCD study as having at least one form of "mental disorder", the vast majority of whom were receiving no mental health health service. [19]

The Assessment, Consultation and Therapy Service (ACTS) proposal discussed above, which seeks to address the mental health needs of children in detention and children in special care and high support units, to include a forensic mental health team and an in-reach service for St. Patrick's Institution. The most recent inspection reports for the detention schools state that the IYJS has carried out an internal review of the mental health needs of children in the detention schools. The inspection reports also reference the ACTS service. It is imperative that this service is now put in place without delay and that the identified needs in the IYJS internal report are met. The new service should include a national assessment standard for children in detention for all those with an identified need, follow-up support and treatment provided, both in detention and/or at community level post release. Treatment should be multidisciplinary and ensure that there is a holistic approach in dealing with these young people. The Coalition notes that the multidisciplinary teams proposed in the ACTS document does not include an Occupational Therapist (OT). The input of an OT is particularly important in the context of children with offending behaviour or

[18] The most recent Health Information and Quality Authority (HIQA) inspection of Oberstown Boys' Detention School found that the school still has no access to child and adolescent mental health services. Similarly, HIQA's inspection in April and May of 2010 found that while staff were making arrangements for child and adolescent psychiatric services for children at Trinity House Detention School, there was still no final determination on how this service would be delivered. (HIQA, 'Oberstown Boys' Detention School Inspection Report ID Number: 454, published 18 August 2011 and 'Trinity House Children Detention School Follow-up Inspection Report ID 453, published 4 November 2010 at www.hiqa.ie)

[19] http://www.ucd.ie/news/may07/051807_research_det.html

children in secure care as support in managing their life is often key to their re-integration into family, school and community life post release.

A needs analysis and an examination of best Irish practice should commence. The Coalition is of the view that current changes in the policy environment could facilitate the introduction of innovative policy to meet the mental health needs of young people in contact with the law, specifically the recently appointed Minister for Children and Youth Affairs, the transfer of the IYJS to the Department of Children and Youth Affairs, the HSE Governance Bill and the establishment of the Child and Family Welfare Agency, as well as the approval of funding and posts for the new ACTS Service. However, as addressed above in relation to children in the care system, there are gaps in the ACTS proposal in terms of the mental health needs of children in the youth justice system which are outside of the scope of ACTS. There is a need for a comprehensive Government policy to address the mental health needs of children who come into contact with the youth justice system in various ways: children with patterns of offending behaviour, children coming before the children's court, children on bail or on remand, children in detention and post-release.

The Coalition welcomes the Government's commitment that children under 18 will no longer be sentenced to St. Patrick's Institution. The Ombudsman for Children, in a report about St. Patrick's Institution states that she is deeply concerned about young people's accounts as regards their perceptions and experiences of being in the special observation cell in St Patrick's Institution. [20] These accounts indicated that young people are anxious and fearful about the special observation cell and that they regard aspects of placement in 'the pad' as degrading. The Inspector of Prisons has reported that at any one time, a third of those detained in St. Patrick's Institution request to be held 'on protection' as they fear for their own safety.[21] This involves up to 23-hours a day lock up in single protection cells, with limited access to education, physical activity and association with other prisoners. There were eight children on protection as of 31 October 2011.[22] This regime can only have a severely negative effect on the mental health of these vulnerable children. The Ombudsman for Children strongly recommended the implementation of measures to address this unacceptable inconsistency between the intended purpose of the special observation cell and how it is perceived and experienced by young people themselves.[23] There has been no implementation of these recommendations to date.

The Coalition welcomes the recent announcement that the Ombudsman for Children's remit will be extended to include St. Patrick's Institution. The Coalition is very concerned about the continued detention of exisiting children and young people in St. Patrick's Institution who have not been transferred, and particularly the negative impact this adult regime has on the mental health of the children detained. It is crucial that the mental health needs of children and young in St. Patrick's Institution are met as a matter of priority. The pilot in-reach mental health service introduced by The Central Mental Hospital to St. Patrick's Institution should be extended and continued in anticipation of the refurbishment of children's detention schools or the building of a new National Detention Facility, and the implementation of the ACTS proposal outlined below.

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[20] *Ibid* at p.37.

[21] Inspector of Prisons (2010) *The Irish Prison Population – an examination of duties and obligations owed to prisoners,* Office of the Inspector of Prisons, p.81. See Children's Rights Alliance, Report Card 2012, *Is the Government Keeping its promises to Children?* p.59.

[22] See Children's Rights Alliance, Report Card 2012, *Is the Government Keeping its promises to Children?* p.59.

[23] The 2007 Prison Rules permit its use and clearly state when and how it may be used. Exceptional circumstances may arise when a young person under 18 requires observation for medical reasons or by virtue of presenting an imminent risk of injury to himself and/or others.

## 4. Responses to consultation questions

### Question 1 (a): In your opinion, what are the 3 best things about life for children and young people in Ireland?

A survey of children's health and well-being found that more than 90 per cent of Irish children aged 9-17 are happy with their lives[24]. Nevertheless, the National Disability Survey conducted in 2006 found that 9,900 children aged 0-17 had an emotional, psychological or mental health disability. Almost two in three young people in Ireland are 'unable to cope with the problems they face' according to a report launched in March 2009 by Headstrong, the National Centre for Youth Mental Health[25].

### Question 1 (b): In your opinion, what are the 3 worst things about life for children and young people in Ireland?

The 2012 Headstrong My World Survey, which conducted a national study of youth mental health in Ireland from the ages 12-25 years, found that "the majority of young people were found to be functioning well across a variety of mental health indicators. Interesting findings emerged when we looked at our data across the age span of 12-25. It was evident that mental health difficulties emerged in early adolescence and peaked in the late teens and early 20s. This peak in mental health difficulties, in general, was coupled with a decrease in protective factors such as self-esteem, optimism and positive coping strategies. This stage in a young person's life, therefore, is a particularly vulnerable period."[26]

Pre-school childcare services are not good and evidence suggests that intervention at this point in time can help to ameliorate difficulties experienced later in life. Services for parents from pregnancy onwards are not widely available: supports and expert advice can make a crucial difference during this particularly important time[27].

### Question 2. What can be done so that children and young people are safe and protected?

The Government's 2006 national mental health policy, *A Vision for Change*, makes important recommendations for children: for improving and expanding mental health services for children including addressing the glaring gap in provision for 16 and 17 year-olds; for promoting emotional well-being and prevention of mental health difficulties; and for cross-departmental action, in particular regarding the crucial role of the formal and informal education system. It has respect for human rights as an underlying core value/principle, to guide all planning and decision-making. The Government should fully implement this policy.

Similarly the very early years of life can be crucial to mental health outcomes. The development in the first three years can greatly affect the mental well-being of children. Informal supports are often in place for many families and children, but informal supports cannot be relied upon universally.

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[24] Hanafin, S., Brooks, A.-M., Macken, A., Brady, G., McKeever, R., Judge, C., Ryan, B., Nic Gabhainn, S. & Gavin, A. (2008). *State of the Nation's Children: Ireland 2008.* Dublin: Department of Health and Children.

[25] *Somewhere To Turn To, Someone To Talk To*. Just 38% of young people reported being able to cope with the problems they face; only 64% reported having an adult available to them to talk through their problems regularly; 47% reported having been bullied at some point in their life; and 10% reported that they have had serious problems and have not sought professional help.

[26] http://www.headstrong.ie/sites/default/files/My%20World%20Survey%202012%20Online.pdf pvii

[27] Childhood Development Initiative, Preparing for Life, Youngballymun, Joint Submission to Public Consultation on Improving the Lives of Children and Young People. p3

**By families:** An important aspect of the multidisciplinary nature of community mental health teams is that services provided should be family centred. Each child with mental health needs should have an up-to-date care plan, which has a recovery focus. This care plan should be multi-disciplinary and take a family centred approach to ensure that the family are empowered to support the recovery of the child.
Informal supports provided to parents and infants are often invaluable. However independent expertise and supports should be made available to parents of infants from pregnancy onwards to help families during this sensitive time, and in turn help the mental wellbeing of children.
**By communities:** Children with autism and children with an intellectual disability should have access to community mental health teams. Specialist mental health services for children with autism and children with an intellectual disability should also be put in place in line with *A Vision for Cha*nge.
Appropriate community services to support parents from pregnancy to school years should be co-ordinated.
**By Government:** Provide age-appropriate and specialist mental health services for children. This will require both adequate, age-appropriate inpatient bed capacity and development of day patient and community-based care services that minimise the need for inpatient care. The Government should establish a national directory with comprehensive information on the types of services available and what each service provides in each region and how schools can access them.
There is currently no infant mental health strategy in place. This can be an especially stressful time for parents and a time when they can be in particular need of support. Lack of support at this time can increase children's susceptibility to mental health difficulties later in life. An infant mental health strategy would help with greater positive outcomes for children later in life.

**Question 3. What can be done so that children and young people can enjoy learning in all aspects of their lives?**

Education is a key context for addressing children's mental health. Article 29 of the UN Convention on the Rights of the Child outlines that the aim of education should be directed to "the development of the child's personality, talents and mental and physical abilities to their fullest potential." Article 23 draws particular attention to the State's obligation to assist children with disabilities: "Recognising the special needs of a disabled child, assistance… shall be designed to ensure that the disabled child has effective access to and receives education, …preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development."

For children aged between 5 and 12, schools provide an ideal setting for the promotion of positive mental health. Adolescence is a key stage of psychological development when children require an understanding of the life challenges they face and need to develop basic skills to cope with difficult emotions, and an important time for early identification and intervention. Article 24(2)(e) of the CRC requires states to adopt all appropriate measures to "ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health".

Schools can also act as an early identification and referral point for any mental health difficulties. Early identification of any problems is an important factor in successful treatment. Poor early identification and referral in schools further disadvantages

children with mental health difficulties. Where timely and appropriate interventions are provided for young people with mental health difficulties, there is clear evidence that many recover or at least develop coping strategies to manage their problems more effectively.

The WHO advises:

"The importance of schools in the provision of mental health related services for children and adolescents is crucial. In some settings schools can be a primary venue for the delivery of diagnostic and treatment services, and in others the school can serve as a support for getting primary treatment elsewhere. Schools in all cases are to be viewed as a potential resource for the recognition of children and adolescents in need of formal diagnosis and treatment."[28]

**By families/ By communities:** Research shows that mental health promotion programmes can be effective in equipping people with the skills necessary to avoid or deal with mental distress. Studies indicate that the whole-school approach is the most effective approach to mental health promotion. This involves students, school staff, parents as well as key community groups.
**By Government:** The Government should take steps to ensure schools and early years settings engage in mental health promotion and provide early supportive intervention. The years prior to enrolment in school are vital in this regard; early intervention with parents can lead to a much improved positive mental health outcome for children with consequent positive affects during schooling years.

**Question 4: What can be done so that children and young people are healthy and active?**

School-based mental health programmes can have positive effects for students in terms of: behaviour and self-control;

- Social and emotional skills;
- Ability to learn and achieve academically;
- Problem-solving in social settings.

The biggest challenges to implementing mental health promotion programmes in schools are: funding, timetabling, programme fidelity and achieving full participation from all stakeholders. While researchers argue that mental health programmes are most effective between the ages of 2-7, many of the programmes available around the world target children older than this.

Health promotion is about realising people's potential to make them more resilient and involves building strengths, competencies and resources. Characteristics of successful mental health promotion programmes are:[29]

- Good theoretical and research base;
- Clarifying key goals and objectives;
- Evaluation and high quality research methods;
- Infrastructural support from management;
- Programme fidelity, not re-invention; and
- Transferability between countries and cultures.

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[28] WHO (2003) 'Caring for children and adolescents with mental disorders: Setting WHO directions', Geneva: World Health Organisation.
[29] Barry, M. (2007). *Generic Principles of Effective Mental Health Promotion. International Journal of Mental Health Promotion*.

**Question 5: What do children and young people need to feel economically secure?**

The CRC recognises the right of every child to a standard of living adequate to his or her physical, mental, spiritual, moral and social development (Article 27) and requires States Parties to take effective measure to protect children from all forms of violence, abuse, neglect and exploitation (Articles 19, 32-36 and 38).[30]

The prohibition of cruel, inhuman and degrading treatment and torture and the prohibition of arbitrary deprivation of liberty are also expressly covered by the CRC (Article 37). Specifically Article 37 requires that "every child deprived of their liberty shall be treated … in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so".

Article 3(3) is also of relevance with regard to mental health services for children. This requires State Parties to establish standards for institutions, facilities and services responsible for the care or protection of children particularly in the areas of health, safety and the number, qualifications and supervision of staff.

**Question 6: What can be done so that children and young people have a say in decisions that affect their lives?**

It has long been acknowledged that the protection afforded to children's rights in the Irish Constitution is inadequate. The commitment to constitutional change to strengthen children's rights in this regard is therefore very welcome. The absence of an explicit statement of children's rights in the Constitution means that children are often ignored in decision-making processes that affect them and that law and policy are insufficiently informed by the rights of the child.[31] Article 12 of the CRC states:

" 1. State Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law."

The UN Committee on the Rights of the Child, having considered Ireland's second report on implementation of the CRC recommended that the child's right to participate and to be heard should be included in the Irish Constitution. In a report commissioned by the Ombudsman for Children on the *Barriers to the Realisation of Children's Rights in Ireland*, the invisibility of children and children's rights in the process of law and policy and in government decision-making were identified as the main barriers. One of the key issues identified as contributing to this invisibility by the report is the "systematic failure to listen to the voices of children, to give due weight to their views and to appreciate the value of their contribution."[32]

Although the Office of the Minister for Children has carried out a number of initiatives in which children and young people have been involved, the report found that the

[30] Committee on the Rights of the Child, General Comment No. 4 (2003) Adolescent Health and Development in the context of the Convention on the Rights of the Child, para 12.

[31] Dr. Ursula Kilkelly, *Children's Rights in Ireland,* p. 82.

[32] Dr. Ursula Kilkelly, *Barriers to the Realisation of Children's Rights in Ireland*¸ Ombudsman for Children's Office, 2007, p.62.

culture of participation is lacking in many agencies, particularly State agencies and that there is a need to build structures at both local and central government levels to facilitate the participation of young people into this work. While the National Children's Strategy identifies listening to children as one of its three goals, there is no national plan or policy on consultation with children and no guidance and mechanisms regarding when to consult with children and how to take their views into account. In particular, the report found that marginalised children in particular faced additional barriers to having their voices heard.

The Ombudsman for Children has highlighted the importance of including a provision on the voice of the child in the Constitution to facilitate a change in culture regarding children's rights across the full range of public administration. Ensuring that the child has an opportunity to express their views is of particular importance in the context of children engaging with mental health services. The 2001 Mental Health Act, deals with involuntary admission to inpatient facilities, consent to treatment and review of detention. In relation to the voice of the child, the 2001 Act does not currently make any provision for independent advocacy services, either for adults or young people. The Steering Group reviewing the Mental Health Act have recommended consideration of advocacy supports for children and a separate section on children be developed when the Act is reviewed. [33] The Coalition would welcome this development and would urge that the National Children's Strategy ensures the voice of the child is strengthened.

**By Government:** Procedures and mechanisms should be put in place to ensure that the voices of children are heard, particularly in relation to policy making and decision making that affects them.

**Question 7: What can be done to help children and young people behave positively and to be good citizens?**

Clarke and Barry (2010) show that programmes which adopt a whole-school approach are particularly likely to lead to positive mental health, social and educational outcomes. The whole-school approach is favoured by many experts in the field of mental health promotion as it involves students, staff, parents and is sustained over time; factors which tend to make intervention more successful.

Mental health promotion in schools has the following benefits:

- Improvements in behaviour and self-control;
- Improved social and emotional skills;
- Increased ability to learn and achieve academically; and
- Improved problem-solving in social settings.

Clarke and Barry (2010) write that without intervention, emotional and behavioural problems in young people may be less amenable to intervention after eight years of age, resulting in an escalation of academic problems, antisocial behaviour and eventual school drop-out in later years.

**Question 8: What can be done to help young people move confidently into adulthood?**

International best practice shows that mental health services need to be provided from childhood to early adulthood. The International Youth Declaration on Mental Health advocates that young people who require specialist intervention between the

[33] http://www.dohc.ie/publications/pdf/int_report_sg_reviewMHA_new.pdf?direct=1

ages of 12-25 years should experience continuity of care as they make the transition from adolescence to emerging adulthood. The declaration challenges the present configuration of systems arguing they are currently weakest where they should be strongest. This goes beyond requiring more appropriate levels of resource, essential as this is. The Declaration argues that a fundamental shift in how we think about and respond to the mental health needs of our young people is required. [34] The Government should consider how young people experience the transition from child and adolescent services and to adult services.

**5. Recommendations for the new National Children's Strategy**

The Coalition recommends the second National Children's Strategy should consider the following:

*Overarching recommendations:*

- The need for **a specific section on the mental health needs of children and young people**. In line with the intention of the National Strategy to be outcomes focused it should include a specific outcome in relation to mental health. The section should explicitly deal with mental health services and supports, mental health in the education system and the mental health needs of children in care and in the youth justice system.
- The new strategy should **expressly use the Convention on the Rights of the Child** as a guiding framework and clearly state how it will implement this Convention. **Consideration should also be given to the Convention on the Rights of Persons with Disabilities and other human rights laws** and standards of relevance to children and young people.
- The strategy should **clearly reference how the cross departmental action on children and youth mental health will occur**, in particular with the Department of Health, the Department of Justice, Equality and Defence and the Department of Education and Skills. This should set out aims, actions, activities, named senior post holder accountable for delivery of the actions, timelines and budgets.

*Mental health services for children*

The National Children's Strategy should consider how the Government could:

- Provide age-appropriate and specialist mental health services for children. This will require both adequate, age-appropriate inpatient bed capacity and development of day patient and community-based care services that minimise the need for inpatient care.

*Mental health in the education system*

The National Children's Strategy should consider how the Government could:

- Take steps to ensure schools and early years settings engage in mental health promotion and provide early supportive intervention.

*The mental health needs of children in the youth justice system*

The National Children's Strategy should consider how the Government could:

- Provide mental health services to children with mental health difficulties who come before the courts and for children in detention as envisaged in *A Vision for Change*.

[34] http://www.drugsandalcohol.ie/16297/1/YMH-Declaration_full-version_september-2011.pdf

For more detailed recommendations see:
http://www.dohc.ie/publications/vision_for_change_5th/hse_local/childrens_mental_health_coalition.pdf?direct=1.

## 6. Overview of international human rights law and standards relating to children and mental health

The International Bill of Rights (which comprises the Universal Declaration of Human Rights (UDHR), the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR)) applies to all persons, including children. The most relevant overarching right covered by these instruments in the context of mental health is the right to the highest attainable standard of physical and mental health (Article 12 ICESCR). It is well established that this does not equate to a right to be healthy; instead this right contains both freedoms and entitlements and is closely linked to and dependant on the realisation of other rights, such as the right to food, housing, work, education, non-discrimination, privacy and the prohibition against torture, cruel, inhuman and degrading treatment and punishment.[35] The right to health requires that health services, goods and facilities, including the underlying determinants of health are available, accessible, acceptable and of adequate quality.[36]

As a State Party to the ICESCR, Ireland is bound to respect, protect and fulfil the right to the highest attainable standard of mental health of all persons, including children. While the ICESCR requires Ireland to take steps "to the maximum of its available resources, with a view to achieving progressively" the right to the highest attainable standard of mental health, it also imposes immediate obligations on the State, including, for example, that there be no discrimination of any kind in the protection of the right to health.[37] The requirement of progressive realisation requires the State "to move as expeditiously and effectively as possible towards the full realisation of Article 12" and retrogressive measures are impermissible, save in the most exceptional of circumstances.[38]

The CRC, which was adopted by unanimous resolution of the United Nations General Assembly on 20 November 1989 and entered into force on 2 September 1990, is the most widely ratified international human rights convention. Some 193 States Parties, including Ireland have signed and ratified this Convention. The CRC includes both civil and political rights and economic, social and cultural rights; it sets minimum standards pursuant to which States must respect, protect and fulfil the full spectrum of human rights of every human being below the age of 18 years. The CRC has been credited with bringing about "an understanding that children are not the property of parents or guardians, nor objects of generosity or goodwill, but are rights-holders, just like adults".[39] Its provisions represent and reflect the meaning of a rights-based approach to children's issues and services.[40]

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[35] Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000) on the right to the highest attainable standard of health E/C.12/2000/4, paras 3 and 8.

[36] Report of the Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health Paul Hunt 11 February 2005, E/CN.4/2005/51, para 46.

[37] *Ibid* para 30.

[38] *Ibid* paras 31, 32.

[39] Louise Arbour 'Happy Birthday' in *18 Candles: The Convention on the Rights of the Child Reaches Majority* (Institut international des droits de l'enfant, Switzerland, 2008) 7, available at http://www.ohchr.org/Documents/Publications/crc18.pdf, accessed on 25 February 2009.

[40] Committee on the Rights of the Child 'General Comment No 5 *General Measure of Implementation of the Convention on the Rights of the Child* CRC/GC/2003/5 (2003) cited in U Kilkelly *Barriers to the*

The obligations of States Parties set out in the CRC are underlined by the key principles of non-discrimination (Article 2), best interests of the child (Article 3), respect for the views of the child (Article 12) and recognition of the evolving capacities of the child (Article 5).[41]

The CRC contains a number of provisions that are of particular relevance in the context of mental health. Article 24 recognises the right of the child to the highest attainable standard of health and requires State Parties to "strive to ensure that no child is deprived of his or her right of access" to health care services for the treatment of illness and rehabilitation of health. The Committee on the Rights of the Child has emphasised the importance of prevention, early intervention and multidisciplinary care in the protection of the right to the highest attainable standard of health.[42] The CRC also contains special provisions relating to children with physical and mental disabilities, in recognition of the fact that additional measures may be required to ensure that such children achieve the fullest possible social integration and individual development (Article 23). Article 25 requires that States "recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement".

The CRC recognises the right of every child to a standard of living adequate to his or her physical, mental, spiritual, moral and social development (Article 27) and requires States Parties to take effective measure to protect children from all forms of violence, abuse, neglect and exploitation (Articles 19, 32-36 and 38).[43] Article 38 requires the State to "take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of any form of neglect, exploitation or abuse".

The prohibition of cruel, inhuman and degrading treatment and torture and the prohibition of arbitrary deprivation of liberty are also expressly covered by the CRC (Article 37). Specifically Article 37 requires that "every child deprived of their liberty shall be treated … in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so".

Also of relevance to mental health services for children is Article 3(3), which requires State Parties to establish standards for institutions, facilities and services responsible for the care or protection of children particularly in the areas of health, safety and the number, qualifications and supervision of staff.

While the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) is not child focused, the civil and political rights protected by that instrument are available to children and adults. The ECHR does not recognise the right to the highest attainable standard of mental health but it does include a number of rights and protections relevant to children who experience mental or emotional distress. So, for example, in 2002 the European Court of Human Rights held that the detention of a non-offending child with serious behavioural problems in St Patrick's Institution amounted to a breach of Article 5

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*Realisation of Children's Rights in Ireland* (Office of the Ombudsman for Children, 2007) available at http://www.oco.ie/policyResearch/research.aspx.

41 See MHC Reference Guide to the Mental Health Act, 2001 Part Two – Children, para 2.1 for a useful summary of relevant provisions of the UNCRC.

42 Committee on the Rights of the Child, General Comment No. 9 (2006) on the rights of children with disabilities, CRC/C/GC/9.

43 Committee on the Rights of the Child, General Comment No. 4 (2003) Adolescent Health and Development in the context of the Convention on the Rights of the Child, para 12.

(right to liberty and security).[44] Although there is no express right of autonomy or self-determination in the ECHR, Article 8 (right to private and family life) has been found to include this right by the European Court of Human Rights[45]. The right to bodily integrity is also protected under Article 8. Thus the European Court of Human Rights has held that Article 8 was breached by the administration of medication for a 'mental disorder' to the applicant against her will while she was informally detained in a psychiatric clinic.[46] Article 3 (prohibition on torture, inhuman and degrading treatment and punishment) imposes a positive obligation on the State to protect children from harm and ill-treatment.

While they do not have the status of binding international law, the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles)[47] provide useful guidance on the human rights of persons who may experience mental or emotional distress. They apply equally to all persons and require at the outset that special care be given to the protection of the rights of minors (Principle 2). While certain aspects of the MI Principles are widely criticised as outdated (including, in particular, the provisions relating to informed consent to treatment and involuntary admission to mental health institutions), they helpfully emphasise and have brought attention to the right to care and treatment in the community (Principle 7) and the right to the least intrusive treatment in the least restrictive environment in accordance with an individually prescribed treatment plan (Principle 9). The MI Principles also specify that care and treatment be provided to persons with mental health difficulties in accordance with the same standards as other ill persons (Principle 8) and that "the environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age" (Principle 13(2)).

Although Ireland was one of the first signatories to the United Nations Convention on the Rights of Persons with Disabilities (CRPD) it has not yet ratified the CRPD, which entered into force in May 2008. This means that while Ireland has indicated an intention to ratify the Convention, it is not yet legally bound by its provisions.

The CRPD moves towards a social model of disability and has been described as marking a 'paradigm shift' in attitudes and approaches to persons with disabilities, which are defined as including persons experience mental health difficulties. The CRPD does not create any new rights but reaffirms that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms on an equal basis with others.

The CRPD is built on principles including non-discrimination, respect for the inherent dignity, autonomy and freedom to make ones own choices, full and effective participation and inclusion in society and respect for the evolving capacities of children with disabilities (Article 3). It requires States to closely consult with and actively involve children with disabilities and their representative organisations in the development and implementation of legislation and policies to implement the Convention (Article 4(3)). The CRPD reaffirms the importance of the best interests of the child as a primary consideration in all actions concerning children with disabilities and requires States Parties to ensure that children with disabilities have the right to express their views freely on all matters affecting them and that their views be given due weight in accordance with their age and maturity, including by providing appropriate assistance to realise that right (Article 7). In relation to the right to the highest attainable standard of health, the CRPD expressly requires States Parties to

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44 *DG* v *Ireland,* judgment of 16 May 2002 (application number 39474/98).
45 *Pretty v UK,* judgment of 29 April 2002 (application number 2346/02).
46 *Storck v German,* judgment of 16 June 2005 (application number 61603/00).
47 Adopted by General Assembly resolution 46/119 of 17 December 1991.

"provide those services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate" (Article 25).

**7. Evidence of good practice in other jurisdictions**

Several countries around the world have school-based mental health promotion programmes. State bodies implement some of these while others are carried out by non-governmental organisations. Australia, for example, has several programmes. In Ireland, programmes such as Zippy's Friends, Mind Out and the Jigsaw Meath Project are being implemented in schools with positive outcomes being reported.

MindMatters is funded by the Australian Government and takes a whole-school approach to mental health and well-being, which focuses on the entire school community as well as the school environment. The approach is influenced by the WHO model for school mental health promotion. MindMatters helps schools and their communities to:

- create a positive climate of mental health and wellbeing;
- be pro-active in the promotion of mental health and wellbeing for all students; and
- support prevention and early intervention initiatives for young people with mental health and wellbeing challenges.

For further examples of models from other jurisdictions see: http://www.oireachtas.ie/parliament/media/housesoftheoireachtas/libraryresearch/spotlights/spotWellbeing280212_101701.pdf.

Since devolution and the establishment of the National Assembly for Wales in 1998, Wales has adopted a children's rights approach to the development of policy and structures to protect and improve the outcomes for children. A whole series of policies and structures have explicitly used the CRC as an underpinning.[48] The Coalition would also like to draw the Department of Children and Youth Affairs attention to *The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care* (2005) from the Scottish Executive and *Together for Mental Health: A Cross Government Strategy for Mental Health and Well-being in Wales* (2012) from the Welsh Government.

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[48] http://www.amnesty.ie/sites/default/files/file/INPLAINSIGHT_28_11_11_SINGLE_PAGES.pdf, page 343.