Children's Mental Health Coalition submission to the Health, Information and Quality Authority (HIQA) on the Draft National Standards for the Protection and Welfare of Children

Introduction and Summary Recommendations

The Children's Mental Health Coalition (the Coalition) welcomes this opportunity to make a submission to HIQA on the Draft National Standards for the Protection and Welfare of Children.[1] The Coalition welcomes the publication of these draft standards and commends HIQA and the various government departments on the extensive consultation which led to the publication of these draft standards. The Coalition particularly welcomes the fact that representatives from NGOs and non-statutory organisations providing services to children were included in the Standards Advisory Group for the development of the Standards.

In relation to section 2.5 of the Draft Standards, this initial assessment should include the child's mental health needs, or, in the case of a younger child/infant, their emotional/behavioural needs specifically. This would arguably be included in the initial assessment by a social worker. However, given that this initial assessment will ultimately become the care plan if the child is taken into care, including this wording or something similar in the guidelines would be a way of ensuring that an assessment standard for the mental health needs of children in care is in place. It would also help to ensure that child protection agencies and staff have a more consistent working relationship with and access to multi-disciplinary mental health teams.

Why is it important to explicitly include reference to mental health in the Standards?

Currently the mental health needs of many children in care are not being 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.[2] In some

[1] The Children's Mental Health Coalition was formed in 2009 to lobby Government for improvements in children's mental health in relation to mental health services, the education system, the youth justice system and the care system (see www.childrensmentalhealth.ie). It comprises 50 members representing groups from service providers, the education sector, human rights and children's rights organisations. (See Annex One).

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

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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, with eight of these in secure care, due to the absence of sufficient appropriate therapeutic facilities to treat these children in Ireland.[3]

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.[4] 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

[3] *Ibid*

[4] 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

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. CAMHS should be resourced to provide outreach services to vulnerable children, such as separated children, children in need of aftercare services and those living in local direct provision centres.

The lack of access to appropriate mental health assessments and supports reflects a broader issue of the inadequate provision of mental health services for children and young people more generally. The Coalition has called on Government to provide age-appropriate 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. 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*.[5] The Coalition is also concerned that these inadequate resources are impacting on teams being able to meet the needs of young people age 16 to 18, while 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.[6] The Report documents a clinical audit carried out in November 2010, during which time 13.7 per cent of cases seen by community teams were 16/17 years.[7] However, 16/17 year olds represented 68 per cent of admissions during 2010.[8]

- ***The Government should establish a national assessment standard for all children in care with provision for all those with an identified need for follow-up support and treatment.***

- ***The features to meet the requirements of standard 2.4 (all concerns in relation to children are screened and directed to the appropriate service) should make specific reference to mental health services.***

- ***Standard 2.5.4, which outlines what should be included in the initial assessment, should include express reference to the child's mental health and social and emotional needs.***

[5] The *Third Annual Child & Adolescent Mental Health Service (CAMHS) Report* shows there was an increase of 6 new community Child and Adolescent Mental Health Teams (CAMHTs) established in 2009.[5] Of the 56 community CAMHTs established, very few are fully staffed. In fact the report shows that in September 2011, staffing levels for the existing 56 teams was at 63.8 per cent of the level recommended under *A Vision for Change*, which is lower than the staffing levels from 2010 (70.2 per cent).
[6] *Ibid,* page 45
[7] *Ibid,* page 24, section 4.6
[8] *Ibid,* page 36, section 5.3

Timely access to child protection and welfare services should include access to mental health assessments and services

In relation to standard 2.3, which states that children and families have timely access to child protection and welfare services, it is important that "timely access" is defined.

Timely access to child and adolescent community mental health teams allows for early intervention, preventing escalation of crises and early treatment with an associated improvement in longer terms prognosis. It also allows for the provision of support for families/carers to facilitate the child/young person remaining at home even when the child is in mental or emotional distress. The length of admission can be reduced, as early discharge can be considered when community-based services are resourced to provide post-discharge support and follow-up that may in turn reduce repeat admissions.[9] 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.[10] 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 150 posts promised under the 2012 service plans will lead to further improvements in this regard. However, 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. It is also imperative that these posts are recruited at the relevant grade required and with sufficient experience and training to ensure that teams are properly equipped to deal with caseloads and to accept more complex cases and older children. While it is clear that significant efforts continue to be made to reduce waiting times, no child should be waiting more than six weeks for an appointment and children in crisis should receive immediate access to appropriate services.

Recommendation:
In relation to standard 2.3, which states that children and families have timely access to child protection and welfare services, it is important that "timely access" is defined.

Best interests of the Child
The features that meet the requirements of standard 2.3 as outlined in the draft document should also explicitly state that access should be provided to services and assessments that are in the "best interests" of the child, to include access to mental health services and assessments. Each child in care should have an up-to-date care plan, which also addresses any mental health and emotional needs a child may have and has a recovery focus and includes access to multidisciplinary services. This care plan should be multi-disciplinary and, where the child is in foster care, take a

[9] The *Report of the HSE Services Forum on Child and Adolescent Psychiatric In-Patient Capacity* also highlights the fact that the absence of fully developed CAMHTs increases the likelihood of an individual child's mental health deteriorating to such an extent that in-patient admission is required. The HSE Third Annual CAMHS report itself acknowledges that in order for community teams to work effectively a range of skills, disciplines and perspectives are required.
[10] *Ibid,* section 3.1, page 16.

family centred approach to ensure that the foster family and, where appropriate, the child's own family, are empowered to support the recovery of the child.

Recommendation:
The features that meet the requirements of standard 2.3 should also explicitly state that access should be provided to services and assessments that are in the "best interests" of the child, to include access to mental health services and assessments.

The Voice of the Child

Article 12 of the UN Convention on the Rights of the Child (UNCRC) 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 Convention on the Rights of the Child 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 was identified as one of 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."[11] In order to address this failure, 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. 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 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.

The Report on the Barriers to the Realisation of Children's Rights in Ireland found that marginalised children in particular faced additional barriers to having their voices heard. Ensuring the voice of the child is heard is therefore particularly important in relation to vulnerable children. The Ombudman for Children also commissioned a piece of research examining a number of investigations undertaken by her office with

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

a view to assessing whether and to what extent the actions of the public bodies in question met children's rights standards. The report, entitled *A Children's Rights Analysis of Investigations*[12], examines an investigation in relation to a young person who died in HSE care. The report found the voice of the young person was not always heard in the general way that the case was handled by the Social Work Department and Child and Adolescent Mental Health Services (CAMHS), despite attempts to organise meetings, therapy and other interventions. In particular, the explicit statement by the young person that he would attempt suicide if forced to return to the special care unit was not comprehensively addressed. The report also found that there was a lack of genuine engagement with the young person, who does not appear to have had an independent representative or advocate when dealing with decision makers, with the exception of the Guardian *ad Litem,* who's role is solely in relation to court proceedings. This highlights the need not only to listen to the voice of the child, but also to give due weight to those views in accordance with the age and maturity of the child. The report also highlighted the importance of putting outreach and advocacy services in place in relation to a child with severe difficulty who may not want to engage, particularly in relation to mental health services where a child's life may be at risk.[13]

The Coalition welcome the themes of the standards as outlined in the Draft document. In relation to theme 1, Child-centred Services, the Coalition submit that the wording of this theme (and the corresponding Standard 1.2) should be amended to reflect the Ireland's obligation under Article 12 of the UNCRC to listen to children and also to ensure that their views are given due weight in accordance with their age and maturity. In relation to Standard 1.2.3, where children are facilitated to communicate a concern and report abuse or neglect, it is crucial that, as well as being listened to, children receive feedback in relation to their views and are kept fully informed at all stages of the complaints process.

Recommendation: ***The wording of theme 1 and the corresponding Standard 1.2 should be amended to reflect the Ireland's obligation under Article 12 of the UNCRC to listen to children and also to ensure that their views are given due weight in accordance with their age and maturity.***

[12] Dr. Ursula Kilkelly, *A Children's Rights Analysis of Investigations,* Ombudsman for Children's Office, April 2011,
[13] *Ibid*, p.66-67

Summary of Recommendations

- ***The Government should establish a national assessment standard for all children in care with provision for all those with an identified need for follow-up support and treatment.***

- ***The features to meet the requirements of standard 2.4 (all concerns in relation to children are screened and directed to the appropriate service) should make specific reference to mental health services.***

- **Standard 2.5.4, which outlines what should be included in the initial assessment, should include express reference to the child's mental health and social and emotional needs.**

- ***In relation to standard 2.3, which states that children and families have timely access to child protection and welfare services, it is important that "timely access" is defined.***

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