Child and Adolescent Mental Health in NI

A Scoping Paper which includes the human rights basis of mental health, a review of evidence regarding prevalence and need, an overview of the CAMHS system, and an outline of key policy implications.

April 2017

Executive Summary

This Paper sets out what it means to take a human rights based approach to health, with a particular focus on the United Nations Convention of the Child and the advice given by the Committee on the Right of the Child. This is followed by an overview of evidence on the nature and extent of mental health issues for children and young people in Northern Ireland; a brief outline of the key legislative and policy developments; key issues within child and adolescent mental health; an outline of strategic policy implications; and concludes by setting out relevant work that NICCY plans to undertake.

1.0 A Human Rights Based Approach to Health

1.1 NICCY adopts a holistic and rights based understanding of mental health and wellbeing which is outlined in the UNCRC and other international instruments. The UNCRC is the most complete statement of children's rights ever produced and is the most widely-ratified international human rights treaty in history. It contains 54 articles that cover all aspects of a child's life.

1.2 The UK and devolved governments' are required to report every 5 years to the Committee on the Rights of the Child on the progress they are making towards implementation of the UN Convention on the Rights of the Child. The most recent examination took place in May 2016.

1.3 A child's right to the highest attainable standard of health depends on the realisation of nearly all rights outlined in the UNCRC. Article 24 of the UNCRC sets out children's right to health, and builds on and develops the rights to life, survival and development to the maximum extent possible set out under Article 6.

1.4 The core features of child rights based practice is where the child is at the centre of planning and delivery, it is also one in which a holistic approach is taken and where needs are not compartmentalised.

2.0 Children and Young People's Mental Health

2.1 More than 20% of young people are suffering significant mental health problems by the time they reach 18 (DHSSPS, 2010; Khan, 2016).

2.2 A range of sources highlight the increasing prevalence of mental ill health of children and young people in Northern Ireland in terms of the scale and complexity of problems.

2.3 Rates of mental ill health are estimated to be 25% higher in NI than in other parts of the UK (Bamford, 2006).

2.4 Indicators for poor mental health include disproportionately higher rates of suicide in NI within under 18s compared to other parts the UK, increasing anti-depressant prescription rates for 0-19 yr olds, increasing self harm rates for 0-18 year olds and self reported poor emotional well being of children and young people.

2.5 There is an average 10 year delay between young people presenting first symptoms and getting support (Khan, 2016). Research indicates that many young people are not accessing mental health services even when they self report as experiencing serious mental health problems (Schubotz & McMullan, 2010).

2.6 There are specific groups of children who are more likely to face discrimination in the realisation of their rights to the highest attainable standard of healthcare; this includes care experienced children, those living in poverty and in economically deprived areas, children in contact with the criminal justice system, those with long-term disability or illness and children belonging to ethnic minorities (Lundy et al. 2012; Devaney et al. 2012; Khan, 2016).

3.0 Health and Social Care System Reform

3.1 There have been significant positive changes to the CAMHS system, particularly in the last 10 years. In 2012 a preferred regional model for the organisation and delivery of

CAMHS in Northern Ireland was agreed, greater consistency has been achieved since this framework was published, however, significant fragmentation of services still exists across the Health and Social Care Trusts (DHSSPS, 2012; DHSSPS, 2016).

3.2 Currently 7.8% of Northern Ireland's mental health budget is allocated to CAMHS (£19,574,861 million). The Health and Social Care Board calculates that investment should be 10% and hence there is an acknowledged funding gap of £4.8 million (Letter Response to Request for Information from NICCY- dated March 2017). If this money was made available it would be targeted at step 2 early intervention services (Presentation to NICCY by HSCB- dated 2015).

3.3 There is a chronic lack of regional, publically available, data and monitoring reporting of mental health need or disaggregation of child and adolescent mental health service usage. Therefore it is unclear how well current services are meeting the needs of children and young people (needs analysis), where the gaps are (service mapping) and what impact current services are having on outcomes for children and young people (evaluation and outcome measurements).

4.0 Key Issues within Child and Adolescent Mental Health Services

Key issues for NICCY in relation to children and young people's mental health are:

4.1 Lack of data collection and monitoring:

- Insufficient data collection and monitoring of the operation of CAMHS i.e. demographics, presenting need, services / therapies offered, service user experience and outcomes.
- Lack of prevalence data on scale of mental health need within population.
- Limitations in ability to provide evidence based service delivery and planning which takes account of needs and outcomes.

4.2 Unequal availability and accessibility of services:

- Inconsistency in provisions- regional and local;
- Threshold and criteria for accessing services;
- Waiting lists;
- Access / choice of therapeutic supports;
- Community Provision- including out of hours / crisis support;
- Specialist provision- alcohol and drugs, forensic, eating disorder; dual diagnosis / complex needs and
- Co-ordination between services.

4.3 Transitions between child and adult mental health services.

4.4 Gaps in workforce planning.

4.5 Inadequate support in schools and for schools.

4.6 Lack of Participation of Children and Young People:

A lack of system(s) for listening to children and young people's views about their:

- Own Care Planning;
- Development of service, policy, and legislation; and
- Lack of evidence of advocacy provision.

5.0 Strategic Policy Implications

5.1 Implementation of CAMHS Improvement Plans

Investment has not met the system's ambition for service reform and has impeded the rate of significant tangible change. The cost of establishing the CAMHS model in full is not clear, however, if it is not possible to fund it in its entirety, then strategic evidence based decisions need to be made to ensure that scarce resources are invested where most needed and in which human rights issues have been fully considered.

5.2 Mapping Need and Measuring Outcomes

There needs to be much greater clarity and transparency in children and young people's mental health needs and on the evidence base being used by Government to shape policy and practice, identify unmet need and direct resources. This is a fundamental requirement for progress towards equality in access to mental health services.

Clarity and transparency on the mental health needs of children and young people is only possible with robust, regionally available, regularly updated, datasets on the operational aspects of CAMHS. This operational data must be considered alongside a Northern Ireland wide prevalence survey on children and young people's mental health and an evaluation framework for services which has a focus on measuring the outcomes achieved for children and young people.

Furthermore, child rights principles should underpin the measurement of outputs and outcomes. In practical terms this means that children and young people should be asked directly about their satisfaction levels and experiences as mental health service users.

5.3 Co-ordination, communication and Integration

There is a need for much greater strategic planning and prioritisation in CAMHS to ensure there is consistency in the availability and quality of all levels / tiers of mental health services when and where they are needed. A holistic approach is necessary to ensure that all children and young people achieve the best possible health and are able to flourish. This cultural change needs to come from the highest levels of policy making and governance.

Although, the system's openness to review and reform is welcome there needs to be much greater follow through and recorded progress on the plans made, for these plans to be put in place more quickly and for the implementation to be done in a more co-ordinated and sustained way. The Children's Services Co-operation Act (Northern Ireland) 2015 (CSCA) is a significant legislative development which aims to improve the well-being of children

and young people in a manner which realises their rights and places obligations on Departments / Agencies to co-operate with each other in order to contribute to the improvement of outcomes for children and young people. The lack of co-ordinated strategic direction in the transformation of our health and social care services means that our systems tend to operate in silos rather than being driven by the assessed need of the population (Bengoa, 2016).

5.4 'Mental Health in all Policies' Approach

Although the Department for Health is the main driver of mental health policy in NI, by applying a 'health in all policies' approach, policy making at all levels of governance and across all sectors would ensure that we take a more holistic view of a child's life, and the root causes of poor emotional and mental health are addressed. Taking this approach is the most effective way of ensuring long term positive change in the mental health outcomes of children and young people.

5.5 Addressing the root causes poor mental health

Health behaviours and outcomes are not simply a matter of personal responsibility; they are influenced by the wider socio-economic circumstances within which people live. They can also be driven by unequal access to services and support, it is important that those delivering health services identify and address any systemic and/or attitudinal barriers to access within the service and which may lead to disadvantage and subsequent health inequalities within specific communities and groups. (TEO 2016)

5.6 Participation of children and young people

New approaches are emerging that are attempting to change the way that health services are planned and commissioned. For example, a new quality healthcare experience frameworks such as the '10,0000 voices' project (NIE 2016). These present a real opportunity to embed, strengthen and promote the involvement of children and young people in decision making and in so doing demonstrate a real tangible commitment to realising children's rights as citizens on an equal footing with everyone else. Research,

good practice and child rights compliant approaches would recommend that every effort should be made to ask children and young people directly about how they feel about issues affecting their lives. This approach is much more likely to lead to services which meet the needs of children and young people and provides best value for money.

6.0 Conclusion & Next Steps for NICCY

To fully support children and young people's emotional and mental well-being, a comprehensive suite of services and support are required. The lack of publicly available robust, disaggregated, regional data on mental health need and key operational aspects of the CAMHS system means it is very challenging to fully review the adequacy and effectiveness of current provision.

There are a range of ongoing broad system reviews and implementation plans being undertaken in CAMHS which are focused on transformation and improvement and this is to be welcomed. They do not however, take sufficient account of whether current services across CAMHS are meeting child rights principles such as those which focus on the availability, accessibility and quality of services. Nor is there sufficient evidence that service user or patient feedback mechanisms are effectively gathering the direct experiences and views of children and young people or that these views are informing policy and services.

NICCY has decided to carry out a rights based review to examine children and young people's experience of receiving mental health services. This includes those who have attempted to access mental health services and those who have experience of transitioning between child and adult mental health services. The review will use those experiences to develop a set of recommendations for those planning and delivering services. The Terms of Reference for the Mental Health Review is available from the Mental Health page of the NICCY website.

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1.0 Introduction

This Paper sets out what it means to take a human rights based approach to health, with a particular focus on the United Nations Convention of the Child (hereafter UNCRC') and the advice given by the Committee on the Right of the Child.   This is followed by an overview of evidence on the nature and extent of mental health issues for children and young people in Northern Ireland; a brief outline of the key legislative and policy developments; key issues within child and adolescent mental health; an outline of strategic policy implications; and concludes by setting out relevant work that NICCY is undertaking.

The report is structured into the following sections:

1. Introduction- A Human Rights Based Approach to Health
2. Children and Young People's Mental Health
3. Health and Social Care Reform
4. Key Issues within Child and Adolescent Mental Health Services
5. Strategic Policy Implications
6. Conclusion & Next Steps for NICCY

The Office of the Commissioner for Children and Young People (NICCY) was created in accordance with 'The Commissioner for Children and Young People (Northern Ireland) Order' (2003) to safeguard and promote the rights and best interests of children and young people in Northern Ireland. Under Articles 7(2) and (3) of this legislation, NICCY has a mandate to keep under review the adequacy and effectiveness of law, practice and services relating to the rights and best interests of children and young people by relevant authorities. Under Article 7(4), NICCY has a statutory duty to advise any relevant authority on matters concerning the rights or best interests of children and young persons. The remit includes children and young people from birth up to 18 years, or 21 years, if the young person has a disability or has been/is in the care of social services. In carrying out these functions, paramount consideration is to be given to the rights of the child or young person, having particular regard to their wishes and feelings and to all relevant provisions of the United Nations Convention on the Rights of the Child (UNCRC).

As set out by the 2003 Order, the UNCRC is the guiding framework by which NICCY carries out its work taking into account the the views of children, young people and their parents/carers. The key statutory duties of the Commissioner fall into three categories, namely promoting, monitoring and advising:

- Promote children's rights and the voice of children and young people;
- Review, research and advise;
- Support complaints from children and young people; and
- Investigate suspected violations of children's rights.

1.1 A Human Rights Based Approach to Health

NICCY adopts a holistic and rights based understanding of mental health and wellbeing which is outlined in the UNCRC and other international instruments. The UNCRC takes an approach which is not simply focused on the absence of mental illness but on the promotion of health and wellbeing which aims to develop and support children, communities and the population to flourish (Schubotz & McArdle, 2014).

The UNCRC is the international monitoring body for the Convention on the Rights of the Child. It is the most complete statement of children's rights ever produced and is the most widely-ratified international human rights treaty in history. It contains 54 articles that cover all aspects of a child's life and sets out the civil, political, economic, social and cultural rights to which all children everywhere are entitled. It also explains how adults and governments must work together to make sure all children can enjoy these rights.

The UK State Party and NI as a devolved administration ratified the UNCRC in 1991 and it subsequently came into force in 1992. As a binding international treaty, it places obligations and responsibilities on States and their institutions to realise these rights.

The UNCRC defines a child as 'every human being below the age of 18 years (Article 1). It also emphasises non-discrimination as a core right, and that all convention rights apply equally to all children under 18 years, irrespective of age (Article 2). The UNCRC acknowledges children as 'rights holders' and imposed obligations on States as duty bearers for the respect, protection and fulfilment of children's rights. The principles of child rights are grouped into three key domains of participation, protection and provision (TAT, 2014).

The Committee on the Rights of the Child (hereafter 'the Committee') reaffirms that health rights are inclusive in that they cover prevention, health promotion, intervention and rehabilitative services. However, there are a number that are of particular relevance when one considers health; Article 24 of the UNCRC sets out children's right to health, and builds on and develops the rights to life, survival and development to the maximum extent possible set out under Article 6. Paragraph 1 of Article 24 specifically refers to the rights of a child to the highest attainable standard of health and to facilities for treatment and rehabilitation.

24 (1) States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

Paragraph 2 provides a list of appropriate measures that States must take in pursuing the full implementation of Article 24 (1). This includes the need to ensure the provision of necessary medical assistance and health care to all children with an emphasis on the development of primary health care. Due to the holistic nature of the Convention, all rights contained within it are indivisible and inter-dependent, therefore children's access to other UNCRC rights such as, protection from violence and abuse (Article 19) and access to an adequate standard of living (Article 27) will directly impact on their physical and mental health.

24 (2) States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

a. To diminish infant and child mortality;

b. To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

c. To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

d. To ensure appropriate pre-natal and post-natal health care for mothers;

e. 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 and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

f. To develop preventive health care, guidance for parents and family planning education and services.

Article 25 sets out the role of State Parties where a child has been admitted to hospital for treatment, and in particular their right to a periodic review.

25. States Parties 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.

Article 23 specifically refers to children with a disability and the need to ensure that they have effective access to services, including health care and rehabilitative services.

23 (3) (…) shall be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development.

Article 33 sets out the obligations on States Parties to take all appropriate measures to protect children from narcotic drugs and psychotropic substances (which include legal highs).

(..) take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.

There are four guiding principles of the UNCRC which should underpin all other rights outlined in the Convention, including the right to health:

Article 2: Children's right to non-discrimination.
Article 3: Best interests being a primary consideration in all matters.
Article 6: Right to life and to survival and development to the maximum extent.
Article 12: Views being given due weight in accordance with age and maturity.

 Article 2, in the context of health, requires State Parties to recognise every child's equal right to the best possible health and access to health services without discrimination.

Article 3 places an obligation on State Parties to ensure that the best interests of the child are assessed as a primary consideration in all actions affecting the child. This principle must be adhered to in all health related decisions concerning individual children or groups

of children. Individual children's best interests should be based on their physical, emotional, social and educational needs, age, sex, family and social background, and after having heard their views as stipulated by Article 12. The Committee urges States to place children's best interests at the centre of all decisions affecting their health and development, including the allocation of resources, and the development and implementation of polices and interventions that affect the underlying determinants of health. For example, the best interests of the child should guide treatment options and includes giving children and young people access to appropriate information on health issues (CRC/ C/ GC/ 15, 2013).

Article 12 emphasises children's right to participation, including in health promotion, and the need to respect the views of the child in decisions made about their own health care, and in the planning and provision of health services (UNICEF Handbook). One aspect of this is children's evolving capacity to determine their own health care. Although no explicit distinction is made under international human rights law between children of different ages, the Committee does stress that implementation of rights must take account of children's development and their evolving capacities (Article 5). This is a very significant issue when one considers the lack of input and autonomy children often have in decision making about their own health issues. In particular, the Committee has emphasised the need to ensure that appropriate weight is afforded to the views of adolescents and has emphasised that the approaches required to ensure the realisation of rights of adolescents differ significantly from those required for younger children (CRC/C/GC/20, 2016). A child's right to be heard, also implies that the right to access information must also be fulfilled, as children cannot adequately exercise their right to be heard unless they have an 'informed voice'. (Article 17)

The right to health is not to be understood as a right to be 'healthy'. The right to health contains both 'freedoms' and 'entitlements'. The 'freedoms' include the right to control one's health and body, for example, the right to decline certain medical treatment. By contrast, 'entitlements' include the right to a system of health protection which provides

equality of opportunity for people to enjoy the highest attainable standard of health. (UNICEF Handbook).

Further to this, Article 4 set out the principle of progressive realisation of children's rights, which includes children's right to health, and the obligation on Governments to adopt measures to the maximum extent of available resources. More specifically it affirms that, "States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention. With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation."

State obligations fall into three categories, they are:

1. *Respect*, which requires States to refrain from interfering directly or indirectly with the right to health.
2. *Protect*, which requires States to prevent third parties from interfering with the right to heath.
3. *Fulfil*, which requires States to adopt appropriate legislative administration, budgetary, judicial, informational, educational, promotional, and other measures to fully realise the right to health.

The core features of child rights based practice is where the child is at the centre of planning and delivery, it is also one in which a holistic approach is taken and where needs are not compartmentalised. The need for co-operation and integration between systems is key to achieving better outcomes for CYP. The Committee reminds State parties that accountability is at the core of the enjoyment of children's right to health, and of their obligations to ensure that relevant authorities and service providers are held accountable for maintaining the highest possible standards of children's health and health care up to the age of 18 (CRC/C/GC/15, 2013).

The UK and devolved governments' are required to report every 5 years to the Committee on the Rights of the Child on the progress they are making towards implementation of the UNCRC. The most recent examination took place in May 2016, the Committee made a number of specific recommendations regarding mental health support and services. The comments made by the Committee are outlined in section 4 of this paper (CRC/C/GBR/CO/5).

It is vitally important that the principles of human rights, social justice and equity are translated into all legislation, policy and practice. In carrying out her functions, the Commissioner's paramount consideration is the rights of the child and NICCY is required to base all its work on the United Nations Convention on the Rights of the Child (UNCRC). The Commissioner also takes cognisance of other international human rights instruments and standards including the UNCRPD, when considering the rights and needs of children and young people. NICCY actively promotes the rights and best interests of children and young people with disabilities, by highlighting gaps in policy and practice, promoting the voice of children and young people with disabilities and providing advice to Government to effect improvements in service provision. In February 2017, NICCY submitted an alternative report to the UN Committee on the Rights of People with Disabilities; this included a focus on Article 25 of the UNCRPD which relates to the right to health of people with a disability (NICCY, 2017). The first report by the Committee on the Rights of Persons with Disabilities, to the UK State Party, is due in 2017.

2.0 Children and Young People's Mental Health

2.1 Prevalence of mental ill health of children and young people

According to the latest Northern Ireland Health Survey, around one in five adults in Northern Ireland show signs of a mental illness (DHSSPS, 2015). For under 18s prevalence is less clear because of a lack of epidemiological research (Mental Health Foundation, 2016). It has been estimated that around 45,000 (1 in 6) children and young people in NI have a mental health problem at any one time (DHSSPS, 2010). There are a range of more recent sources which indicate considerable variation in the reported

prevalence rates of poor mental health of children and young people. Figures can range between prevalence rates of 1 in 10 or 1 in 4 depending on the parameters applied e.g. age range, whether self reported or clinical tools are used and which target group is included i.e. general population or only those known to services (Schubotz & McMullan, 2010; Schubotz & McArdle, 2014; Orr, 2015; and Khan, 2016). It has also been reported that mental health difficulties increase during teenage years (DHSSPS, 2010; Khan, 2016).

Northern Ireland does not have a recurring population wide survey that measures the mental and emotional wellbeing of children and young people, therefore it is difficult to be completely sure about the rates of mental ill health for this group and how it has changed over time. In the absence of local research, English surveys are used as a benchmark, however, figures are likely to be an under-estimation of the extent of mental health problems here because of the specific circumstances in NI, including the impact of the conflict. One of the most significant reviews of mental health services in NI indicated that rates of mental ill health are potentially 25% higher in NI than in other parts of the UK (Bamford, 2006). However, despite the absence of a NI prevalence survey, there is a growing body of evidence, which is highlighting the increasing prevalence of mental ill health of children and young people in Northern Ireland. The evidence is demonstrating increasing prevalence both in terms of the scale and complexity of problems, and indicates that these issues are appearing at an increasingly younger age. A selection of sources are outlined below regarding a range of indicators for poor mental health, these are, anti-depressant prescription rates for 0-19 yr olds, self harm rates for 0-18 year olds, self reported poor emotional wellbeing by children and young people, and referrals to family support services for emotional and behavioural support.

2.1.1 Suicide

Rates of suicide in under 18s is disproportionately higher in NI compared to other parts the UK (NISRA, 2016). In 2012, the five-year average suicide rate for 15 to 19 year olds was 4 times higher in NI than for England and Wales. For 10 to 14 year olds, rates were 10 times higher (SBNI, 2014). Annual suicide rates are also consistently higher for males under 19

yrs old compared to females. In 2014, 15 of the 18 registered deaths of under 19 yrs olds were by males (NISRA, 2016:1).

2.1.2 Anti-depressant prescription rates for 0-19 yr olds

There is a reported upward trend in the numbers of children and young people being prescribed anti-depressants. In 2014-15, 550 under 16s and 5500 16-19 yr olds were prescribed anti-depressants or anti-anxiety drugs, representing a year on year increase from 2012[1]. These statistics are alarming as they indicate an increasing number of children and young people with serious mental health problems. These figures also raise questions about the extent to which psychological therapies also being offered to children and young people as an alternative to medication. (NICE, 2011). There are no publically available statistics available on the therapies provided to children and young people as part of their treatment. However, it is known that the specific therapies offered by each Heath and Social Care Trust vary[2]. We also understand from figures provided by the HSCB that regional recurrent funding of £50,000 was invested in CAMHS training in psychological therapies in 2015 / 16 (HSCB, 2016). What is less clear is to what extent the current provision is meeting the needs of children and young people and what impact it is having on those availing of it.

2.1.3 Self Harm Rates

The NI Self Harm Registry which provides an annual monitoring report of presentations of self harm to Accident & Emergency departments, has reported that between 2012/13 and 2014/15 rates of self harm in the 15-19 yr old bracket has increased by 30%, with this age range seeing the most pronounced increase (PHA, 2016). An earlier report for the period 2012 / 13 and 2013/ 14 showed a 14% increase in presentations by under 16's (PHA, 2015). The Self Harm Registry does not take account of those young people who are attending community based services, nor does it account for young people who are not

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[1] Assembly Written Question 52569/11-16.
[2] Response to request for information from NICCY to HSCB- dated 2 March 2017.

accessing any services. Therefore these figures are likely to be a significant under-estimation of the true scale of the issue.

2.1.4 Self reported poor emotional wellbeing by children and young people

There are indications of increasingly poor 'emotional' wellbeing of younger children. In one NI survey it found that one in ten children aged 11-13 years reported to have never been or were seldom happy with the way they were, with only half of children aged 13-16 years old feeling that they were always dealing with problems well (NISRA, 2014).

Furthermore, statistics from community based programmes for primary and post primary school children have reported that 5-10 year olds have consistently been the highest referral age group, with emotional and behavioural support being the main reason for referral. Between 2014/15 and 2015/16 there has been a 115% increase in referrals for primary school age children to the family support hub programme (from 512 to 1103) (CYPSP, 2016). Although as a new service one would expect an increase in uptake, it also demonstrates the need for such support, and although poor emotional well being should not be conflated with mental health problems, it does provide early warning signs of possible mental health problems in later years, particularly if early intervention is not provided or is ineffective.

2.2 Children and young people at greater risk of poor mental health

There are specific groups of children who are more likely to face discrimination in the realisation of their rights to the best possible health outcomes and access to health services; this includes care experienced children, those living in poverty and in economically deprived areas, children in contact with the criminal justice system or who have a parent in prison, children affected by the conflict, including those exposed to trans-generational trauma, young carers, those with long-term disability or illness, those exposed to parental mental ill health, roma, gypsy and traveller children, children belonging to ethnic minorities, migrant children and LGBTI children (Lundy et al. 2012; Devaney et al. 2012; Khan, 2016).

There are also a wide range of environmental factors that can contribute to the development of poor mental health. The impact of the conflict and poverty represent two of the most significant determinants of poor mental health. The effects of the conflict on parents and in particular their mental health, presents a potential but serious risk to the wellbeing of younger generations, this includes trans-generational trauma. Trans-Generational Trauma is defined as the 'shown impact of trauma experienced by one family member on another family member of a younger generation, regardless of whether the younger family member was directly exposed to the traumatic event' (CVS, 2015). Over 40% of children growing up in Northern Ireland are living with parents who have high or moderate experience of the conflict. The added stresses of economic and social deprivation, exacerbated by parental substance misuse and poor parenting practices, can compromise a child's capacity to regulate their own emotions and behaviours which can increase the risk of poor health from childhood in adulthood (CVS, 2015).

There is a large body of evidence which highlights the impact of poverty on mental health. An ongoing longitudinal study found that children and young people who live in families and communities who experience persistent poverty have 3 times (30%) more chance of having a mental health problem by the age of 11yrs old, compared to those who have never experienced it (10%) (Lancet, 2016). In 2014/15, 26% of children were in absolute poverty after housing costs, representing approximately 116,300 children (NISRA, 2016:2).

2.3 Impact of poor mental health

There is now strong evidence that common mental health problems that first emerge in adolescence have a higher chance of remaining into adulthood without prompt and reliable early intervention (Khan, 2016). There is also a range of research which indicates significant delay in young people both seeking and receiving mental health support. It has been reported that although 20% of 16-25 year olds will experience a diagnosable mental health problem, there is an average 10 year delay between young people presenting first symptoms and getting support (Khan, 2016). We also know from a NI survey of 16 year

olds that although 26% stated that they had experienced serious personal, emotional or mental health problems only 9% had sought professional help (Schubotz & McMullan, 2010). More recent NI research with 11-18 year olds has also reported a similar trend towards those most vulnerable to experiencing mental health problems being less likely to seek face to face support from family or health professionals. This research which was conducted with 752 young people to inform the NGO Alternative report to the UN Committee on the Rights of the Child recommended that,

"In order to meet their obligations under Article 24 of the UNCRC, duty bearers should promote mental health awareness and encourage young people's uptake of mental health service provision by working to improve the services available and reducing social stigma attached with mental health concerns. CAMHS should be assessed as a matter of priority, both for suitability and sufficiency of provision. Young people are asking for a quality assured, specialised service for children and young people, their views on how this service should look, feel, and operate must be considered" (Orr, 2015).

Mental health problems are a primary cause of ill health, morbidity and mortality among adolescents. The Committee on the Rights of the Child in its most recent examination raised their concerns regarding access to services for adolescents in particular, they stated that 'when adolescents do seek help, they often experience discrimination, lack of confidentiality and respect, stigma and judgmental attitudes from health care personnel' (CRC/C/GC/20, 2016).

Responding effectively and in a timely manner to the mental health concerns of children and young people reduces the likelihood of life limiting damage such as excessive alcohol and drug misuse, self harm and death through suicide (Devaney et al., 2012). There is also very clear evidence that mental illness and adversities in childhood have significant negative impact on life opportunities with regards to employment, economic security, relationship and physical health. There is also strong evidence of the relationship between poor mental health and chances of coming into contact with the criminal justice system. In

NI almost all (95%) of the 15-21 year olds in the criminal justice system have at least one mental health problem (CJNI, 2010). In the recent Department of Justice / Department for Health consultation on improving health within the criminal justice system, it was acknowledged that research shows that a 'very large proportion of imprisoned young people have one or more of the following conditions, personality disorder, psychosis, neurotic disorders or substance misuse.' It also reports that 'young adults have higher rates of self harm and suicide than older prisoners and are more likely than older prisoners to have been in the care system' (DOJ / DHSSPS, 2016).

Understanding the relationship between physical and mental health is also fundamental to achieving the best outcomes for children and young people. Poor mental health is associated with a greater risk of physical health problems, and similarly poor physical health is associated with a greater risk of mental health problems (Unützer et. al., 2009).

3.0 Health and Social Care System Reform

Child and adolescent mental health services sit within the broader health and social care system. There has been a range of reports that have reviewed different aspects of the Northern Ireland health and social care system and provided recommendations on how to restructure it. These have included the Bamford Review of Mental Health and Learning Disability, Transforming Your Care (TYC), the Donaldson Report and most recently the Bengoa report (Transforming Your Care, 2013; Donaldson, 2014; Bengoa, 2016). The impetus for such reviews has been increasing concerns that the system is unsustainable in financial terms and does not meet the current or projected needs of the whole population.

The Bamford Review of Mental Health and Learning Disability has been the most wide-ranging and independent review of the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland. Although it is now over 10 years since the Bamford review of CAMHS was published, it remains a seminal piece of work that continues to influence the development of services. There is a monitoring process in place which checks on progress made on key actions set by Government to

deliver on the vision set out by Bamford. An inter-Ministerial group, chaired by the Minister for Health, was established to oversee the work and structures put in place to support the delivery of key actions. The Bamford Monitoring Group forms part of the overall Bamford monitoring structure, as the main mechanism for capturing the views of service users and carers. However, none of the 16 members are under 18 yrs old. It is unclear how effective the Bamford Review mechanisms are for engaging with children and young people, or what impact that engagement makes to informing service planning or delivery.

Transforming Your Care was published in 2011 and made specific recommendations for child and adolescent mental health services, in particular the implementation of the recommendations outlined in the RQIA CAMHS review and the DHSSPS Policy Guidance 'Child and Adolescent Mental Health Services: A Service Model' (RQIA, 2011; DHSSPS, 2012). The NI Audit Office made the first official commentary on the management and delivery of the TYC programme in 2017, it found that the impact of the programme overall has been more limited and the pace of change not as swift as originally envisaged. With respect to mental health the report highlighted positive change in the resettlement of patients from institutional to community care, but there was no specific progress reported regarding CAMHS. The report identified a series of factors which need to be addressed in order to increase the pace of transformation and the implementation of more effective models of care, these include the need to develop a clear action plan for transformation and the implications for workforce planning; the need for evidence-based planning; promoting the commitment and involvement of medical professionals to improvement initiatives; and having a dedicated funding stream to support transformation (NI Audit Office, 2017). The more recent review of Health and Social Care, referred to as the 'Bengoa report', reinforced the position that we have a 20th century model of service delivering for a 21st century population, and that the only long term solution is to reconfigure our Health and Social Care System (Bengoa, 2016). In response to Bengoa, the Health Minister published a 10 year plan 'Health and Wellbeing 2026 - Delivering Together', for taking forward its recommendations (DoH, 2016:1). NICCY has welcomed the human rights basis upon which these early plans have been set and the emphasis

placed on addressing the mental health needs of young people and the adversities which can lead to poor mental health. Unfortunately, the plan lacks the detail needed to fully understand the actions that will be taken to address it.

3.1 Child and Adolescent Mental Health System

There have been significant positive changes to the CAMHS system, particularly in the last 10 years. In 2012 a preferred regional model for the organisation and delivery of CAMHS in Northern Ireland was agreed, as a result of the acknowledgement that there needed to be more consistency in services being offered across Health and Social Care Trusts (DHSSPS, 2012). This 'Stepped Care' model of CAMHS was a response to a specific recommendation from a Review carried out by the Regulation and Quality Improvement Authority in Northern Ireland (RQIA, 2011) and also aligned with the overall strategic direction for CAMHS as set out in the Bamford Review (Bamford, 2006). Although it should be acknowledged that greater consistency has been achieved since this framework was published, significant fragmentation of services still exists across the Health and Social Care Trusts (DHSSPS, 2016). Although it is unclear exactly how much money is required to fully implement the model, it is apparent that there is insufficient funding to do so and in fact, sustainability of existing services is already at risk due to budget cuts for Health and Social Care Trusts' services. More generally, there is a chronic lack of regional, publically available, data and monitoring reporting of mental health need or disaggregation of child and adolescent mental health service usage. Therefore it is unclear how well current services are meeting the needs of children and young people(needs analysis), where the gaps are (service mapping) and what impact this is having on outcomes for children and young people (evaluation and outcome measurements).

Currently 7.8% of Northern Ireland's mental health budget is allocated to CAMHS (£19,574,861 million). The Health and Social Care Board calculates that investment should be 10% and hence there is an acknowledged funding gap of £4.8 million (Letter Response to Request for Information from NICCY- dated March 2017). If this money was made available it would be targeted at step 2 early intervention services (Presentation to

NICCY by HSCB- dated 2015). This investment target of 10% of the mental health budget for children and young people doesn't appear to take account of actual need of children and young people in NI which is likely to be much higher. It has been estimated that mental health need in Northern Ireland is 25% greater than England (Bamford, 2006). There are a range of reasons for this but it is accepted that the legacy of the conflict, high rates of poverty and economic deprivation are significant contributing factors (CVS, 2015; NISRA, 2016:2; Lancet 2016).

Insufficient resourcing of CAMHS, alongside the lack of a robust regional mechanism for evaluating need, service use and outcomes, has contributed to the slow progress in the realisation of the vision set out by Bamford for child and adolescent mental health. Bamford's vision was for all children and young people to have:-

   "access to a comprehensive array of services that address the child's physical, emotional, social and educational needs in order to promote positive mental health" (Bamford 2006; RQIA, 2012).

A more recent review of Acute CAMHS pathways was published in 2014, this review has outlined a number of areas in which systematic reform is needed, these include key changes needed in commissioning of CAMHS, steps for improving the co-ordination and integration of services including the interfaces between primary care and CAMHS, the development of therapeutic models and regular engagement with children, young people and carers (Rees et al., 2014). It is encouraging that all of the recommendations from this report were accepted by the HSCB and an implementation plan developed with actions for the period 2015-2016. Unfortunately, progress of implementation is not regularly publically reported on, but it would appear that very few of the actions have been completed. The establishment of a Managed Care Network is one of the priority recommendations. The expectation is that this Network will bring acute services into one managed system thereby ensuring greater consistency across the region and streamlining of access to Northern

Ireland's Regional Child and Adolescent In-Patient Unit (Beechcroft). [3] It would appear that a lack of funding to implement necessary changes within a reasonable timescale is a major barrier to progress.

Insufficient investment is a significant issue for health and social care generally and CAMHS specifically. It is useful to consider investment in mental health from a parity of esteem angle. The need to embed the parity of esteem principle between physical and mental health must be at the centre of any changes to mental health services. In simple terms, this means that mental health must be valued equally to physical health. Furthermore, it must be understood that this cannot be achieved by simply calling for equal funding for services; rather it must also be about ensuring that there is equality of consideration across mental and physical health care provision which can best be achieved by ensuring that there is (1) quality access to the most effective and safest care and treatment; (2) equal effort to improve quality of care; (3) the allocation of time, effort and resources on a basis commensurate with need; (4) equal status within healthcare, education and practice; (5) equally high aspirations for service users; and (6) equal status in the measurement of health outcomes. (RCP, 2013).

3.1.1   Mental Capacity (NI) Act 2016

The Mental Health (Northern Ireland) Order 1986 ('the Order') is the main Mental Health Legislation in Northern Ireland, this includes for those aged under 18. The Bamford Review of Mental Health and Learning Disability found that the Order was not being fit for purpose or compliant with the European Convention on Human Rights (ECHR) (Bamford, 2007).

New mental health legislation, namely the Mental Capacity (NI) Act[4], came into effect in 2016. This legislation does not include under 16s within its scope, and therefore the Mental Health (Northern Ireland) Order 1986 remains the main legislation for them. The

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[3] Response to request for information from NICCY to DoH- dated 23 September 2016.

[4] http://www.legislation.gov.uk/nia/2016/18/contents/enacted

exclusion of under 16s from this legislation means that solely on the basis of age, under 16s will not be able to access a range of new protections and safeguards contained in the legislation which will be afforded to those over 16 who lack capacity as a result of a mental illness or learning disability. NICCY does not believe that this approach is compliant with the UNCRC, in particular Articles 2 – non-discrimination, 3 – best interests of the child, 6 – right to survival and maximum development, 12 – right to be heard and have views taken into account, 23 – right of a disabled child to a full and decent life and 24 – highest attainable standard of healthcare. NICCY has previously advised on these concerns about the exclusion of under 16s from the legislation as being in violation of obligations set out in the United Nations Convention on the Rights of People with Disabilities (UNCRPD)[5] and in particular Article 7 – the right of children with disabilities to enjoy all human rights and fundamental freedoms on an equal basis with other children and Article 12 – relating to full and equal legal capacity for everyone.

3.1.2   The Children's Services Co-operation Act (NI) 2015 (CSCA)

The Children's Services Co-operation Act (NI) 2015 (CSCA)[6] places a statutory duty on government departments and their agencies to work together with other 'children's authorities' and with 'other children service providers' to improve the wellbeing of children and young people. The CSCA is a significant legislative development which aims to improve the 'well-being' of children and young people in a manner which realises their rights. This legislation is grounded in the principle that 'co-operation' is the most effective way to realise children's rights. For the purposes of the legislation 'wellbeing' is defined through 8 high level outcome areas, one of which is physical and mental health. It also states that in determining the meaning of wellbeing for the purposes of this Act, regard is to be had to any relevant provisions of the United Nations Convention on the Rights of the Child.

The obligations under the Act should inform all of the work which Government

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[5] http://www.ohchr.org/EN/HRBodies/CRPD/Pages/ConventionRightsPersonsWithDisabilities.aspx

[6] http://www.legislation.gov.uk/nia/2015/10/contents/enacted section 2 and 9

Departments and agencies undertake to improve the lives of children and young people in Northern Ireland. The Act places a statutory duty on Government to adopt a Children and Young People's Strategy. This is in line with the UN Committee on the Rights of the Child General Comment No. 5 on General Measures of Implementation of the UNCRC which obliges State Parties to produce a 'national action plan for children'. The proposed Children and Young People's Strategy 2017-2027 will therefore be the main overarching government instrument for improving the wellbeing of children and young people in Northern Ireland.

4.0 Key Issues within Child and Adolescent Mental Health Services

There can be no doubt that child and adolescent mental health services offer vital, often life saving interventions. However, there are a range of issues within the current system, many of these are long standing, reflect chronic under-investment and lack of parity of esteem between mental health and physical health services and between child and adult mental health services.

In the most recent examination, the committee recommended that the State party:

60.

(a) Regularly collect comprehensive data on child mental health, disaggregated across the life course of the child, with due attention to children in vulnerable situations, and covering key underlying determinants.

(b) Rigorously invest in child and adolescent mental health services and develop strategies at national and devolved levels, with clear time frames, targets, measureable indicators, effective monitoring mechanisms and sufficient human, technical and financial resources. Such strategy should include measures to ensure availability, accessibility, acceptability, quality and stability of such services, with particular attention to children at greater risk,

including children living in poverty, children in care and children in contact with the criminal justice system.

(c) Expedite the prohibition of placement of children with mental health needs in adult psychiatric wards or police stations, while ensuring provision of age-appropriate mental health services and facilities;

(d) Support and develop therapeutic community-based services for children with mental health conditions;

(e) Review current legislation on mental health to ensure that the best interests and the views of the child are taken duly into account in cases of mental health treatment of children below the age of 16, in particular with regard to hospitalization and treatment without consent.

62. The Committee also recommended that the State party:

 (b) Ensure that prescription of drugs is used as a measure of last resort and only after an individualized assessment of the best interests of that child, and that children and their parents are properly informed about the possible side effects of this medical treatment and about non-medical alternatives. (CRC/C/GBR/CO/5, 2016)

The Committee continues to repeat its recommendation that States legislate for: specific proportion of expenditure to be allocated to children's health; that this should be made visible in budgets; disaggregate data for planning and monitoring purposes; and produce child impact assessments (CRC/C/GC/15, 2013 and CRC/C/GBR/CO/5, 2016).

NICCY's key concerns which are highlighted below reflect evidence gathered from a range of sources including evaluation reports and reviews, Assembly Papers, answers to Assembly written questions (AWQs), NICCY's legal casework, direct engagement with professionals and practitioners and children and young people. It also includes the Concluding Observations (recommendations) of the Committee on the Rights of the Child.

Key concerns for NICCY in relation to children and young people's mental health are:

4.1 Lack of data collection and monitoring;

4.2 Unequal availability and accessibility of services;

4.3 Poor transition from child to adult mental health services;

4.4 Gaps in workforce planning;

4.5 Inadequate support in schools and for schools; and

4.6 Lack of participation of children and young people.

4.1 Lack of data collection and monitoring

Summary of NICCY concerns regarding data collection and monitoring

1. Insufficient data collection and monitoring of the operation of CAMHS i.e. demographics, presenting need, services / therapies offered, service user experience and outcomes.
2. Lack of prevalence data on scale of mental health need within population.
3. Limitations in ability to provide evidence based service delivery and planning which takes account of needs and outcomes.

4.1.1 Insufficient data collection and monitoring

To deliver the best support and services for children and young people who are at risk of developing poor mental, or who are presenting with mental health problems, it is necessary to understand what the scale of the need is, what services need to be in place to meet that need and how much investment is required to ensure that those services and support are in place. There is a limited amount of publically available, standardised regional government data on the services contained in the regional CAMHS model. For example, there is no central database which can provide a reliable regional breakdown of the demographic profile of children and young people accessing Tier 1 to Tier 5 CAMHS

by age, ethnicity, disability or by presenting need / mental health diagnosis of children and young people using services, the reasons referrals are declined, detail on the interventions being used, or the outcomes achieved by such interventions. The Health and Social Care Board, in conjunction with the Health and Social Care Trusts, recognise that data management needs to be improved and are currently developing a regional CAMHS dataset, however, the timeframes for completion of this work is unclear.

4.1.2 Lack of prevalence data

Northern Ireland does not undertake a recurring population wide survey of mental and emotional wellbeing of children and young people which makes it impossible to fully understand the scale of mental health need. Although the value of such prevalence data has been acknowledged by Health and Social Care Board, no resource has been ring fenced to conduct this in the short to medium term[7]. The results of the 2016 Young Person Behaviour and Attitude Survey is due to be released in 2017, there are a number of questions relating to children and young people's (age 11-16 years old) self reported mental and emotional wellbeing which will provide useful indication of mental health in absence of a more comprehensive prevalence survey [8].

4.1.3 Evidence based service delivery and planning

Population wide prevalence data, alongside a reliable monitoring database of those accessing CAMHS is required in NI, and is essential to ensure that resources are being utilized in the most effective and efficient manner to achieve the best outcomes. It is also necessary in order to fully meet equality of opportunity obligations set out under Section 75 (1) of the Northern Ireland Act 1998. The legislation outlines 9 categories / groups against which public authorities are required to monitor for and eliminate discrimination- this includes between persons of different age and between persons with a disability[9]. The legislation also requires them to take proactive action to promote equality of opportunity

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[7] HSCB- Review of Acute CAMHS- Action Plan 15/16

[8] http://www.csu.nisra.gov.uk/survey.asp96.htm

[9] The remaining 9 s75 groups are and persons without religious belief, political opinion, racial group, marital status or sexual orientation; between men and women generally, and between persons with dependants and persons without.

between members of the 9 section 75 categories. It also encourages public authorities in Northern Ireland to take action to address inequality among members of the 9 specified groups where inequality has been identified.

Other parts of the UK, particularly England and Scotland have been making progress in terms of collecting and collating this type of data. The necessity of making improvements to national CAMHS data collection and monitoring was emphasised by the Children and Young People's Mental Health Taskforce[10] which was established in England to look at ways of improving the outcomes for children and young people's mental health and well-being. A population wide survey of children and young people's mental health in England and Wales is due to be reported on in 2018-2019 and progress is being made in England to develop a CAMHS data set.[11]

4.2 Unequal availability and accessibility of child and adolescent mental health services

Summary of NICCY concerns regarding availability and accessibility of services

1. Inconsistency in provisions- regional and local;
2. Threshold and criteria for accessing services;
3. Waiting lists;
4. Access / choice of therapeutic supports;
5. Community Provision- including out of hours / crisis support;
6. Specialist provision- alcohol and drugs, forensic, eating disorder; dual diagnosis / complex needs and
7. Co-ordination between services.

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[10] https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people
[11] http://content.digital.nhs.uk/CAMHS

4.2.1 Regional Inconsistency in the availability, accessibility and quality of mental health services

There is regional inconsistency in availability, accessibility and quality of mental health services across all tiers of CAMHS. The regional stepped care model of CAMHS was developed to address these issues and to ensure that no matter where children and young people live in NI, they would have access to the same or comparable services. Children and young people continue to experience fragmented service and unequal access to services between and within Health and Social Care Trusts (RQIA, 2011; Rees et al. 2014). It is also apparent that the CAMHS system is too complicated for Practitioners supporting children and families, as well as children and families themselves (NICCY, 2016:1). It has been reported that during 2015- 16, 10,000 children and young people were referred to mental health services and between April and November 2016, 6,000 had been referred to CAMHS which represents a 30% increase in referrals since 2012 (BBC, 2017).

4.2.2 Threshold and Criteria for Accessing Services

The increasing budgetary pressures on services have led to increasing reports of thresholds being raised to access mental health services. Higher thresholds have meant that early intervention community based services are experiencing an increase in inappropriate referrals from Trusts and that these organisations are dealing with young people with increasingly complex issues. This can mean that by the time these children access CAMHS their symptoms have often significantly deteriorated. The percentage of referrals refused at first appointment to Tier 3 CAMHS has risen from 33% in 2013/14 to 42% in 2015/ 16[12]. There is no official information available on the reasons for this, nor is there information on whether these young people are being referred on to other services, or if so, which services.

A considerable percentage of young people referred to Tier 3 CAMHS are being recorded as either not attending (DNA) or cancelling attendance (CNA). For the period 2015/ 16,

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[12] Information provided to NICCY from the Health and Social Care Board-August 2016.

did not attend (DNA) and cannot attend (CNA) figures were 15% for first appointments and 24% for review appointments. These rates have not changed for the 3 year period, 2013 to 2016. It is unclear what the reasons are for DNAs and CNAs, neither is there clarity around the actions taken to address non-attendance. There is very little publicly available monitoring information available on community mental health services e.g. what services are available across NI, a breakdown of the demographic profile of those using it, waiting lists for referral and from referral to treatment, interventions offered, outcomes achieved etc.

4.2.3   Waiting Times

The numbers of young people waiting prolonged periods of time to see a mental health professional has increased significantly. Statistics also highlight significant variation in waiting times across Health and Social Care Trusts. According to current targets no one should have to wait longer than nine weeks for an appointment with CAMHS, however, this target was missed 130 times in 2016 (AQW 4864/16-21). Furthermore, this figure represents an increase of 62% on the previous year, and a rise of 136% from 2014. In the year to the end of August 2016, the Western Health and Social Care Trust had most delays, with 72 cases having to waiting longer than the target time. In comparison, the Belfast Trust had 58 cases, while both the Southern and Northern Trusts recorded no patients having to wait longer than nine weeks for an appointment (AQW 4864/16-21).

It is widely and publicly acknowledged by the Department of Health and the Health and Social Care Board that waiting times for CAMHS are unacceptable and causing a negative impact on the quality and experience of care (AQW 4864/16-21). Official waiting times are calculated from the date of acceptance of a referral to the time the patient is seen and assessed at their first appointment. Although very useful, these statistics do not include the time that children and young people can be waiting to be referred and it doesn't include waiting times for second appointments or time taken for treatment to begin. Furthermore, the waiting time statistics published only relate to Tier 3 CAMHS therefore

there is a considerable part of the system where there is no information available on how long children and young are waiting to access services once referred.

4.2.4   Specialist Provision

Specialist provisions include services for children with co-occurring conditions with mental health i.e. drugs and alcohol problems, Autism / ASD, children who are deaf or hearing impaired. Regional referral criteria guidance states that children with co-occurring conditions should have access to CAMHS services (HSCB, 2012), however; there are cases which indicate that children and young people with dual diagnosis are not receiving mental health services (Short, 2016). This includes those who have been assessed as having a mental illness or who are presenting or reporting with very clear signs of mental illness. There are a range of reasons provided for this, this includes children and young people and their parents / guardians having difficulty getting access to services, being refused services because they are deemed not to meet the criteria, and disengagement of children and young people from services (Kelly et al., 2016: 1; Kelly et al., 2016: 2). There is also significant variation in the funding being provided to different specialist services, even a cursory assessment of the top-line funding profile to addiction, forensic and eating disorder services would indicate that it is not sufficient to fully meet need. An investment profile of CAMHS for the period 2015 / 16 includes an allocation of £333,464 to addiction services (HSCB, 2016).

The establishment of the regional in-patient psychiatric unit at Beechcroft is positive progress in terms of mental health provision for children and young people. There have been significant improvements in the number of children and young people being accommodated in adult wards. The DHSSPS have reported that in 2014/15, 21 children and young people were accommodated in adult psychiatric wards, although lower than the rates being reported by the RQIA Review in 2012 (RQIA, 2012), it is unacceptable that any child should be accommodated in anything other than a specialist age appropriate facility. The Committee on the Rights of the Child has been very clear in each of its examinations of the UK State Party that admission and treatment of children and young people on adult wards is a gross violation of a child's rights (CRC/C/GBR/CO/5 2016). Eating Disorder

care is another area in which Northern Ireland services are unable to fully meet all of the need presented. There is currently a scoping study being conducted to review the potential for a specialist eating disorder facility in NI (DoH, 2016:2). There are also concerns about the 'crisis driven' nature of the psychiatric in-patient facility for children and young people and the increasing complexity of cases referred to it (Rees et al., 2014). Part of the reason for the demand pressure which it faces, is that it is the only in-patient psychiatric facility for children and young people in NI. There are no additional in-patient facilities for young people who require specialist care i.e. forensic, substance misuse or eating disorders. The limitations to the availability of in-patient care is part of the issue, however, the under-development of community provision is also a concern which is leading to increasing referrals to facilities such as Beechcroft, the secure care unit at Lakewood and to other acute health and social care services (Rees et al., 2014).

4.2.5   Community Provision- Out of hours / crisis support

Community based mental health services such as the Crisis Assessment Teams (CAT) and Intensive Treatment Teams (IIT) are a key part of the regional CAMHS care model. These services are in the early development stage in many Trust areas, with provision remaining fragmented and inconsistent across different geographic areas.

Community provision for young people with alcohol and drug problems is one example of where community services, in particular out of hours and crisis response, require further investment. There are very serious gaps in services for children and young people with alcohol and drug addictions and/or mental health problems. This includes a lack of crisis support/community provision and intensive in-patient treatment and support. In recent months there have been a number of debates in the NI Assembly regarding the need for specialist support for this group of vulnerable young people. Current mental health legislation prevents mental health assessments from being conducted whilst children and young people are under the influence of alcohol or drugs. When a mental health assessment cannot be carried out, Child and Adolescent Mental Health Services can't be offered and where parents are unable to cope, young people are referred to social

services, however, as is often the case, the support they can offer in such circumstances is limited[13].

Limited access to specialist, multidisciplinary community CAMHS is leading to young people experiencing delayed discharges from regional facilities (Rees et al., 2014). In other cases a lack of suitable community infrastructure is leading to young people's needs escalating to a point that in-patient care is required (Rees et al., 2014). The lack of community based services raises serious concerns about whether children and young people have equal rights and equal access to the full range of services to support them to have the highest attainable standard of health.

4.2.6 Access / choice of therapeutic supports

The investment profile of CAMHS for the period 2015 / 16 outlines recurrent investment of £50,000 in CAMHS training in psychological therapies. Although recurrent funding is to be welcomed, this funding is inadequate when it is set against a backdrop of spiraling increases in mental and emotional health problems being identified from a very young age, and year on year increases in the numbers of children and young people being prescribed anti-anxiety and anti-depression medication (Assembly Written Question 52569/11-16).

4.2.6 Collaboration and co-operation between services

There is a need for greater collaboration and co-operation between CAMHS and key referral and service delivery agencies such as Education, Social Services, A&E, GPs and NGOs. Professionals who work with children and young people describe their frustration with the lack of co-ordination, communication and integration within and between children's services (NICCY 2016). The need to address this issue has been stressed in a range of review processes that CAMHS has undergone including the independent review by Dawn Rees (Rees et al., 2014). An Implementation Plan was developed for the period 2015/16 to action all of the recommendations from the Rees Report. This covered key changes needed for improving the co-ordination and integration of services, including the

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[13] NICCY meeting with Social Worker 9th August 2017

interfaces between primary care and CAMHS. This plan committed to establishing a managed care network of CAMHS to develop the regional arrangements for the management of services which would include a process of revising clinical pathways to ensure they are fully integrated and in line with NICE guidelines. It is unclear how much progress has been made to achieve this aim; it would appear that much work is still required including investment to fully embed the reconfigured services. [14]

There are considerable issues with children and young people moving between a range of regional facilities most notably Beechcroft, Woodlands Lakewood and Glenmona. There have been a range of reviews and inspections in recent years which have highlighted this revolving nature of admission for a vulnerable group of young people. NICCY has also identified a concerning pattern involving these services through its legal casework. The HSCB are taking steps to commission a review to look holistically at the provision offered by these regional facilities and the relationship between them.

A related issue which has been identified in the Rees report is the culture of 'referring on' by services because they are working in an environment where demand is out-stripping its ability to respond. This practice of 'referring on' prevents the joint working that is needed to ensure children and young people receive a seamless service (Rees et al., 2014). The lack of joint working and integration of CAMHS with other health services is concerning as this is vital for those very vulnerable groups of children and young people who have multiple and complex needs i.e. health, social, education and justice.

4.3 Poor transitional planning from child to adult mental health services

Research evidence indicates that young people tend to look for help for their mental health problems in their adolescence / young adulthood which is also the point at which young people are being moved from children to adult mental health services (Khan, 2016). There is also much evidence of poor preparation for young people transitioning to adult services

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[14] Response to request for information from NICCY to DOH- dated 23 Sept 2016

with unpredictable continuation of care and poor follow-through being consistently reported (NICCY, 2012). NICCY has had recent engagement with professionals on their experience of supporting children and young people through this transitional process, there was a strong emphasis on the importance of relationships and the need to build in time to the transitional process for young people to get to know new professionals. They also highlighted the need for adult services to adapt itself to make the transition easier for young adults who have different needs and expectations to older adults (NICCY, 2016:1).

"a person, particularly a vulnerable one, doesn't just become an adult after reaching 18, therefore adult services need to be better tailored to young adults needs" (NICCY, 2016:1)

There is a need for clear interfaces and transitional arrangements between children and adult mental health services to ensure a continuity of care. NICE has recently published new guidance on this which includes the need to involve young people and carers in the design, delivery and evaluation related to transitions, being person centred, strengths based, developmentally appropriate, with each young person having a named worker to co-ordinate their transition care and support (NICE, 2016).

Most if not all Trusts, will have policies or protocols in place around transitional arrangements between CAMHS and AMHS (RQIA, 2011). What is less clear are the current barriers / enablers influencing the quality and consistency of the transition process and what the outcomes are for children and young people who are making the transition between services.

4.4 Gaps in workforce planning

There are concerns about the ability of the CAMHS workforce to provide therapeutic care which meets NICE guidelines and which offers real therapeutic choices for children and young people due to widening gaps in the workforce skills mix (Rees et al., 2014). Although more funding is being directed to services such as 'primary care talking therapy

hubs[15,] which provide an alternative to medication, the HSCB admits that "much more needs to be done in order to provide alternatives to drug therapy for people who present with common mental health needs" (The Detail, 2014). We understand from figures provided by the HSCB that regional recurrent funding of £50,000 was invested in CAMHS training in psychological therapies in 2015 / 16 (HSCB, 2016). What is less clear is to what extent the current provision is meeting the needs of children and young people and what impact it is having on those availing of it.

4.5 Inadequate support in schools and for schools

Schools have a critical role in promoting emotional wellbeing and preventing mental health problems. Article 29 of the UNCRC's refers to the role of schools in 'developing every child's personality, talents and abilities to the full'. This clearly demonstrates that from a child's rights perspective the role of the school goes further than teaching children and young people the curriculum. The i-Matter programme is the name of the current programme for promoting resilience and emotional health for all pupils in post primary schools in Northern Ireland. Under this programme a suite of homework diary inserts, leaflets and posters are available to schools on topics of concern to young people such as self esteem, substance abuse and coping with stress, worry and anxiety. It is very clear however, that many schools and teachers do not feel equipped to address aspects of mental and emotional wellbeing with children and young people.

The Department of Education funds an independent counselling service for post-primary aged pupils' in grant-aided schools called the Independent Counselling Service for Schools (ICSS). This is a vital service and one which is reporting an increase in the number of children experiencing self harm, mental ill health, alongside other issues such as neglect. There is no equivalent service for primary schools even though there is evidence of increasing levels of mental and emotional health need of this age group. This

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[15] The HSCB as part of Transforming Your Care proposals is at the start of a 5 year plan to establish Primary Care Talking Therapy Hubs across each Trust area. The focus is on providing a range of psychological therapies (such as Counselling, CBT, Psychotherapy) and lifestyle support for people who are experiencing common mental health problems.

policy decision runs counter to the prevention and early intervention agenda that is being adopted across Government. The Department for Education has conceded that a lack of funds, rather than a lack of need for such as service, has prevented the extension of existing services. School based counselling is a vitally important service; however, it should be one of a number of supports offered to children and young people. NICCY understands from talking to children and young people, that school based counselling although very important, it is not always appropriate for a number of reasons, including perceived or experienced lack of confidentiality and school being a cause of anxiety, therefore community based counselling must also be available and easily accessible (NICCY, 2016). Many organisations which provide community based counselling for children and young people report that they are unable to access statutory funding to extend and sustain their services to meet demand for services.

There is a significant shift in policy focus and discourse on prevention and early intervention with regard to emotional health and well being. It is also clear that schools can and should play an important role. However, it is also critical to understand the equally important role of specialist and crisis response services for those young people who require it.

4.6 A lack of participation of children and young people

Participation of Children and Young People

Summary of NICCY concerns regarding lack of system(s) for listening to the views of Children and Young People.

1. Own Care Planning;
2. Development of service, policy, and legislation; and
3. Lack of evidence of advocacy provision.

4.6.1 Own Care Planning & Development of Services

Meaningful engagement with children and young people and their families is the most effective way of ensuring that child and adolescent services are age appropriate, responsive and accessible. Being consulted with and having their views taken seriously is also a right that children have under both domestic and international law. There is little evidence of a NI-wide system for listening to the views of children and young people as users of mental health services on a regular basis, therefore it is unlikely that planning and development of these services are properly informed and shaped by children and young people. The lack of a regionally robust system for collecting and analysing patient and client experience data is a concern and is part of the wider issue of poor data collection and monitoring on mental health need, service use and investment. Investing in a feedback mechanism is a necessary way of ensuring that people who are at risk of discrimination or have experienced ineffective or unsafe treatment or care have a vehicle through which they can have their voices heard. It also benefits service providers and commissioners who can ensure that the health system provides interventions which support patients as early as possible and which are meeting minimum quality standards. It is very important that the views of children and young people are collected as part of any process and where possible, this should be the direct feedback from children and young people and not through a 'proxy'.

The Committee on the Rights of the Child has advised State Parties on how they can ensure that children and young people have their right to express their views freely and to have them taken fully into account in relation to health matters as set out in Article 12. The Committee highlights the need to ensure that feedback mechanisms and consultations are carried out directly with children and young people and which are adapted to the age and maturity of the child.

"State are encouraged to conduct regular participatory consultations, which are adapted to the age and maturity of the child, and research with children, and to do this separately with their parents, in order to learn about their health challenges, developmental needs and

expectations as a contribution to the design and effect interventions and health programmes." (CRC/C/GC/15, 2013)

Under domestic law, Personal and Public Involvement (PPI) is a legislative requirement as under the Health and Social Services (Reform) Northern Ireland Act 2009. It places legal duties on all Health and Social Care organisations and the Department for Health, to put mechanisms in place to involve the public and consult with them in relation to their health and social care. Under Section 19, each HSC organisation and the Department must prepare a consultation scheme setting out what arrangements it has in place to ensure that the Patient and Client Council and the general public are consulted on matters relating to the planning and delivery of health and social care services.

The Patient and Client Council (PCC) is the independent statutory body for ensuring that the public has a say in what happens in their local health and social care services. It is concerning that the complaints service does not receive calls from children and young people or on behalf of children and young people[16]. This lack of engagement severely limits the role that the PCC can have in representing the experiences of this group to commissioners and Health and Social Care Trusts.

4.6.2   Advocacy Services for Children and Young People

It is more common for adults to look for help in relation to a child's or young person's mental ill health, than for a young person to do so themselves. Unfortunately, not all young people will have a trusted adult in their life who can support them to seek help and to make decisions about their healthcare. Recently published UK based research found that even though three quarters of parents seek help on their child's behalf, only a quarter receive any (Khan, 2016).

Children and young people who have mental health difficulties and who require treatment or services are particularly vulnerable to not having their rights or best interests fully taken

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[16] Update on service use provided by email from PCC to NICCY-Jan 2017.

into account. An RQIA review of CAMHS in 2011, found a lack of independent advocacy services for children and young people who have mental health needs. More recently a separate review of advocacy services for children and adults reported an increase in demand for advocacy services, including more complex cases.[17] The review found that the current profile of services varies across geography and different programmes of care, with evidence of particular variability in service provision for those with specific conditions such as autism. The review provided a range of recommendations for advocacy services, which include, carrying out a needs assessment to determine future capacity requirements and improve access to advocacy; clarifying arrangements with/for advocates to link with other sectors including education, health, housing when this is required to seek to resolve cross-agency issues; and establishing outcome measures to enhance the evaluation of services and to inform future commissioning (RQIA, 2011; RQIA, 2016).

Effective advocacy services have the potential to contribute to key strategic priorities for Health and Social Care which ultimately promotes wider equality and human rights objectives. Independent advocacy plays a crucial role for service users and carers; the importance of such has been articulated in the Bamford Review.

"Advocacy seeks to support individuals to express and have their views heard. It aims to redress any imbalance of power between the individual and professional. It is concerned with empowerment, autonomy and self determination, the safeguarding of citizenship rights and the inclusion of otherwise marginalised people." (Bamford Review Report on Human Rights and Equality of Opportunity)

The Mental Capacity (NI) Act 2016 provides for the appointment of independent advocates. This is a positive development as it puts advocacy on a statutory footing. Unfortunately, the legislation is restricted to those aged 16 and over therefore when this part of the legislation is commenced; there will be unequal access to this most critical of services for young people under 16.

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[17] Advocacy services for children and young people are provided by VOYPIC, Barnardos and NIACRO.

5.0 Strategic Policy Implications

This section of the paper sets out reflections on some of the overarching strategic policy issues that are faced by child and adolescent mental health service commissioners and providers. These overarching areas highlighted below take cognisance of the concluding observations and recommendations made by the UN Committee on the Rights of the Child in their most recent examination in which they advised the UK State Party to rigorously invest in child and adolescent mental health, develop strategies to ensure services are provided on a child rights compliant basis with a focus on providing measurable indicators, disaggregated data and addressing key underlying determinants of poor mental health.

5.1   Implementation of CAMHS Improvement Plans

The lack of investment to fully implement the findings of CAMHS reviews and associated implementation plans has impeded the rate of significant tangible change. The lack of implementation of the independent review of acute CAMHS is a recent example of where investment has not met the system's ambition for service reform - although the report recommendations were fully endorsed and an implementation plan (minus budget allocation) developed for 2015-2016, limited progress has been made in achieving the outcomes. A lack of ring-fenced funding is one of the main reasons for failure to implement plans or to see consistent regional improvement in CAMHS such as a reduction in waiting times to access services, less fragmentation and unequal access to services across Trust areas (Rees et al., 2014). The cost of establishing the CAMHS Model in full is not clear, however, if it is not possible to fund it in its entirety, then strategic evidence based decisions need to be made to ensure that scarce resources are invested where most needed and in which human rights issues have been fully considered.

5.2 Mapping Need and Measuring Outcomes

Part of the problem facing mental health service provision is a lack of parity of esteem between mental health and physical health. To achieve this we need to have much more focus on objective need being the key driver in decision making - whether addressing

physical or mental health issues. Equality in access to high quality services will require robust data and monitoring systems which can help to better identify need and direct resources to best effect.

There needs to be much greater clarity and transparency in children and young people's mental health needs and on the evidence base being used by Government to shape policy and practice, identify unmet need and direct resources. It is impossible to know if the needs of children and young people are being met, or whether better outcomes are being achieved, if neither are being measured. Greater clarity and transparency can only come from robust regionally available datasets on the operational aspects of CAMHS which is regularly updated and publicly available. This dataset should include information on levels of demand, availability of and access to services, diagnoses of service users and a breakdown of expenditure on different aspects of the regional model of services. This should be complemented by a Northern Ireland wide prevalence survey on children and young people's mental health and an evaluation framework for services which has a focus on measuring the outcomes achieved for children and young people. Child rights principles should underpin the measurement of outputs and outcomes. In practical terms this means that children and young people should be asked directly about their satisfaction levels and experiences as mental health service users. The measurement of experiences and outcomes should go beyond the medical understanding of mental health to include outcomes that are defined by and important to, young people i.e. improvement in relationships with friends and family, in addition to psychometric scores (STAG, 2016).

5.3 Co-ordination, communication and integration

Greater strategic planning and prioritisation in CAMHS is required to ensure there is consistency in the availability and quality of all levels of mental health services, when and where they are needed. Applying a more holistic approach will ensure that all children and young people achieve the best possible health and are able to flourish. This cultural change needs to come from the highest levels of policy making and governance. There have been many examples of reviews and reform plans for health and social care and

mental health more specifically. A number of these key reviews and reforms have been highlighted in this paper. Unfortunately, one of the main weaknesses in these processes has been in the implementation- issues include a lack of investment to implement actions, unclear timeframes set or time frames not met, lead partners not clearly defined, limited accountability or oversight mechanisms etc.

We are now at a time where there is great impetus for change, not least because we have the new Children's Services Co-operation Act (Northern Ireland) 2015 (CSCA). The Act addresses Bengoa's assessment that the lack of co-ordinated strategic direction in the transformation of our health and social care system means that services tend to operate in silos rather than being driven by the assessed need of the population (Bengoa, 2016). The CSCA is a significant legislative development which aims to improve the well-being of children and young people in a manner which realises their rights and places obligations on Departments / Agencies to co-operate with each other in order to contribute to the improvement of outcomes for children and young people. It also places a statutory obligation on Government to adopt a Children and Young People's Strategy, the development of a new Strategy is currently underway, the consultation on the proposals closed on 31 March 2017. The Children and Young People's Strategy 2017- 2027 will be the overarching framework under which all services provided to children and young people in Northern Ireland and all issues impacting on their lives will sit, and which should be understood as the Programme for Government for Children and Young People.

5.4 'Mental Health in all Policies' Approach

A culture change is required in Northern Ireland where health is not just seen as the sole responsibility of the Health Department and its agencies. Although the Department for Health should be the main driver of policy in this area, by applying a 'health in all policies' approach, policy making at all levels of governance and across all sectors would ensure that we take a more holistic view of a child's life, which includes addressing the root causes of poor emotional and mental health. The Committee on the Rights of the Child reminds State Parties of the need for a 'child health in all policies' strategy to be applied

and for every effort to be made to remove bottlenecks that obstruct transparency, co-ordination, partnership and accountability in the provision of services affecting children's health (CRC/C/GC/15, 2013). Taking this approach is the most effective way of ensuring long term positive change in the mental health outcomes of children and young people.

5.5 Addressing the root causes of poor mental health

There are a wide range of socio-economic and environmental factors that can lead to poor mental health in children and young people, these issues which are specific to Northern Ireland, such as the legacy of the conflict and higher rates of poverty and mental health problems across the population as consequences of this. We also know that children and young people who experience multiple adversities are at much higher risk of poor mental health; therefore addressing the holistic needs of these children and young people is vitally important. (Devaney et al., 2012) A holistic 'interdependent' approach to child and adolescent mental health is more likely to lead to the desired / best outcomes; this is also central to the realisation of children's rights which recognises the indivisibility and interdependence of them.

It is also important that barriers which lead to inequalities in health are identified and removed- "Health behaviours and outcomes are not simply a matter of personal responsibility - they are influenced by the wider socio-economic circumstances within which people live. They can also be driven by unequal access to services and support, and it is important that those delivering health services identify and address any systemic and/or attitudinal barriers to access within the service which may lead to disadvantage and subsequent health inequalities within some communities and groups." (TEO, 2016)

5.6 Participation of children and young people

At a strategic policy level, new approaches are emerging that are attempting to change the way that health services are planned and commissioned, which includes the new quality healthcare experience framework, '10,0000 voices' project (NIE, 2016). These feedback mechanisms present a real opportunity to embed, strengthen and promote the

involvement of children and young people in decision making, and in so doing demonstrate a real tangible commitment to realising children's rights as citizens on an equal footing with everyone else. Research, good practice and child rights compliant approaches recommend that every effort should be made to ask children and young people directly about how they feel about issues affecting their lives. This approach is much more likely to lead to services which meet the needs of children and young people. Moreover, there is a range of domestic legislation and international obligations which require provisions to be made to listen to children and young people- under Section 75 of the Northern Ireland Act 1998, public bodies have a duty to consult with children and young people, there are also Personal and Public Involvement (PPI) responsibilities under the Health and Social Services (Reform) Northern Ireland Act 2009, and international obligations under Article 12 of the UNCRC for children and young people to be listened to and for their views to be taken seriously.

6.0 Conclusion: NICCY's Next Steps

Mental health services offer vital and often life savings services. We also know that to support children and young people fully, a comprehensive suite of services and support are required at prevention, early intervention, through to specialist care and intensive support. There is a lack of publicly available robust, disaggregated, regional data and monitoring on prevalence of poor mental health and key aspects of the CAMHS system, such as service usage, presenting need, outcomes and budgetary breakdowns. This lack of data means it is very challenging to fully review the adequacy and effectiveness of current provision with respect to children and young people's rights and best interests or to advise relevant authorities in a fully informed manner. More specifically, this chronic lack of regional, publically available data also means that it is unclear how well current services are meeting the needs of children and young people (needs analysis), where the gaps are (service mapping) and what impact this is having on outcomes for children and young people (evaluation and outcome measurements).

There are a range of ongoing broad system reviews and implementation plans being

undertaken in CAMHS which are to be welcomed. They do not however, take sufficient account of whether current services across CAMHS are meeting child rights principles such as those which focus on the availability, accessibility and quality of services. Nor is there evidence that sufficient account is being taken of the direct experiences and input from a range of children and young people requiring CAMHS. Children and young people have a right to have their needs understood and responded to as early as possible. They also have a fundamental right to be listened to and have their views fully considered when decisions are being made about services that affect them.

As a consequence of the scoping work carried out by this Office, including extensive engagement with children and young people and relevant stakeholders on the many issues surrounding child and adolescent mental health, NICCY intends to carry out a rights based Review of CAMHS. This Review will have a particular focus on children and young people's experience of accessing or attempting to access mental health services or support. It will include direct engagement with children and young people, their parents/carers and professionals working with and for them, to establish a robust evidence base.

The methodology includes a survey which will be widely disseminated for completion by young people. This will be carried out in conjunction with interviews with children from specific target groups which the Office has identified as experiencing specific issues in regard to accessing CAMHS. These target groups are children and young people with mental health conditions which co-occur with learning, physical or sensory disabilities and those with an addiction disorder. The Review will also include a full mapping and analysis of available official statistical information on the operational aspects of CAMHS and an analysis of budgetary spend / investment.

This Review is being conducted in accordance with NICCY's functions under Article 7(2) and (3) of the Commissioner for Children and Young People (NI) Order 2003 which includes a duty to 'keep under review the adequacy and effectiveness of law, practice and

services provided for children and young people by relevant authorities.' It is also in line with the Commissioner's duties under Article 7(5) (b) and (d) to encourage children and young people to communicate with the Commissioner, and for the views of children and young people, and their parents, to be sought whilst carrying out her functions. Furthermore, under Article 7(4) (b) NICCY has a duty to advise relevant authorities and or Executive Committee of the Assembly on issues concerning the rights and best interests of children and young people identified during the Review.

As a rights based Review, a central aim of this piece of work will be to explore the challenges to realising children and young people's rights in accessing mental health services, as grounded in the principles of the UNCRC, in particular Articles 2 – non-discrimination; 3 – best interests of the child; 6 – right to survival and maximum development; 12 – right to be heard and have views taken into account; 23 – right of a disabled child to a full and decent life; and 24 – highest attainable standard of healthcare. NICCY also takes cognisance of other international human rights instruments and standards when considering the rights and needs of children and young people including the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). With respect to child and adolescent mental health, there are a number of articles of particular relevance, these are, Article 25 - highest attainable standard of health without discrimination on the basis of disability; Article 7- which refers to the right of children with disabilities to enjoy all human rights and fundamental freedoms on an equal basis with other children; Article 12 which states that the aim of the UNCRPD is full and equal legal capacity for everyone and Article 21 - freedom of expression and opinion, and access to information.

In compliance with these international obligations, the Review will endeavour to hear from children and young people directly, or where appropriate, with a trusted adult i.e. parent, guardian or advocate. It will also seek the views of a range of professionals who work within the CAMHS system or who have a role in supporting children and young people in accessing CAMHS.

The specific aims of the review are to:

- Enable children and young people (and their parents, guardians and advocates) to share their direct experiences of accessing or trying to access CAMHS and the impact of that 'journey';

- Identify barriers which prevent children and young people from fully realising their rights to the highest attainable standard of health and access to adequate mental health services;

- Identify good practice and produce a range of recommendations for improving services which are informed by children and young people and directed at key government departments and agencies; and

- Increase public awareness of children's rights and in particular children and young people's rights to health and to access to health services.

The full Terms of Reference for the Mental Health Review are available from the NICCY website- http://www.niccy.org/speakyourmind

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