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Preface

Ireland ratified the UN Convention on the Rights of the Child in 1992. While this Convention represents the minimum obligations of States in respect of their children, it also marked a turning point in global efforts to guarantee children the right to healthy survival, development, education, healthcare, and freedom from abuse or exploitation. Significantly, the Convention enshrined the right of children to participate meaningfully in their futures. No longer would it be all right to view or treat them as anything less than full and equal world citizens. What is so unique about this treaty is that over 190 States have ratified it, and only two have refused to do so – it is the most ratified human rights treaty to date. This means that unprecedented consensus exists on the world stage on how we should respect our children.

Many people are surprised at the level of mental health problems that occur in childhood. Others are shocked at the poverty of government responses. In ratifying the Convention, Ireland promised before the eyes of its citizens and the world to do everything in its power to respect the right of its children to basic mental health services and to dignity.

Ireland is no less bound by the norms of human rights law than elsewhere in the world. Amnesty will pursue these obligations with the Irish Government, and the publication of this report marks the beginning of our campaign focus on children's mental health rights.

Our objectives for our 2003 campaign '*Mental Illness: The Neglected Quarter*' are to establish general awareness that mental health is a human rights issue, to place this fact firmly before Government, and to lobby for much needed reform in Government policy, practice and legislation, in solidarity and cooperation with national stakeholder organisations. Staff of mental health, childcare and other services also deserve recognition for the invaluable work they do in often difficult circumstances.

The message of this report is simple: Ireland is failing its children by neglecting their mental health services. Is it not time that the Government did something meaningful about this?

Seán Love
Director, Amnesty International (Irish Section)



Introduction

“The lack of attention to the mental health of children and adolescents may lead to mental disorders with lifelong consequences, undermines compliance with health regimens, and reduces the capacity of societies to be safe and productive.”

World Health Organisation¹

Amnesty International (Irish Section) launched a campaign on the rights of people with mental illness in February 2003, with the publication of a report, ‘Mental Illness: the Neglected Quarter’², outlining its concern that the Government of the Republic of Ireland (Ireland) does not comply with its international human rights obligations in provision of mental health services. That report received the endorsement of almost 40 national support groups, service users’ advocacy organisations, professional bodies and unions.

In May 2003, Amnesty International published ‘Mental Illness: The Neglected Quarter – Homelessness’, the first of its three follow-up reports. This highlights the significant interrelationship between the experiences of homelessness and mental ill health, and that the slow pace of reform in mental health is disproportionately affecting this vulnerable group.

The purpose of this report on children is to supplement the above reports, many recommendations in which apply equally to children; and to determine the degree to which Irish legislation, policy and practice pertaining to children’s mental health complies with the requirements of international human rights standards.

Ireland ratified the UN Convention on the Rights of the Child (CRC) in 1992, and made a commitment to respect the rights of children under 18 years of age provided therein. The CRC represents binding minimum standards, not aspirations or high ideals, and requires special endeavours from Government to prioritise the rights of children. A new approach to children is now demanded, recognising that children are the subject of rights and entitlements, and these rights should be safeguarded and mainstreamed in all national policy and legislation. An holistic approach to the development of the child is central to the CRC, and its rights provide a framework within which Government policies and laws can be judged, with the best interests of the child placed centrally. In this context, this report looks at children’s mental health in a wider sense than mental health services, and at the roles of a number of Government departments and agencies.

This report aims to assess Ireland's performance of its obligations under the CRC to provide a comprehensive regime to promote mental well-being, and identify, treat and protect children with or at risk of mental ill health. However, many aspects of child development with relevance to mental health – family environment, poverty and social deprivation, etc. – are outside the scope of this report. (The Children's Rights Alliance will submit a 'shadow report' to the UN Committee on the Rights of the Child when Ireland sends its periodic report to the Committee, which will address many of these issues.³) Amnesty International's objective is to contribute to meaningful and timely reforms that serve the best interests of children with or at risk of mental ill health, through promoting equitable and sufficient provision by Government of mental health, educational and rehabilitative services, appropriate to the age and circumstances of all children.

Amnesty International's intention is not to criticise individuals – primary responsibility for compliance with international human rights standards lies with the Government. The ambition behind this campaign and report is to complement the advocacy work of national bodies, service users and service providers, by promoting general awareness that mental health is a human rights issue, and placing this fact firmly before Government. Amnesty International seeks to work in solidarity and cooperation with national stakeholder organisations for greater political attention to this marginalised area, and to act as an ally to disability and mental health nongovernmental organisations which are increasingly vociferous on disability and mental health rights. Radical improvement of children's mental health services will take time, and requires the introduction of a range of legal and procedural reforms, significant expansion of resources to provide these services, and a shift in the political priority given to mental health generally.

The past few years has seen a heightened impetus at the international level to address the inequalities experienced by people with mental ill health, and a drive for recognition of this issue as a human rights one. World Health Day in 2001 was dedicated to mental health for the first time, with the theme, 'Stop Exclusion-Dare to Care'. In its 2001 annual report, the World Health Organisation (WHO), the United Nations' health agency, observed that, throughout the world, mental health is neglected, and it made a renewed call to States to live up to the standards expected of them in their national systems.⁴ WHO advises nongovernmental organisations to advocate for Government action: "Advocacy is an important means of raising awareness on mental health issues and ensuring that mental health is on the national agenda of governments. Advocacy can lead to improvements in policy, legislation and service development."⁵ This is the challenge that Amnesty International and many national organisations are attempting to meet.

Amnesty International acknowledges that many children have very good experiences of Ireland's mental health services. Others have achieved recovery and realised their potential even in the face of a less than perfect system; the dedication of the many thousands of people caring for children with mental ill health throughout the country – families, service providers and voluntary organisations – is at the heart of this. Amnesty International also points to welcome Government initiatives throughout this report, such as funding of support and advocacy groups for families of children with mental illness, the National Children's Strategy, the National Educational Psychology Service Agency, the Ombudsman for Children Act, 2002, and the commitment to revising national mental health policy.

Chapter 1 International Standards

“Children’s rights and what the world wants for its children, are articulated most clearly in the Convention on the Rights of the Child. This Convention and its near-universal acceptance by the community of nations and the work of the Committee on the Rights of the Child, have brought into sharp focus for the first time the human rights of children. Children uniquely touch the conscience of the world, and the Convention has placed children effectively centre-stage in the quest for the universal application of human rights.”

Office of the High Commissioner for Human Rights⁹

Introduction

Ireland, through the ratification of international human rights treaties, has assumed basic responsibilities towards everyone in its jurisdiction under international law. These exist in addition to those in Ireland’s domestic law and Constitution and where there is a conflict, at the international level, international law is superior. Even if international treaties are not expressly reflected in domestic law, they are binding on states once ratified. Ultimate responsibility for compliance with international law lies with the Government, not with individual Government departments, health boards, voluntary agencies or service providers. Each general international human rights treaty protects the rights of persons with mental illness, through the principle of non-discrimination.

The rights and freedoms that are guaranteed the International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic, Social and cultural Rights (ICESCR), and the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR), extend to children without discrimination, including those with mental ill health. Article 12 of the ICESCR enshrines the right to the highest attainable standard of mental health for all.

The Convention on the Rights of the Child (CRC) was adopted by the United Nations in November 1989, and has to date received unprecedented support from the international community. It establishes standards for the Irish Government’s realisation of children’s civil, political, economic, social and cultural rights contained in the ICCPR and ICESCR. It requires

States Parties (states which have ratified the CRC) to take all appropriate measures to implement its provisions, monitor the progress of implementation measures, and to report on progress at periodic intervals to the United Nations Committee on the Rights of the Child (the UN Committee), which is charged with evaluating State Parties' compliance. In 1996, the Irish Government submitted its first compliance report⁷, and the Committee issued its conclusions and recommendations in 1998⁸. Ireland's second and third reports will be submitted jointly in 2004, and nongovernmental organisations will be invited to submit 'shadow reports'.

The CRC affirms that children are the subjects of rights and responsibilities, not just objects of concern or beneficiaries of discretionary State benevolence. Article 4 elaborates Ireland's duty to undertake "all appropriate legislative, administrative and other measures" for the implementation of CRC rights. While there is no hierarchy of human rights – all are interdependent and of equal importance – the obligation to implement children's civil and political rights is absolute, whereas States are required to progressively realise the implementation of economic, cultural and social rights "to the maximum extent of their available resources"⁹. Guidelines issued by the Committee provide guidance on what States Parties' reports to it should contain¹⁰, and General Comments of the Committee explain what is expected in particular contexts.

The 1991 UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (the MI Principles)¹¹ elaborate the basic rights and freedoms of people with mental illness under the ICESCR and ICCPR. Not only do they apply to children, but "[s]pecial care should be given ... to protect the rights of minors" they contain¹². MI Principle 1 enshrines the overarching criterion: "All persons have the right to the best available mental health care, which shall be part of the health and social care system." MI Principle 23 instructs: "States should implement these Principles through appropriate legislative, judicial, administrative, educational and other measures, which they shall review periodically."

The rights in the above treaties are further explained in other secondary UN instruments, which will not be discussed in this report, such as the Standard Rules on the Equalisation of Opportunities for Persons with Disabilities¹³, Declaration on the Rights of Mentally Retarded Persons¹⁴, and Declaration on the Rights of Disabled Persons¹⁵. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) visits States Parties to the ECHR to review their compliance with Article 3 in relation to those held under any form of detention. The CPT's third periodic visit to Ireland took place in 2002, and its report is due shortly.

Chapter 2 **Mental Health Problems in Childhood**

“Mental illness can be defined as the experiencing of severe and distressing psychological symptoms to the extent that normal functioning is seriously impaired, and some form of help is usually needed for recovery. Examples of such symptoms include anxiety, depressed mood, obsessional thinking, delusions and hallucinations. Help may take the form of counselling or psychotherapy, drug treatment and/or lifestyle change.”

Mental Health Ireland¹⁶

Nature and prevalence of mental ill health

There is limited public awareness of the nature and prevalence of childhood mental health problems and illnesses. The growing occurrence of childhood depression and suicide has been reported in the media, but it still surprises many to discover the extent to which children experience mental ill health. WHO suggests: “World-wide up to 20% of children and adolescents suffer from a disabling mental illness¹⁷.” It must first be noted that while the CRC defines children as under 18 years, mental health services in Ireland differentiate between the under 16 years age group, and those 16 years or over. On the likely incidence of mental ill health in children under 16 years in Ireland, the Chief Medical Officer of the Department of Health and Children concludes:

“As regards psychological/psychiatric conditions, while data are not comprehensive, some epidemiological studies show that as many as 18 per cent of the child population under the age of 16 years will experience significant mental health problems at some period of their development; but a much smaller proportion, of the order of 3-4 per cent, will actually suffer from a psychiatric disorder such as anorexia nervosa or a crippling, obsessive, compulsive state. Recent data compiled in the USA suggest that one in ten children and adolescents have a mental illness serious enough to cause some level of impairment in any given year¹⁸.”

Regarding children between 16 and 18 years, it is suggested:

"International and Irish epidemiological studies indicate that psychological disturbances of varying intensity exist in up to 20% of adolescents ... (and) 2% of the total adolescent population has moderate to severe disabling conditions such as major psychiatric disorders¹⁹."

The range of childhood mental illnesses includes depression²⁰, anxiety disorders, eating disorders, attention deficit hyperactivity disorders (ADHD/HKD); and more rarely, serious forms of mental illness begin in childhood such as schizophrenia and bipolar disorder²¹. Other behavioural problems and conduct disorders occur in children, often in tandem with mental health problems, and require specialist regimes. Many adult experiences of mental illnesses begin in adolescence, and early identification and intervention at this stage can mitigate later potential impairment.

A better understanding of the nature and prevalence of childhood mental ill health in Ireland, both of which vary according to social groups and life experiences, would be of much assistance in planning a responsive service²². While indicators of children's mental health needs exist, such as socio-economic deprivation, alcohol consumption, suicide and parasuicide, one of WHO's principal recommendations is that states should conduct more research into biological and psychosocial aspects of mental health, including epidemiological data collection and evaluation, which is "essential for setting priorities within ... mental health, and for designing and evaluating public health interventions²³."

Suicide

The UN Committee expressed its concern in 1998 "about the incidence of teenage suicide" in Ireland²⁴. With increasing awareness of childhood suicide, there is understandable anxiety within families. While a significant increase in suicide has been recorded in Ireland in recent years, including among the 15 to 24 year age group²⁵, "the most dramatic rise in suicide rates (is in) the 18-55 age group²⁷." Suicide is a multifactorial concern, involving a complex interrelationship between sociological, psychological and medical factors; mental health is just one aspect of the complicated picture it represents. "Depression is one of the most frequently identified variables associated with suicide. In fact, studies report that between 40-60% of those who die by suicide were depressed²⁷." Therefore, promoting mental well-being is a necessary component of a multi-pronged

response. WHO advises: "State-of-the-art research indicates that the prevention of suicide, while feasible, involves a whole series of activities, ranging from the provision of the best possible conditions for bringing up our children and youth, through the effective treatment of mental disorders, to the environmental control of risk factors. Appropriate dissemination of information and awareness-raising are essential elements in the success of suicide prevention programmes²⁸." The Final Report of the National Task Force On Suicide was published in 1998²⁹, and a number of Government and nongovernmental initiatives have responded to its over 80 recommendations³⁰. A National Suicide Review Group was established in response to the 1998 report, to co-ordinate research and advise health boards on suicide prevention initiatives, and Suicide Prevention Officers have been appointed in health boards. A criticism has been raised that the "report made wide ranging recommendations, but without setting measurable targets³¹". It has also been suggested: "The increasing rate of youth suicide, particularly in young men, is a major public health problem. Little is known about what lies behind these stark figures. Research in this area is needed as a matter of urgency, to provide the background information which is essential before preventative programmes can be planned or evaluated³²." A subsequent Government report on suicide recommended: "access to mental health services should be improved by the development of a community-wide, flexible range of mental health services. ... barriers to referral or access to mental health services should be eliminated³³". Accessible mental health services of adequate quality for children are therefore of vital importance.

Vulnerable Groups

Special measures must be taken to address the inequality and discrimination experienced in accessing appropriate services by vulnerable or marginalised groups of children, for whom mental health indicators are generally worse than the remainder of the child population. The rights in the CRC and other standards apply equally to these children, without discrimination of any kind³⁴. The UN Committee has commented on Ireland, however:

"With respect to the principle of non-discrimination (article 2 of the Convention [on the Rights of the Child]) the Committee is concerned by the disparities with regard to access to education and health services. While recognising the steps already taken, the Committee notes with concern the difficulties still faced by children from vulnerable and

disadvantaged groups, including children belonging to the Traveller community, children from poor families and refugee children, as to the enjoyment of their fundamental rights, including access to education, housing and health services³⁵.”

- **Homelessness**

In Amnesty International’s May report³⁶, the correlation between homelessness and mental ill health is outlined. An Irish nongovernmental organisation, Focus Ireland, has highlighted the problem of child homelessness in Ireland³⁷, and the particularly high rate of homelessness experienced by children once they leave state residential care³⁸. The UN Committee has also voiced particular concern about the incidence of homeless children in Ireland³⁹. The use of Bed & Breakfast accommodation by the State for homeless families has been criticised as deleterious to children’s mental health⁴⁰. Recommendations made in the Government’s 2002 Homeless Preventative Strategy, intended to prevent homelessness among persons leaving mental health services, young offenders leaving custody and young people leaving care must be fully implemented. (The challenges presented by the high level of child poverty are discussed in Chapter 7.)

- **Asylum Seekers & Refugees**

Article 22 of the CRC obliges Ireland to “take appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee in accordance with applicable international or domestic law and procedures shall, whether unaccompanied or accompanied by his or her parents or by any other person, receive appropriate protection and humanitarian assistance in the enjoyment of applicable rights set forth in the (CRC) and in other international human rights or humanitarian instruments”.

The unique situation of vulnerability of juvenile asylum seekers and refugees is such that rigorous attention must be paid to their mental health care. This has been recognised in a recent inquiry by the Australian Government:

“The experiences of child asylum seekers raise specific mental health and development issues. The social conditions that give rise to a child’s flight from her or his home country may include experiences of war, persecution, death, sexual assault, violence, fear, flight and displacement. Many child asylum seekers will have witnessed harm to family members or directly suffered abuse or violence prior to or during

flight. A child may also experience the fears and insecurities which attach to migrant flight, an uncertain future and exposure to different cultures, languages and religions⁴¹.

Even where they have not experienced such distress directly, if the child's primary carer experiences mental health problems, such as stress or trauma, the child may exhibit similar symptoms. Asylum seekers present as "a highly traumatised population at risk of persisting emotional disturbance⁴²", and the United Nations High Commissioner for Refugees (UNHCR) advises that "the more trauma or stress the parents or care-taker has been subjected to, the greater the danger that children risk neglect or abuse⁴³". Hence the mental health needs of the care-givers must also be addressed as part of the comprehensive regime to protect the mental health of asylum seeking and refugee children.

The asylum process itself can negatively affect mental health; the impact of the policy of dispersing asylum seekers throughout Ireland to centres often isolated from the local community, and with a small financial allowance to supplement full-board accommodation (Direct Provision), is condemned by the Irish Refugee Council as causing high levels of stress and stress-related illnesses in children⁴⁴.

UNHCR instructs that asylum seeking or refugee children who suffer "emotional distress or mental disorders [should] benefit from culturally appropriate mental health services and treatment⁴⁵". Ireland falls short of this, not alone because of deficiencies in general child mental health services⁴⁶, but because of the need for a comprehensive programme of counselling and mental health services for this vulnerable group. Asylum seeking children who arrive in Ireland unaccompanied by their parents or an adult guardian, are at particular risk⁴⁷.

• Lesbian, Gay and Bisexual Children

A recent Equality Authority report has noted that within the health field, fear of prejudice and discrimination restrict access to health services for lesbian, gay and bisexual people, and that their marginalisation "indicates the need for a supportive, appropriate and accessible health service⁴⁸". It suggests:

"Bringing about inclusion requires strategies to move us from the assumption that a generic service or provision will suit everyone equally ... These strategies suggest that the public profile of an organisation or

service deliverer be examined; likewise its policies and procedures, the content and levels of professional development and training that are available, and finally, if necessary, the question of specific programmes targeting certain groups – in this case lesbian, gay and bisexual people – also need to be examined.”

Given the high suicide rate among young people struggling with their sexual orientation in the United States identified in this report⁴⁹, it is vital that mental health policy and services respond to their particular experiences. Research into their mental health needs and service provision is currently lacking, however. The Equality Authority observes that the Report of the National Task Force on Suicide “contains no reference or recommendation on the relationship between sexual orientation and youth suicide”, and concludes: “It is relevant to explore the relationship between sexual orientation and youth suicide with a view to alerting professionals of appropriate preventive measures.” It recommends that national mental health policy should take account of the needs and marginalisation of this group.

• Children who are victims of abuse

Children who are victims of abuse are particularly at risk of mental ill health. While there are no accurate statistics on the numbers of children who have been victims of physical, emotional or sexual abuse, of the 8,269 child abuse cases reported during 2002 by health boards, 3,085 were confirmed (778 were deemed unfounded)⁵⁰. Of children in state care during 2000, the primary reasons for admission included emotional abuse (3.7 per cent), sexual abuse (4.7 per cent) and physical abuse (6.6 per cent)⁵¹.

A lack of assessment facilities, particular in the Dublin area, means distressed children who may have been sexually abused must reportedly wait up to three months to be assessed, and after assessment they may wait as long as five months for therapy⁵². This delay in the provision of services to distressed children is unacceptable given, especially the potential negative impact on their mental health and well-being.

Awareness raising

Awareness raising measures on mental ill health should be targeted at children and their families. A recent study of children attending co-educational public primary and secondary schools in Dublin found “a relatively low level of awareness of the role of mental health professionals in helping individuals with problem behaviour . . . and there was no evidence

that older children were more aware than younger children⁵³. It concluded: "These findings suggest a need for the development of health promotion and educational material to inform children about mental health issues and the roles of mental health professionals. If appropriate promotional material is to be developed then we need to gather information on developmental changes in children's perceptions of causes and treatments of common disorders of childhood."

Early intervention in addressing children's mental health problems requires awareness raising on many levels regarding the childhood mental illness:

"In order to facilitate early intervention, we must maximise the ability of parents, teachers, carers, health professionals and other key persons to identify potential mental health problems at an early stage. This requires that awareness is raised among the public and, in particular, among parents. ... In addition to raising awareness, it is necessary to provide training for primary health care and educational professionals to recognise early signs and symptoms of mental health problems in children⁵⁴."

Article 24(2)(e) of the CRC requires all appropriate measures to "ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health". Increased awareness of the prevalence, varieties and causes of childhood mental health problems is therefore an essential component of State responsibility in safeguarding children's mental health.

Stigma and public attitudes

WHO observes: "It is now well documented that stigma associated with those who are mentally ill, and ironically with those providing for the treatment of those with mental disorders, is evident at all levels of society⁵⁵." While many national nongovernmental organisations have been active in promoting understanding of childhood mental health problems, a more strategic and mainstreamed approach by Government is needed to counter the myths and negative stereotypes still existing. WHO advises that stigma can act as a barrier to the utilisation of services that are available, and recommends: "Well-planned public awareness and education campaigns can reduce stigma and discrimination, increase the use of mental health services, and bring mental and physical health care closer to each other⁵⁶."

An Irish voluntary organisation, AWARE, suggests: “a successful suicide prevention programme is not possible without a change in attitudes to suicide and mental health problems among the general public and caring professions. A well thought out initiative ... will be poorly received unless an attitudinal change is effected. A fundamental assessment of public attitudes in these areas needs to be carried out and programmes developed to encourage more positive approaches⁵⁷.”

“Approaches to the promotion and development of sound mental health for children, and the identification and treatment of psychological and psychiatric disorders, have been patchy, uncoordinated and underresourced.”

Chief Medical Officer
Department of Health and Children⁵⁸

Mental health promotion

Comprehensive strategies for the promotion of mental well-being and the prevention of mental health problems from an early age are essential components of a national mental health policy, according to WHO⁵⁹. A national five-year Health Promotion Strategy was published in 2000, proposing three major strands for the future development of health promotion: the establishment of a National Health Promotion Forum; the provision of more comprehensive and reliable data on health indicators; and greater inter-sectoral and multi-disciplinary approaches. In Ireland, it is suggested: “Mental health promotion remains the most underdeveloped area of health promotion although there is an increasing recognition that ‘there is no health without mental health’⁶⁰.” An all-Ireland mental health promotion strategy is proposed by the Centre for Cross Border Studies and the Institute of Public Health in Ireland⁶¹. They suggest that “integrated strategies are needed rather than isolated and once off developments”, but observe “little support and training available to new projects embarking on cross-border working for the first time”, and “for successful cross-border collaboration in this area, there needs to be support at a high political level”.

Children’s mental health promotion is largely school based. The Education Act, 1998 places an obligation on schools to promote the social and personal development of students and to provide health education for them. At primary and post-primary levels, Social and Personal Health Education is now part of the curriculum, and has an emotional health component. An independent audit of its implementation to date would be useful in identifying any gaps or resource constraints that should be addressed. A Mental Health Matters resource pack produced by Mental Health Ireland is aimed at 14 to 18 year olds, and consisting of exercises, information, and support materials for teachers.

Mental Health Ireland also runs a Public Speaking Project on mental health issues for senior classes in post-primary schools.

Early identification & intervention

Adolescence is a time when early intervention can be crucial to the prevention of impairment in adulthood, but international studies suggest: “Only a tiny proportion (between 5% and 10% percent) of young people with mental health disorders are in contact with helping agencies Most mental health disorders in adolescents are unrecognised and untreated. This is due to the complex interplay of many factors including the difficulties experienced by parents and teachers in distinguishing between the normal ‘ups and downs’ of adolescent mood and behaviour and mental health disorders, stigma leading to reluctance to acknowledge the presence of mental health disorder, and lack of appropriate mental health services for adolescents⁶².”

Role of the education system

All children would benefit from school-based preventive mental health interventions, and effective and continuous mental health promotion and education in the curricula of all stages of the education system. Children with mental health problems, particularly childhood depression, may remain undetected for long periods, and it is children with learning difficulties or challenging behaviour that are most readily identified. A well-equipped education system is a useful setting for early identification and interventions for all children at risk of mental ill health, by enhancing the ability of parents, teachers, and other key persons to identify and deal appropriately with children’s mental ill health through training and education, and liaising with mental health services. WHO advises:

“[T]he importance of schools in the provision of mental health related services for children and adolescents is crucial. In some settings schools can be a primary venue for the delivery of diagnostic and treatment services, and in others the school can serve as a support for getting primary treatment elsewhere. Schools in all cases are to be viewed as a potential resource for the recognition of children and adolescents in need of formal diagnosis and treatment⁶³.”

The establishment of the National Educational Psychology Service Agency (NEPS) in 1999

was a welcome development – its work comprises consultation and support for teachers and parents, project work and promotion of mental health in schools, and limited casework with individual children. An overall target number of 200 psychologists is planned to be in place by 2004, of whom approximately 180 would be in NEPS and the remainder elsewhere in the educational system. At present there are 120 psychologists in the NEPS service⁶⁴. The rate of progress of its expansion into primary schools has been criticised by the Irish National Teachers Organisation (INTO): “It is unacceptable that there are large parts of the country without a service⁶⁵.” Schools that do not yet have access to NEPS must apply for funding under the Scheme for the Commissioning of Private Assessments (SCPA): “The scheme is an interim measure intended to meet current urgent needs for psychological advice”, and “is in no way a substitute for a full educational psychological service of the sort envisaged by NEPS⁶⁶”. Furthermore, in order for children to receive individual support from educational psychologists, a school must prioritise the pupil in question for assessment, and schools have a limited quota of assessments allocated per year.

In a 2003 report, the National Crime Council recommends that all young people be able to avail of NEPS including those in Youthreach or similar centres, and those in detention centres⁶⁷. It also recommends that NEPS “continue to prioritise their waiting lists according to the needs of the individual child and that the service endeavor to provide support for all children as soon as possible”.

As noted by a Government Working Group on Child and Adolescent Psychiatric Services⁶⁸, enhanced cooperation between schools, NEPS and the child and adolescent mental health services requires formal liaison protocols. The Working Group also pointed out that plans to establish specialist mental health services for children aged 16 years and over, and increasing awareness and identification of ADHD/HKD in children, are likely to lead to an increase in the demand for NEPS services. These issues underline the urgency of expanding the services in NEPS.

Accessibility and inclusiveness in education

Unfortunately, low achievement and early school leaving is a common experience for children with more serious forms of mental illness. While Article 28 of the CRC provides the right to education, Article 29 outlines that the aim of education should be directed to “the development of the child’s personality, talents and mental and physical abilities to their fullest potential.” The UN Committee advises that Article 29(1):

“insists upon the need for education to be child-centred, child-friendly and empowering; and it highlights the need for educational processes to be based upon the very principles which are recognised in article 29(1). The education to which every child has a right is one designed to provide the child with life skills, to strengthen the child’s capacity to enjoy the full range of human rights and to promote a culture which is infused by appropriate human rights values. The goal is to empower the child, through developing his or her skills, learning and other capacities, human dignity, self-esteem and self-confidence⁶⁹.”

Article 23 draws particular attention to the State’s obligation to assist children with disabilities: “Recognising the special needs of a disabled child, assistance... shall be designed to ensure that the disabled child has effective access to and receives education, ... preparation for employment and recreation opportunities in a manner conducive to the child’s achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development.”

A recent Irish publication by the National Disability Authority, ‘Encouraging Voices’⁷⁰, contains many helpful insights from children and educators with a range of experiences, both positive and negative, of a variety of schools’ ethos and teaching methods. It provides an informative account of the benefits of active child participation in developing and implementing education models, as advocated by the CRC in Article 12.

The recently published Education for Persons with Disabilities Bill, 2003 contains many positive elements for children with an “educational disability”, and its Explanatory Memorandum introduces “the best interests of the child” as an overarching criterion. However, concerns expressed by the Association of Secondary Teachers in Ireland on a previously abandoned Education for Persons with Disabilities Bill, 2002 remain of relevance: “that insufficient attention is paid in the Bill to issues such as the availability of support services in schools – for example, Learning Support, Resource and other specialist teachers; Special Needs Assistants and other non-teaching personnel; counselling services and welfare supports for students with disabilities ... and in-service training for teachers⁷¹.” Regarding primary education, the INTO observed in relation to the 2002 Bill: “Responsibility falls on schools which are all too often left with the task of trying to implement (Government) policy of inclusion without adequate resources or support. Current procedures whereby schools are asked to enrol children

with special needs without resources in place to meet their needs must be changed. . . . Even if children have access to additional help from a resource teacher or special needs assistant, the child with special needs very often spends the majority of their school day being taught by the class teacher. The class teacher gets no recognition for this either in terms of a reduction in class size or extra funding to purchase extra teaching resources. This system needs radical overhaul. In addition class teachers have very limited access training in the area of special education⁷².” These issues must be resolved and adequate resources be secured if full, equitable and timely implementation of the 2003 Bill is to be ensured.

"In April a 14 year old girl was placed in an acute psychiatric ward for adults before being moved to an equally inappropriate remand centre. The girl deteriorated, and in August was returned to the psychiatric ward. In March a 15 year old girl's behavioural problems following her mother's death resulted in her being detained for psychiatric and psychological assessment. No places were available and she was sent to a secure remand centre without the appropriate therapeutic services. In the same month 10 seriously disturbed Irish children were sent to Britain for treatment because adequate facilities did not exist here."

Irish Examiner 2000⁷³

Introduction

Given the anticipated level of mental illness in children outlined in chapter 2, the provision of adequate and sufficient children's mental health services should be a priority. However, for children who require mental health interventions, services and supports are seriously out of step with need. There is limited availability of the appropriate range of services – those in primary care, community care, in-patient centres, day centres, rehabilitation services and outreach services to provide support in the home and school. A Government Working Group also pointed to the lack of formal liaison between child and adolescent psychiatry and other elements of the health service⁷⁴.

There is a dearth of publicly available Government information and research on the level and quality of service responses, due in the main to shortcomings in systems of data collection and information technology – other than regarding children admitted to in-patient services, there is no central data collection or reporting system on children's uptake of other mental health services at primary care or on an out-patient basis. There is an urgent need for a centralised information bank, based on nationally accepted and supported data collection methods. Otherwise, proper analysis of trends and statistics in the quality or efficiency of service provision cannot be made by the Department of Health and Children or other interested parties.⁷⁵

Therapies

The 2001 WHO annual report recommends the comprehensive and widespread availability of “a full range of therapies considered essential to modern psychiatric care: psychotherapy, psychosocial rehabilitation, and vocational rehabilitation and employment⁷⁶”. The Irish College of Psychiatrists agrees: “Psychotherapy and psychological treatments are not alternative therapies but should be available as part of a comprehensive mental health service⁷⁷.” Yet, in primary, community and in-patient care, there is widespread over-reliance on medication alone as therapy, because the range of other therapies and therapists is not available. It has been observed that “gaps in the range of services and professionals providing these services, has resulted in uneven and restricted availability of psychotherapy and other interventions⁷⁸”. This is due to a variety of factors, including “a lack of funding for Consultant Psychotherapy and clinical psychologist posts⁷⁹” and insufficient training places for certain professionals. While medication is an essential component of a treatment range, failure to provide the full choice of treatments is inconsistent with the right of many to the “least restrictive or intrusive treatment” in MI Principle 9(1). Furthermore, as pointed out in Chapter 6, without the option of other forms of therapy, consent to treatment cannot be fully informed.

Community-based multidisciplinary services

A Working Group was established by the Department of Health and Children in 2000 to review child and adolescent mental health services. It published its first report on services for children under 16 years in 2001, and observed: “The internationally acknowledged best practice for the provision of child and adolescent psychiatric services is through the multi-disciplinary team⁸⁰.” It recommended a significant expansion of the number of such teams nationally. It advised that, whereas teams should have a minimum complement of members, “many of the child psychiatric teams currently in place throughout the country do not have the full complement of team members”. Psychologists, mental health social workers and occupational therapists are widely underrepresented on these teams. Each member of a team supplies a unique and essential service, and incomplete teams cannot by definition supply a quality service despite their best efforts. In addition to resource constraints, this is due to the insufficient number of training places to supply the numbers required.

Members of these teams, the Working Group suggested, should be permanent with fulltime commitment to the relevant clinic – but it reported that a large number are still working part-time or on temporary contracts. It recognised that 30 per cent of the total

workload of each of the existing multi-disciplinary child and adolescent teams was concerned with ADHD/HKD, and suggested that, as the condition is increasingly recognised, the numbers to be referred to the mental health services is likely to increase substantially in coming years. Progress on its recommendations have not occurred as quickly as had been hoped. It is reported that over 2000 children are currently on waiting lists for psychiatric assessment, and that some have to wait for up to a year. A 1997 report by the Irish College of Psychiatrists (ICP) recommended a minimum of 120 consultant child psychiatrists for those under 16 years throughout the State⁸¹, but there are currently 45. According to the ICP, progress on the establishment of specialist teams to treat ADHD recommended by the 2001 report of the Government Working Group “has been slow to date and it is disappointing that that budgetary restrictions are likely to delay this⁸²”.

The UN Committee on the Rights of the Child has noted “with concern that in implementing their obligations under the Convention, States Parties have given insufficient attention to the specificities of adolescents as rights holders and to the promotion of their health and development⁸³”. While services for children under 16 years also require significant expansion, commitments made under the 2001 Health Strategy to the development of mental health services to meet the needs of children aged between 16 and 18 should be prioritized, particularly in light of their higher needs and the opportunity to reduce impairment in later adult life. The Irish College of Psychiatrists notes: “Psychiatric disorders increase in incidence and prevalence during adolescent years. The incidence and prevalence of deliberate self-harm and attempted suicide also increase with increasing age throughout the adolescent phase⁸⁴.” On the basis that 2 per cent of children aged 16 years and over experience “moderate to severe disabling conditions such as major psychiatric disorders”, a second report of the Government Working Group on services for children of 16 and 17 years in 2003 concluded that 2,815 persons in Ireland in this specific target group will require an adolescent psychiatric service at any point in time⁸⁵.

While the definition of the child in the CRC is a person under 18 years, and children are entitled to age-appropriate treatment, children aged 16 years or over are currently treated within the adult mental health services. The 2003 Working Group report acknowledges that treatment in adult settings is now considered inappropriate for most under 18s: “Existing adult services are not resourced to deal with adolescents. They lack appropriate multidisciplinary input which would centre around family, school and social interventions.” It recommends the recruitment in each health board area of a nine-member multidisciplinary team headed by a consultant child psychiatrist with a special interest in the mental illnesses of later adolescence; assertive outreach services

to provide services in the home, school etc.; day hospital services for those who require more in depth assessment and a more comprehensive treatment than can be offered in the general outpatient setting, but do not require in-patient treatment, to include a mix of occupational therapy, various treatment programmes, such as group therapy, social skills etc. and an educational focus; rehabilitation services; and step down services such as community residences for the recovery and early rehabilitation phases of treatment. Amnesty International welcomes its recommendations, which should be implemented as a matter of priority.

Many voluntary agencies endeavour to fill gaps in state services with core funding provided by the State, but funding arrangements can be precariously unresponsive. Children at Risk in Ireland (CARI) provides therapy to victims of child sexual abuse, and consultancy services to other State and non-State agencies. It hopes to expand its services to deal with other forms of trauma where local services are inadequate⁸⁶. However, an escalating case load due in part to increased referrals from state services has not been met with increased State funding. Its Director recently cautioned: "We will try and put off making cuts in our services for as long as we can but if there is no turn around in the funding situation we will have to start cutting our services in the autumn⁸⁷."

The UN Committee on the Rights of the Child has also expressed concern at the lack of adequate drug and alcohol abuse programmes for adolescents⁸⁸. Voluntary agencies warn: "The abuse of alcohol, heroin, methadone and other drugs by young people, in both the Dublin area and the rest of Ireland, represents an epidemic that is failing to respond to existing policies. Furthermore, the reliance on methadone maintenance as a first treatment option for young opiate abusers is itself a major barrier to recovery. There is a deplorable lack of drug free treatment options available to young addicted people and accurate information about the nature and extent of drug abuse in Ireland is in short supply. ... the most pressing area where policy needs to be reversed is the reliance on methadone maintenance as the first (and in some cases only) treatment option for young opiate abusers⁸⁹." Public mental health services specialising in eating disorders are also widely unavailable.

In-patient services

Community-based services should be the option of first recourse under international best practice and human rights standards. However, children will occasionally require in-patient treatment when suicidal or otherwise acutely ill. It has been observed: "numerous Health

Boards have no policy or procedures for children or adolescents who require in-patient treatment⁹⁰." There is a large discrepancy between the actual and required numbers of appropriate acute psychiatric beds for children. The 2001 Working Group report recommended that 89 beds were required, 35 for children aged 6 years to 12 years and 54 for adolescents aged 12 years to 16 years. Currently there are 35 bed places in three children's centres for under 16s (Court Hall and Warrenstown House in Dublin, and St. Anne's Children's Centre, Galway). Other than in the Eastern Regional Health Authority and Western Health Board, in-patient facilities for children under 16 years do not yet exist. While small in number, children in need of in-patient services outside these areas are admitted to local adult wards, or are transferred to private hospitals in Dublin (which does not comply to the right "whenever possible, to be treated near his or her home or the home of his or her relatives or friends⁹¹"). In adult psychiatric inpatient facilities in 2001, there were 25 admissions for persons aged under 16 years⁹². Furthermore, unlike the available statistics for children's centres, there is no indication in the published annual in-patient reports for adult facilities of the diagnoses of the children; hence it is difficult to assess the appropriateness of their admission. Neither is there mention made of the length of stay of these children.

Others in need of admission remain at home due to long waiting lists throughout much of the country. The national Waiting Lists Initiative, whereby hospitals must publish waiting lists, excludes the mental health sector, for which, according to the ICP, there is no convincing explanation⁹³. Consequently, unlike other health sectors, no figures are published for waiting times for acute in-patient admissions. This is inconsistent with requirement to provide "care and treatment in accordance with the same standards as other ill persons⁹⁴". Nor does it comply with MI Principle 15(2): "Access to a mental health facility shall be administered in the same way as access to any other facility for any other illness."

The 2001 Working Group report observed: "Because of the changing profile of problems with age, child psychiatry services tend to find that, already, the mid-adolescent age group, i.e., the 13-15 year-olds have a propensity to take priority over younger clients. This is primarily due to their high rate of emergency presentations with acute illness and suicide attempts etc." It recommended the creation of five new in-patient centres for children under 16 years⁹⁵, and funding was to have been provided under the National Development Plan (2000-2005). A survey conducted by the Irish College of Psychiatrists this year is expected to establish that "some plans were in place for four of the five centres ... but these were largely limited to architects' drawings or site shortlists, and in no case was funding available⁹⁶".

As noted above, children over the age of 15 years are dealt with by the adult mental health service – consequently, in-patient facilities do not exist for them within the child and adolescent service. The result is again, that many children are inappropriately placed in adult psychiatric units. In adult psychiatric in-patient facilities on one night during 2001, there were 88 young people aged 16 to 19 years (25 of whom were in private hospitals)⁹⁷. (This statistic proves unhelpful in relation to the definition of a child in the CRC. Even the Minister for Health and Children in response to a Dáil question requesting the number of children aged 17 years and under admitted to adult psychiatric hospitals and units in general hospitals in 1998-99 and 2000-01, did not provide figures other than those for the ‘under 16 years of age’ and ‘16 to 19 years age’ groups⁹⁸.) The 2003 report of the Working Group observed: “Adult services . . . are not considered appropriate for the admission of adolescents. Adult out-patient clinics, day hospitals and mental health centres are generally not appropriate for adolescents and there tends to be a high number of referrals who do not keep their clinic appointments.” It also runs contrary to the requirement that “the environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age⁹⁹”. The report recommends specialist in-patient services, and that acute same day in-patient admission should be available to adolescents who require it.

A further conclusion of the 2003 report of the Group is: “Existing Child and Adolescent Psychiatric services are currently not in a position to deal with the older adolescent age group because of the significant increase in major psychiatric illnesses (Schizophrenia, Manic Depression etc..) which occurs in this age group.”

Under the CRC, children should be treated in a manner that takes into account the needs of persons of their age, and should not be detained in adult facilities unless it is considered in their best interests to do so. That children are, in fact, so placed is a matter of concern to Amnesty International. The Criminal Law (Insanity) Bill currently under consideration by the Government will also require the provision of additional facilities for those aged under 18 years who could be referred under it to “designated centres”. The Mental Health Commission¹⁰⁰ has also pointed to the “need to provide separate facilities for those aged under 18 who could be committed under the provisions of the Bill. The placement of those under 18 in centres for adults is at variance with best practice¹⁰¹.”

Article 24(1) obliges Ireland to provide “facilities for the treatment of illness and rehabilitation of health” and “strive to ensure that no child is deprived of his or her right of access to such health care services”. To comply, the Government should prioritise the prompt development of an adequate number of age-appropriate facilities, since this age group’s

in-patient needs will continue be accommodated in the adult psychiatric wards until then. To date, the three children's in-patient mental health centres have not been the subject of routine inspection by either the Inspector of Mental Hospitals or the Social Services Inspectorate, which has been a concern. The remit of the newly appointed Inspectorate of Mental Health Services, established under the Mental Health Act, 2001, will include these centres, and is expected to begin these inspections in 2004¹⁰².

The Mental Health Act, 2001, which is not yet in full force, expressly provides for the first time for the involuntary admission of children. Under section 25, where it appears to a Health Board that a child, living or found in it's region, is suffering from a mental disorder and requires treatment which he or she is unlikely to receive, then the Health Board may make an application to the District Court for an Order authorising the detention of the child in an approved centre. While the section does not require detention to be in a children's centre, the Mental Health Commission is charged with the approval of centres in which they may be detained. Amnesty International urges that 'approved centres' to which it is proposed to involuntarily admit children should conform with the CRC and other human rights standards. For those involuntarily admitted to adult wards where it this not in their best interests, this violates Article 37 of the CRC. The CRC also provides that the living environment in mental health facilities should be age appropriate and take into account the developmental needs of minors, for example the provision of a play area, age appropriate toys, access to schooling and education. Amnesty International urges that centres where children may legally be involuntarily admitted or detained should not be approved unless they meet these criteria. This will necessarily entail the rapid expansion and improvement of in-patient services for children¹⁰³.

Article 3(3) of the CRC requires States to establish standards for institutions, facilities and services responsible for the care or protection of children particularly in the areas of health, safety and the number, qualifications and supervision of staff. All centres providing in-patient care for children with mental health problems should commit to the principles of the Charter for Children in Hospital, which includes among other things the principle that a child has the right not to be admitted to adult wards¹⁰⁴.

When the Government furnishes its next report to the UN Committee on the Rights of the Child¹⁰⁵: "Information should ... be provided on the steps taken pursuant to article 3, paragraph 3, to establish appropriate standards for all public and private institutions, services and facilities responsible for the care and protection of children and to ensure that they conform with such standards¹⁰⁶."

Children with intellectual disabilities

There is insufficient provision of appropriate specialist services for children with learning disabilities, some of whom are instead treated within mainstream psychiatric in-patient facilities. The ICP notes: "Mental Health Services to this group vary in each Health Board area, e.g. some consultant psychiatrists have responsibility for adolescents although they are adult psychiatrists who provide a cradle to grave mental health service for persons with Learning Disability. In other areas this service is provided by consultant child psychiatrists with special interest in Learning Disability¹⁰⁷." In addition, adolescents with a learning disability and mental illness are considered by the ICP a distinct group with special needs that are not being dealt with in an adequate or consistent fashion, and are sometimes inappropriately dealt with in psychiatric services. Some children with learning disabilities may be inappropriately placed in mental health in-patient facilities in the absence of high-support community residential facilities. A specialist service for these children is badly needed.

Forensic services

For children with behavioural or conduct disorders, especially for children in criminal detention, specialist forensic mental health services should be available. However, "to date there is no forensic service in Ireland for children under the age of 18. ... The experience is that adolescents who present with criminalised behaviour are referred to the generic child and adolescent psychiatrists and adult psychiatrists who do not have the expertise or specialist service to offer. Urgent examination of this issue is required¹⁰⁸." According to the Irish College of Psychiatrists, components of a forensic psychiatric service for adolescents should include: adolescent multidisciplinary teams led by a consultant adolescent psychiatrist with special expertise in forensic psychiatry to consult to all secure detention facilities for adolescents; a specialist forensic psychiatric team for adolescents to provide assessments on a nation-wide basis; secure in-patient units for children and adolescents who experience mental illness and are in need of treatment in a secure setting.

Family support services

With some notable exceptions, mental health services are often unable to support families and carers of children with mental ill health. For instance, preliminary findings from a survey of adult mental health social workers show that "carer/family psychosocial education, family work and family counselling/therapy and mediation rank high as

perceived priority areas” but “ score low in terms of actual work currently done¹⁰⁹”. A survey report on families’ views in five European countries, including Ireland, gives “clear guidance on all the issues which families really want to be addressed¹¹⁰”.

While of course, Article 3(1) of the CRC provides that “in all actions concerning children ... the best interests of the child shall be a primary consideration”, and notwithstanding the child’s right to be with his or her family, respite services to relieve the strain on families or carers can greatly facilitate their ability to provide such care. There are also demonstrated causal links between parental mental illness and childhood depression¹¹¹, so recommendations made by Amnesty International’s in its February report on adult mental health services are of relevance¹¹².

Chapter 5 **Children in State Care**

State residential centres

Many recent initiatives have responded to the needs of children in, or at risk of entering state care. A Youth Advocate Programme commenced service provision in partnership with the Northern Area Health Board and the Western Health Board in September 2002. The service will be subject to ongoing evaluation as a pilot project and aims to reduce the number of young people entering out-of-home placement, and reduce the length of stay of young people in care. 21 Springboard Initiatives have been established through Health Boards since 1998 working intensively with children, mainly in the 7 to 12 year-old age group who are at risk of going into care or getting into trouble with their families. The Department of Health and Children is committed to establishing a further 8 Springboard projects.

Those children living outside a family environment need much stability and support – otherwise they are at considerable risk of developing or worsening mental health problems. Article 20 of the CRC states: “A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.” Article 3 provides: “States Parties shall ensure that the institutions, services and facilities responsible for the care and protection of children shall conform with the standards established by the competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.”

A further concern is the particularly high rate of homelessness of children once they leave state residential care found in a Focus Ireland study¹¹³. It found a number of reasons for this including: lack of family and social support networks; institutionalisation or dependency; and inability to find or maintain a home due lack of experience or lack of home-making skills. The known interrelationship between homelessness and mental ill health reinforces the need for these issues to be addressed while children remain in state residential care.

The Social Services Inspectorate (SSI) was established in 1999 to inspect social services provided by health boards. The annual report of the SSI for 2002¹¹⁴ recorded 176 children’s residential centres. It reported an increase from 36 per cent to 44 per cent in the number of children under the age of twelve in the inspected centres since the previous annual report. 17 per cent of the children were in their current placement for more than five years and 42 per cent for between 1 and 5 years. 73 per cent had at least one previous

placement in state care, and the SSI concluded: “The high level of moves raises questions about the quality of assessments, the availability of appropriate placements as a first option, and the resources available to support and sustain placements. The fewer the moves a young person has in the care system the greater their opportunities to experience continuity and stability in relationships, education and peer support.” It advised health boards to “develop services that ensure young children are not placed in residential care and the number and length of placements is kept to a minimum”.

The SSI found “some children and young people (in the centres) for whom the residential provision is either not suitable or available and whose needs are not met within current services”. Centres were commonly described as only accepting planned admissions when in fact children and young people had been admitted on an unplanned, emergency basis. Some community care areas had no provision for unplanned admissions to residential care, clearly unrealistic, the SSI said. It also found “no formal plans were in place to assist half of the young people over 16 years to prepare for their future . . . a serious deficit given the difficulties of this transitional period.” It recommended: “These issues need to be addressed through the assessments of needs and strategic planning at health board level.”

Significantly, the SSI noted “the overall warmth and care shown by staff in the majority of centres”, and observed that standards are improving, and the ability of managers of centres to access specialist psychological services had improved. In relation to staffing, it found: “15 out of 22 centres staff were in the centre long enough to provide continuity of care. In the remaining centres the high turnover of staff and reliance on agency staff offered poor continuity and consistency for children.” It also expressed concern that “vetting of staff is unsatisfactory and needs urgent attention”, a concern shared by many other organisations.

The SSI found 29 children cared for on their own, and “there were just a small number of instances where these special arrangements where one child is cared for by a team of staff could be justified as being in the best interests of the child”. It found that these arrangements were often characterised by temporary accommodation, temporary staff, poor policy development and weak care planning and were in place long after the originally intended timescale. It concluded: “The increase in special arrangements is a matter of real concern, especially in view of . . . the isolation of the child, the loss of the essential developmental opportunity to mix with peers, particularly if the child is not attending school outside the centre, and the unnatural balance of one child being cared for by 12 to 15 adults.” It noted that the scarcity of special care units for children “may in part explain this year’s increase in the number of special arrangements and centres for one child”.

The quality of placements for children with behavioural problems in care is crucial to their mental well-being. On the care and management of troubled children, The SSI observed: “Troubled children need ongoing suitable care arrangements. Boards should plan for a range of appropriate placements, paying particular attention to the reasons for care admissions, the impact of disruptions, and the accessibility of specialist psychological and support services in the first placement.”

In relation to unaccompanied children seeking asylum in Ireland¹⁵, the majority of whom reside in the care of the East Coast Area Health Board (ECAHB), the SSI report noted: “The ECAHB acknowledges that the standard of care for this group of young people may not meet the National Standards for Children’s Residential Centres.” National organisations have significant concerns about the basic services afforded these vulnerable children: “Service providers working with unaccompanied minors have expressed their concern about the level of care being provided to these children in hostel accommodation. The level of care is below that provided to children in the residential and foster systems. Hostel accommodation may lack basic supervision and psychosocial supports despite the fact that these children often have additional psychological and broad social support needs to deal with the impact of traumatic experiences and with anxiety associated with the asylum process¹⁶.”

In respect of children from the Travelling community, the SSI report said: “on occasion inspectors had cause for concern regarding a centre’s approach to promoting traveller children’s cultural identity. Inspectors found no evidence of active discrimination, but found staff at a loss to know how best to reflect positive images of traveller culture. Some boards had a higher percentage of traveller children in their care than others but had no programme to address any of the issues involved.” Article 20 of the CRC provides that where a child is temporarily or permanently deprived of his or her family environment, due regard should be paid by the State to the child’s cultural background.

Children in need of special care

In relation to children in detention, the CRC states: “No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall . . . be used only as a measure of last resort and for the shortest appropriate period of time¹⁷.”

“Every child deprived of liberty shall be treated with humanity and

respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age¹¹⁸.”

Amnesty International has grave concerns in relation to how children with serious behavioural problems, and those who offend, are dealt with in relation to their mental health needs. In 1998, the UN Committee on the Rights of the Child expressed concern at “the treatment (in Ireland) of children deprived of their liberty, particularly in light of the principles and provisions of the Convention and other relevant international standards such as the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (Beijing Rules), the United Nations Guidelines for the Prevention of Juvenile Delinquency (Riyadh Guidelines) and the United Nations Rules for the Protection of Juveniles Deprived of their Liberty¹¹⁹”.

Juvenile offenders

In relation specifically to mental health, MI Principle 20 provides that all persons, including children, “serving sentences of imprisonment for criminal offences, or who are otherwise detained in the course of criminal proceedings or investigations against them, and who are determined to have a mental illness or who it is believed may have such an illness ... should receive the best available mental health care”. Rule 81 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty¹²⁰ provides: “Personnel should be qualified and include a sufficient number of specialists such as educators, vocational instructors, counsellors, social workers, psychiatrists and psychologists.”

The Children Act, 2001 will introduce the welcome provision that detention should only be used as a last resort¹²¹. In this respect the Act upholds the CRC requirement that detention of those under the age of 18 years “shall be used only as a measure of last resort and for the shortest appropriate period of time”. Concerns have been raised regarding the safeguards in place under the Act. For instance, under section 150, the Minister may designate a ‘place of detention’ suitable for the detention of offenders between the ages of 16 and 18 years of age, but guidelines are needed to govern the type of accommodation and regime that should pertain.

In Ireland, an average of 162 children up to the age of 16 are housed in young offender centres, of whom 24 are in the secure complex, Trinity House, in Dublin. The State has been criticised for not separating 16 and 17 year olds from adult offenders in the prison service. The Government's recent decision to close Shanganagh prison, the only open

prison for 16 to 21 years olds in the country, was much criticised given the absence of equivalent facilities – the Inspector of Prisons and Places of Detention described this as “a retrograde step¹²²”. This closure runs contrary to the philosophy of the Children Act, and commitments made in the National Children’s Strategy, in particular, the commitment to provide an adequate number of specialised juvenile detention places, and to be supported in the least restrictive environment while having their needs addressed.

Non-offending children

The lack of investment in secure health board centres for non-offending children with behavioural or emotional problems has resulted in their detention in inappropriate places such as children’s detention centres, adult prisons and adult psychiatric hospitals. A 2002 media report gave this example:

“In the absence of any alternative, A High Court judge has said he must direct the continuing detention in St Patrick’s Institution [for Young Offenders] for another four weeks of an extremely disturbed teenage boy, an alleged victim of sexual abuse, with no criminal convictions. The 16-year old youth has already been in the prison for some five weeks and has been described as a serious suicide risk. ... [The judge] was told ... the Central Mental Hospital could not take him [and] ... a consultant forensic psychiatrist at the hospital, said its services are already greatly strained¹²³.”

These practices do not comply with Ireland’s duty towards children who are victims of abuse or violence in Article 39 of the CRC to “take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.” The Children’s Rights Alliance has commented: “Primarily due to the failure to provide appropriate services and facilities to children with severe behavioural problems, Ireland’s child care and juvenile justice systems are now thoroughly intertwined. The lack of treatment and secure accommodation for young people with serious emotional and behavioural problems has led to the use of the High Court as a means of accessing placements for non-offending youths within the juvenile justice system¹²⁴.”

In 2002, the European Court of Human Rights in *DG v Ireland* found that the detention in St. Patrick's Institution for offenders in 1997 of a 16 year old non-offending child with serious behavioural problems, who had previously committed offences, was in contravention of the right to liberty guaranteed under Article 5(1) of the European Convention on Human Rights. The Court ruled that the Irish State acted unlawfully in failing to provide the disturbed child with a safe, suitable therapeutic unit.

Two secure Special Care Units have been established to date, but the delay in providing units prompted a High Court judge to tell State authorities "that their failure to provide these facilities for the country's most vulnerable children is tantamount to a scandal"¹²⁵, and hold three Government Ministers in contempt of court in 2001. It has also been reported that the provision of psychiatric and psychological services for the children in question is ad hoc and inconsistent.

Staff shortages are significantly responsible for difficulties in providing adequate places: "The widespread and chronic failure to fill vacancies in the social service, particularly in the Dublin area, has had a crippling impact on efforts to provide non-punitive services to children with behavioural problems, to children who have committed offences and to children in and out of care who are at-risk of becoming offenders. Many centres are operating well below full capacity due to difficulties in recruiting and retaining qualified and experienced staff"¹²⁶. "Adult psychiatric facilities are also inappropriately used; a Government Working Group has referred to "the pressure on adult psychiatric units to accept troubled children who are not suffering from a mental illness", which, it said, would be eliminated by the increased availability of high support and special care places"¹²⁷.

"A very disturbed [16-year old] teenage girl who spent 12 weeks in Mountjoy Women's Prison in the absence of any suitable place for her has now been placed in an adult psychiatric hospital having been described as 'psychotic', the High Court heard yesterday"¹²⁸.

"The judge also heard that an extremely disturbed teenage girl remains detained in the locked ward of an adult psychiatric hospital while construction of a special unit for her, as ordered by the High Court, continues"¹²⁹.

Incidents such as these are not uncommon, and violate international human rights standards, in particular Rule 53 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty: "A juvenile who is suffering from mental illness should be treated in a specialised institution under independent medical management.

Under the Children Act, 2001, it has been recognised that investment in community and statutory services that offer prevention, early intervention and diversion will be necessary for the full implementation and effective functioning of the Act. The preventive elements of the Act should be introduced as a matter of urgency, with investment of resources in community and statutory services to support these measures. Also, children whose behaviour puts them at serious risk of harm or injury to themselves may be detained under the 2001 Act in special care units. There is consequently urgent need for an expansion in the number of places available in these units before the Act comes into force.

A recent UK study on boys aged 12-17 years in secure units found that before being admitted to secure care, the boys had high rates of mental health needs – 22 per cent had major depression and 17 per cent anxiety disorder¹³⁰. While admission to secure care was associated with improvements in aggression, substance misuse, social relationships, and education; the study found that levels of depression and anxiety were high within 3 months of admission. It found that several children developed mental health problems after admission – 39% of those experiencing depression had developed the problem since being admitted. In most of these cases, no appropriate psychiatric or psychological assessment or treatment had been offered.

In respect of the operational Special Care Units, the SSI report for 2002 notes that care planning is weak: "Where there was evidence of a care plan, it often ended at placement in the SCU rather than using the unit as a 'calm haven' to allow the child or young person reorient themselves to their original plan or goal." It also states: "in many instances, the benefits of a SCU placement are diminished by the loss of continuity with a member of the care staff either on admission to or discharge from the unit."

Access to specialist mental health services is considered essential for Special Care Units placements, in particular forensic services – the SSI report advises that they are "important for the assessment, advice, support and consultation that SCUs need in order to undertake their day-to-day work with this group of children [and are] also vital to a small number of children whose placement in detention is specifically to deal with the consequences of disturbed behaviour." The SSI noted its serious concern at the difficulties children and

young people in units had in accessing specialist child and adolescent psychiatric services: "SCUs find access generally to child and adolescent psychiatric services difficult however there was a crisis in obtaining such help for the 16 to 18 year olds.... With this age range inspectors have encountered some extremely vulnerable young people for whom a delay in access to services has seriously aggravated their difficulties."

A Special Residential Services Board to co-ordinate residential services for children detained in detention schools and in special care units was established under the Children Act, 2001. A 2003 report of the Government Working Group suggests that the establishment of consultants and multidisciplinary mental health teams for children aged 16 years and over, currently nonexistent, would provide a consultative service to local High Support and Special Care Units¹³¹. This gives greater urgency to the recommendations in that report. It also cautions: "The role of psychiatry in the high support child care setting is a consultative one. Psychiatrists do not provide in-patient treatment to patients in the high support/special care units because such units are not appropriate therapeutic environments for in-patient care. Therefore, if a resident of a special care unit develops a severe mental illness, admission to an acute psychiatric unit may be required¹³¹." In this context, the rapid development of in-patient adolescent facilities proposed by the Working Group is all the more vital.

Chapter 6 **Informed Consent & Views of the Child**

Age of consent

The UN Committee on the Rights of the Child said in its 1998 report: “In relation to the definition of the child ... the Committee is concerned at the various low age-limits set in the domestic legislation of (Ireland).”

Where children over 16 years are classified as adults under the still operational Mental Treatment Act, 1945, this has been rectified in the Mental Health Act, 2001, which defines children as under 18 years. This conforms with the definitions in the Child Care Act, 1991 and the CRC. In Irish domestic civil and criminal law, consent to medical treatment is required, without which, many forms of mental health treatment would be regarded as trespass to the person in civil law, and assault in criminal law. Section 23 of the Non-fatal Offences Against the Person Act, 1997, provides that a child of 16 years can consent to medical treatment without parental input. It is considered that “psychiatric treatment – involving drug therapy clearly falls within the category of ‘medical treatment’” in this section¹³². However, the small number of children under 18 years involuntarily detained under the Mental Health Act, 2001 appear to have that right removed. These conflicting definitions are a matter that needs to be resolved by the legislature.

Capacity

Even where the definition of a child is correctly set at under 18 years, to comply with the CRC, legislation on consent to treatment should include provisions to encourage taking into consideration children’s views in consent issues, depending on their age and maturity. A significant number of children, especially teenagers, have sufficient maturity and understanding to be able to consent or refuse consent. Article 12 of the CRC provides for “the child who is capable of forming his or her own views, the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child”.

A 1993 report of a Government appointed tribunal of enquiry noted “the very high emphasis on the rights of the Family in the Irish constitution may be interpreted as giving a higher value to the rights of parents than to the rights of children” and recommended a constitutional amendment to expressly provide for an overt declaration of the rights of children¹³³. It has been suggested that “there has never been a national debate or national

forum to debate the issue of the place of children's rights in our society¹³⁴". Incorporation of the CRC into domestic law would not only be a very useful exercise in this context, but under Article 4 of the CRC, the State is obliged to undertake all legislative, administrative and other measures necessary for the implementation of the rights outlined in the CRC. Following its review of Ireland's performance in implementing the Convention, the UN Committee has called on Ireland to fully incorporate the CRC into domestic law.

Involuntary admission to in-patient services

In the Mental Health Act, other than where a health board is involved, the voluntary admission of children appears to lie solely with parents, or a person acting in *loco parentis*. It therefore seems possible for children to be admitted and detained against their will, despite being competent to make their own decisions.

Section 25 provides circumstances where a Health Board may make an application to the District Court for an order to refer a child to an in-patient facility. The ICP suggests: "It would be important that there be accurate definition of 'who' in a Health Board is in a position to make this application¹³⁵."

Amnesty International is concerned that children are denied the protection afforded to adults under the 2001 Act. Under section 25(3) and (4) there is provision for children to be admitted on the application of a Health Board to an approved centre by order of the Court without any examination by a Consultant Psychiatrist, where the parents or guardians refuse consent to such examination or cannot be found. The ICP states: "We view this as a possible serious infringement of children's civil liberties. In these circumstances, ... the provisions of the Child Care Act 1991, Section 13, subsection 7, should be invoked in the first instance rather than the Mental Health legislation, where there has been no medical examination¹³⁶."

Article 25 of the CRC provides "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". While a court order under section 25(1) will be for a period of 21 days and may be renewed by the court, review of the detention by Mental Health Review Tribunals established under the Act will not be available to children; neither is the right to change to voluntary status following a period of involuntary admission.

Involuntary admission should only occur where less restrictive measures are inappropriate – Article 37 of the CRC provides that detention should be an option of last resort. This implies that community-based alternatives must be available and accessible for an involuntary admission to any in-patient facility to be justifiable.

Informed consent to treatment

MI Principle 11 stipulates that except in specified circumstances¹³⁷, no treatment shall be given to a patient without his or her informed consent, and provides that informed consent to treatment is contingent on the availability of a range of treatment options, and giving and receiving of advice and information about the proposed treatment:

“Informed consent is consent obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on:

(a) The diagnostic assessment;

(b) The purpose, method, likely duration and expected benefit of the proposed treatment;

(c) Alternative modes of treatment, including those less intrusive;

(d) Possible pain or discomfort, risks and side-effects of the proposed treatment.”

Where “a personal representative (is) empowered by law to consent to treatment for the patient¹³⁸; ... treatment may be given to such a patient without his or her informed consent if the personal representative, having been given the information described ... above, consents on the patient’s behalf¹³⁹”.

It is clear then, that, in order for a child, or where a child is incapable of consenting, their personal representative, to give informed consent to a course of treatment, quite exacting standards in relation to the provision of information are demanded of the service provider. Failure by the State to ensure that proper guidelines and monitoring procedures are in place in relation to these component requirements of informed consent to psychiatric treatment and are being adhered to, amounts to a failure to comply with these principles. Furthermore, “[c]onsent cannot be lawful if ... alternatives to proposed treatment are not offered for consideration¹⁴⁰.”

Complaints and advocacy

The 2001 Act is deficient in not establishing an effective complaints procedure with respect to services provided under the Act, as well as mental health service provision generally. Building an advocacy and complaints process into legislation is important to ensure that individual children and children's issues and concerns are not neglected, particularly during the process of implementing the Act. MI Principle 21 provides the right of every child with mental illness or being treated within the mental health services "to make a complaint through procedures as specified by domestic law". Ireland is obliged to "ensure that appropriate mechanisms are in force ... for the submission, investigation and resolution of complaints¹⁴¹". An independent and effective health complaints system is required.

The right to complain entails the need to access information about rights and responsibilities. MI Principle 12(1) states: "A patient in a mental health facility shall be informed as soon as possible after admission, in a form and a language which the patient understands, of all his or her rights in accordance with these Principles and under domestic law, which information shall include an explanation of those rights and how to exercise them." Children should have access to a personal advocate to adequately represent their interests, especially when admitted to mental health facilities, and throughout the course of such admission. A personal advocate would, in many instances, be a family member. However where there is potential for real conflict of interest, or where the child's parents are unavailable, there should be legal provision for the appointment of an independent advocate.

The MI Principles reinforce the need for comprehensive advocacy services for children: "Special care should be given within the purposes of these Principles and within the context of domestic law relating to the protection of minors to protect the rights of minors, including, if necessary, the appointment of a personal representative other than a family member¹⁴²." "If and for so long as a patient is unable to understand such information, the rights of the patient shall be communicated to the personal representative, if any and if appropriate, and to the person or persons best able to represent the patient's interests and willing to do so¹⁴³." "A patient who has the necessary capacity has the right to nominate a person who should be informed on his or her behalf, as well as a person to represent his or her interests to the authorities of the facility¹⁴⁴."

Chapter 7 **Government Initiatives & Plans**

“there are . . . huge costs of failing children. Governments are fully aware from research findings that what happens to children in the early years, within the family and within other forms of care, significantly determines their positive or negative growth and development. This, in turn, determines their cost or contribution to society spread over the rest of their lives. As a consequence, the economic motive joins the moral and the social in providing cogent reasons for all governments to accord children a high priority and careful attention. These may seem obvious points which derive from common sense. But they need to be convincing particularly with regard to governments if we are to promote child-centred societies.”

UN High Commissioner for Human Rights¹⁴⁵

National Health Strategy

In 2001, the National Health Strategy, was published, one of the stated visions of which is a “health system that is there when you need it, that is fair, and that you can trust¹⁴⁶”. A wide range of goals, objectives, actions and target dates were set out for achievement over seven to ten years, but few of the 121 Actions refer explicitly to mental health. Action 14 on children’s health promises the expansion of mental health services, the implementation of the first report of the Government Working Group on Child and Adolescent Psychiatry, and the development of services for the 16 to 18 year age group, but provides no target dates. In its 2003 review of the Strategy, the Irish College of Psychiatrists (ICP) commented in respect of the stated initiatives for delivery of the mental-health-specific components of the Strategy: “Little of this has been delivered. In fact, few of the actions points were specific to the Strategy, and many of them had already been in progress prior to the Strategy’s publication and were independent of the development of the Strategy¹⁴⁷.” It observes that two of the main action points, suicide prevention and the establishment of the Mental Health Commission, were already in train before the Strategy, and concludes: “It is clear that none of the actions listed in the Health Strategy for Mental Health have been implemented to date. Progress has only been made on those items that were independent of the Strategy and that were well under way prior to its publication.”

While expectation might have been that relevant non-specific actions would equally benefit mental health, this has not been the experience. The ICP points to a number of examples where “psychiatry does not appear to fall under the remit of fairness or equity as espoused by the Strategy”. Published waiting lists for in-patient services figures only relate to ‘procedures’, hence, the ICP advises, “they specifically exclude psychiatry”. The Waiting List Initiative, designed to reduce waiting lists for public hospital services, consequently does not benefit mental health services; so when waiting times exceed regulations, private mental health services are not supplied under the Treatment Purchase Fund, and additional temporary staff are not recruited to reduce these waiting lists as in the sectors covered.

In 2002, the UN Committee on Economic, Social and Cultural Rights (UN CESCR) noted “with regret that a human rights framework encompassing, *inter alia*, the principles of non-discrimination and equal access to health facilities and services was not embodied in the recently published National Health Strategy, as outlined in paragraph 54 of the Committee’s General Comment No 14 on the right to health¹⁴⁸”. It recommended that the Irish Government “revisit the recently published National Health Strategy with a view to embracing a human rights framework in that strategy, in line with the principles of non-discrimination and equal access to health facilities and services”.

Mental Health Act & Commission

The Mental Health Commission was established in April 2002 as an independent statutory agency under the Mental Health Act, 2001¹⁴⁹. Its statutory functions are to: appoint an Inspector of Mental Health Services; put in place arrangements for an independent review by a Mental Health Tribunal of decisions to admit or detain a patient on an involuntary basis and decisions to extend the duration of such detentions;¹⁴³ and prepare codes of practice and guidelines for those working in the mental health services. The Commission will also be the registration authority for ‘approved centres’ – all in-patient facilities where people may legally be involuntarily admitted or detained. The Commission has mentioned its particular concern about inadequate services for children and adolescents, and it “recognises that it has a major responsibility in the role of advocacy”.¹⁴⁴ The Act will require substantial funding: “There is an urgent need to provide the resources and structures needed to implement the new Act. . . . Certainly, there is little point in having an elegant legislative framework if the resources are not in place to provide high quality mental health care to all¹⁵².”

Mental Health Policy

It has been suggested that the “absence of an up-to-date mental health national strategy” is seen as a “significant cause of the current inequities in clinical resource distribution, and limited availability of specialist services¹⁵³”. Work is to begin this year on a new national policy framework, promised under the 2001 National Health Strategy, to update current mental health policy, *Planning for the Future* (1984). Together with its national partner organisations, Amnesty International submitted to the Department of Health and Children a joint position statement seeking an informed review of the existing services, with the full participation of stakeholder organisations in an open, transparent and accountable process, as a necessary part of this policy update. In August 2003, an announcement was made by the Department of the establishment of an Expert Group on Mental Health Policy to prepare this new national policy framework. Amnesty International welcomed the commitment that the process will involve wide consultation with interested parties, and will take account of “innovative developments in the care and treatment of mental illness and the views of those who use the services, as well as those who work within them¹⁵⁴”. Of particular relevance to children are the commitments to explore measures to reduce stigma, and specialised mental health services for children/adolescents. The particular needs of vulnerable children, such as those referred to in Chapter 2, should be addressed in this policy.

After almost two decades in existence, ‘*Planning for the Future*’ has not led to an adequate, comprehensive or equitably resourced service. Mental health service users and providers are still struggling with an outdated, fragmented, and severely under-resourced system. It is clear that when this new policy emerges, detailed programmes of action for its implementation must follow from Government, with clear timeframes and dedicated resources.

Amnesty International recommends that the values and principles of mental health policy should reflect the civil, political, economic, social and cultural human rights obligations binding on the Irish Government under international law. The World Health Organisation will shortly publish its ‘*Mental Health Policy and Service Guidance Package*’, at the heart of which is a human rights focus, and which Amnesty International has promoted to the Irish Government as a solid basis for Ireland’s policy update¹⁵⁵. Interdepartmental responsibility should be reflected in mental health policy according to this WHO Guidance Package, and it advises: “it is necessary for (the) ministry of health to convince other policy-makers and planners, e.g. the executive branch of government, the ministry of finance and other ministries, the judiciary, the legislature and political parties, to focus

on and invest in mental health¹⁵⁶". A 'Child and Adolescent Mental Health' module of this Guidance Package will be of particular assistance.

The CRC is also considered by WHO to be a useful tool in mental health service planning:

"Increasing awareness about the support for appropriate care for mental disorders engendered in the UN Convention on the Rights of the Child is key to program and policy development in many countries. The Convention can also be used to support the modification of existing systems and for improving access to appropriate care. The UN Convention supports the important role of the child in the family context and of access to education, rehabilitation and a wholesome community life¹⁵⁷."

To comply with the CRC, consultation with children and children's representative organisations is essential during this process. This is also the first goal of the National Children's Strategy described below: that children will have a voice in matters which affect them and their views will be given due weight in accordance with their age and maturity. Several recent Irish studies are of assistance in this regard, including 'Hearing Young Voices'¹⁵⁸, which recommends that all agencies whose work impacts on children should be aware of the need to consult with children. The WHO Guidance Package also advises: "It is important to engage in serious consultation with consumer and family organisations in the development of policy and the delivery of services."

Ombudsman for Children

In 1998, the UN Committee on the Rights of the Child remained "concerned about the lack of an independent monitoring mechanism such as an Ombudsperson or a Child Rights Commissioner accessible to children for dealing with complaints of violations of their rights and to provide remedies for such violations¹⁵⁹". An Ombudsman for Children Act, 2002 was subsequently passed, but the delay by the Irish Government in appointing an Ombudsman seven years after it was first promised has been criticised by children's organisations. Amnesty International understands that arrangements are being made for the recruitment process to be commenced, and the views of children will be included in the selection process; and urges the Government to make this appointment a priority and to fully resource the office.

Disability Bill

The Department of Justice, Equality and Law Reform published a Disability Bill in 2001¹⁶⁰ to address inequalities experienced by people with disabilities, but it lacked a human rights based approach. It was heavily criticised for this by the UN Committee on Economic, Social Rights (CESCR), and for “the fact that it contained a clause purporting to remove the rights of people with disabilities to seek judicial redress if any of the Bill’s provisions were not carried out¹⁶¹”. The Irish Department of Finance had successfully prevailed on the government to introduce this clause stating:

“The Department of Finance cannot accept these recommendations which imply the underpinning by law of access to and provision of services for people with disabilities as a right. This right, if given a statutory basis, would be prohibitively expensive for the Exchequer and could lead to requests from other persons seeking access to health and other services without regard to the eventual cost of providing these services¹⁶².”

Amnesty International considers these sentiments unacceptable, and the fact that the Irish Government yielded to this view, in marked contrast to its international obligations outlined above, is of considerable concern. The Bill was abandoned in 2002, and another is currently in preparation, with a new consultation process completed. What sort of legislative proposal will emerge from this process is quite uncertain in relation to its respect for human rights standards, but clearly, any revived Bill must not again seek to qualify equal rights for people with disabilities. Amnesty International made a submission to the Department of Justice, Equality and Law Reform in April 2003 urging that the emergent Disability Bill should adopt a rights-based, judiciable approach as advocated by the CESCR in 2002.

National Anti-Poverty Strategy

Socio-economic deprivation levels are considered a solid indicator of mental health needs. Article 27 of the CRC provides “the right of every child to a standard of living adequate for the child’s physical, mental, spiritual, moral and social development” and the duty of the State to “take appropriate measures to assist parents and others responsible for the child to implement this right and . . . in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing”. In Ireland

however: "Economic progress has had little impact on the incidence of relative child income poverty figures, with nearly 250,000 or 24% of all Irish children still living in relative poverty¹⁶³."

A report on family policy commissioned by the Irish Government concluded that addressing child poverty is one of the four areas where "public investment ... will be highly cost effective in terms of promoting the relational and economic well-being of families¹⁶⁴". It noted:

"So decisive is the impact of poverty during the early years of childhood development that State intervention to compensate for these negative impacts later in life ... are immeasurably less cost effective than interventions during the early years of the child's life. This is something that should be borne in mind in view of the well documented prevalence of child poverty in Ireland. Second, early interventions in the lives of children and their families are known to be cost effective but only if they are high in quality and well targeted."

In 2002, the CESCR expressed concern that the Irish Government, "despite the Committee's recommendation in 1999 ..., has still not adopted a human rights-based approach to the National Anti-Poverty Strategy (NAPS)", and urged it to integrate economic, social and cultural rights¹⁶⁵. The Government is soon to publish a second National Action Plan against Poverty and Social Exclusion (NAPincl) Ireland – 2003-2005. The Irish Human Rights Commission has expressed its concern "about the ways in which the State upholds its obligations with regard to (economic, social and cultural) rights" and suggests: "Central to these (areas of concern) is the adoption of a human rights framework for the Government's National Anti-Poverty Strategy¹⁶⁶."

The Children's Rights Alliance also suggests: "A strong rights based focus in the NAPincl would advance Ireland's implementation of its international commitment to economic and social rights. It may also begin to redress the lack of reference to rights in the Health Strategy, the treatment of rights as a subset of services in NAPS, the statements by the Minister for Justice rejecting socio-economic rights, the failure to incorporate treaties and conventions into domestic law and the mixed signals given regarding disability rights¹⁶⁷." It further recommends that NAPincl "must comprise a fully-resourced, timetabled, sustained and comprehensive programme of action that can address the multi-dimensional nature of child poverty".

National Children's Strategy

The National Children's Strategy 'Our Children – Their Lives' was launched in 2000, and reflects the holistic approach to child development required by the CRC. It is a 10-year plan of action, which calls on Irish statutory agencies, the voluntary sector and local communities to work together to improve the quality of all children's lives. Its three National Goals are: Children will have a voice in matters which affect them and their views will be given due weight in accordance with their age and maturity, Children's lives will be better understood; their lives will benefit from evaluation, research and information on their needs, rights and effectiveness of service; and Children will receive quality supports and services to promote all aspects of their development. The National Children's Office is to lead and oversee implementation of the National Children's Strategy, including progressing actions under the three National Goals. In relation to mental health, the Children's Rights Alliance urges: "Commitments in the National Children's Strategy, including the expansion of family support and community-based early intervention services, and the introduction of more structured programmes for identification, assessment and treatment of children with emotional and behavioural problems, should be implemented as quickly as possible"¹⁶⁸.

Funding

The ICESCR and the CRC do not require full realisation of the standards therein immediately upon ratification, but require progressive realisation to the maximum of available resources. The purpose of Ireland's 2004 report to the Committee on the Rights of the Child is to assess progress in implementing its provisions since its first review in 1998. In 2002, the CESCR, noted "the favourable economic conditions prevailing in the State party and observes no insurmountable factors or difficulties preventing the State party from effectively implementing the (ICESCR)¹⁶⁹".

WHO advises that funding allocation should form part of a national mental health policy: "Mental health financing is a powerful tool with which policy-makers can develop and shape quality mental health systems. Without adequate financing, mental health policies and plans remain in the realm of rhetoric and good intentions"¹⁷⁰.

A 2002 study points to the fact that Ireland is becoming a less equal society: "The persistence, even the deepening of poverty and inequality in Ireland, indicates that the gains from Ireland's economic growth have been unevenly shared"¹⁷¹. It refers to the Government's low-tax, low-spend model of economic development, and divergence from European social norms. It observes "dismal health and social indicators, the

widening levels of inequality (and) extraordinary low levels of investment in public services". Even where there have been considerable increases in health budgets in recent years – as was pointed out in Amnesty International's February report¹⁷², revenue funding of the mental health programme remains out of step with other medical programmes. In 1990, mental health spending accounted for 10.6 per cent per cent of total health non-capital expenditure; by 2002, it was just 7 per cent. While fiscal measures are the preserve of Government, international human rights standards advise that financial provision in the mental health sector should at least achieve parity with other health sectors. Many nongovernmental and professional organisations protest current funding. The Mental Health Commission has also expressed its view that increased funding is essential to service development¹⁷³.

In the mental health sector there is "a five-fold difference in funding between health board areas¹⁷⁴"; and a 2003 study by the Irish Psychiatric Association found that areas of greatest socio-economic deprivation receive fewest resources¹⁷⁵. It has also been observed that regional budgets promised to the mental health services have been eroded in times of competing needs from other health sectors. Amnesty International welcomes the Government's recently announced plans to reform the health services, and to achieve clear accountability, standardisation and improved planning and delivery of services¹⁷⁶. The Reform Programme recognises that "significant demographic and social changes over the ... are not reflected in the way in which resources have been allocated in the system" and promises that "funding will be determined in a manner that captures these changes in society". Amnesty International urges that this programme for reform ensures equity for mental health services, and that ring-fencing and other measures to protect mental health budgets at central and regional levels will be introduced, as advised by WHO in its 'Mental Health Policy and Service Guidance Package'. WHO advises that "allocation of funds must be tied to policy and planning priorities", and: "Without adequate financing, plans remain in the realm of rhetoric and good intentions¹⁷⁷." Stated Government commitments to equity in mental health service provision for children will require immediate and adequate funding if they are to be meaningful.

It has been noted that "in spite of this decrease in (mental health) funding, services have continued to develop and innovate, due in no small part to the dedication of the people who work in the mental health services", but "the decrease ... coupled with continued demands to provide high quality services, can demoralise staff¹⁷⁸". This financial shortfall has certainly impeded the potential rate of progress in Irish mental health policy implementation and service development.

It must be recognised that investment in the future of children has enormous benefits for society. In immediate economic terms, it leads to increased resources as carers are entering the workforce. Also, mental health problems in children are associated with educational disadvantage, disability, offending and antisocial behaviour, placing extra demands on social services, schools and the juvenile justice system. Untreated mental health problems create distress not only in childhood but pass into adulthood, potentially affecting the mental health of next generation of children. The United Nations advises that “the healthy development and active participation of children are uniquely crucial to the optimum development of any society”, and “children are more affected by the action – or inaction – of government than any other group¹⁷⁹”.

The 2001 Health Strategy acknowledges that “[t]he debate about health spending must recognise the social and economic value which accrues from investment”, and the proper context for such a debate is “one which views health spending as an investment delivering benefits as well as accruing costs”.¹⁷³

The implementation of the Mental Health Act, 2001 will require substantial extra resources. Adequate resources must also be afforded to the Mental Health Commission in the performance of its considerable remit. In addition, resources will be required at local Health Board level to ensure full compliance with the regulations and statutory obligations under the Mental Health Act, and with codes of conduct and guidelines to be issued by the Commission. “For the smooth and effective functioning of the new Act, there will need to be a considerable amount of resources allocated to a number of areas. They include financial resources to ensure systems are put in place, resources for training of staff, medical, nursing and administrative, and resources in terms of manpower and time¹⁸⁰.” Furthermore, the new policy framework described above must be quickly followed by programmes of action, to which sufficient and guaranteed resources will be attached.

Human Resources

Amnesty International recognises that a significant difficulty facing Government is that of accessing and maintaining mental health staff, which is a universal problem:

“In developed countries there are problems of maldistribution, a declining enrolment in child psychiatry training programs, and a recent reduction in those working in community settings. In the developing world there is

an almost universal lack of enough trained individuals to staff even basic child and adolescent mental health treatment facilities and certainly not enough to implement a full continuum of care as conventionally defined¹⁸¹.

WHO suggests: “Creative training programs for a broad range of previously trained pediatricians and adult psychiatrists can add to the pool of child mental health trained individuals at one end of the spectrum, but there is also the need to train larger numbers of primary care workers, religious personnel, school personnel, and community workers in basic child mental health diagnosis and treatment methods¹⁸².”

Research and Statistics

A systematic mechanism for monitoring children’s mental health needs and Government responses is crucial to the process of monitoring and evaluating the progressive realisation of the rights set out in the CRC. Without sufficient collection of data, which is disaggregated, it is impossible to evaluate and monitor the extent to which Ireland has implemented the provisions of the CRC. While local services and individual regions produce statistics, the lack of a comprehensive national database and centralised systems and methods for data collection means that analyses of needs and responses are hampered. A National Longitudinal Study of Children, a Children’s Research Programme, and the development and publication of child well-being indicators committed to under the National Children’s Strategy should also be directed to this end.

Regular and consistent data collection and research is essential for other reasons – mainly in planning policies and responses, but also to assist in international efforts to effectively plan children’s mental health initiatives. Under Article 24(4) of the CRC, Ireland undertook to “promote, in the spirit of international cooperation, the exchange of appropriate information in the field of preventive health care and of medical, psychological and functional treatment of disabled children . . . with the aim of enabling States Parties to improve their capabilities and skills and to widen their experience in these areas”. WHO has also requested states to improve their research into mental health to facilitate the evolution of international and regional understanding of mental illness and its treatment.

The waiting lists for mental health services, an indicator of responsiveness, are largely unknown due to current structures: “To be placed on such a waiting list a patient must first be seen by a consultant in outpatients. No waiting list figures are published to cover the period a patient has to wait from the time of the GP referral to the outpatient

clinic appointment. Therefore, in psychiatry, no (waiting list) figures are published for outpatient waiting lists, admission to acute beds, for elective admissions, for day hospital places, for referral for psychological assessment and treatment, for social work interventions or for hostel placement¹⁸³.”

The UN Committee on the Rights of the Child voiced general concern in its 1998 report about “certain lacunae in the statistical and other information collected by (Ireland), including with respect to the selection and development of indicators to monitor the implementation of the principles and provisions of the Convention¹⁸⁴”. When Ireland reports to the Committee in 2004, it must cite: “measures taken to ensure the systematic gathering of data on children and their fundamental rights and to assess existing trends at the national, regional and local levels, and where appropriate at the federal and provincial levels, as well as the steps taken to develop mechanisms for the identification and gathering of appropriate indicators, statistics, relevant research and other relevant information as a basis for policy-making in the field of children’s rights...¹⁸⁵.”

Research into the mental health needs of children is particularly poor¹⁸⁶.

“The absence of epidemiological information relating to children’s mental health on a national basis is a significant limitation in our current system. No routine information system captures information on children’s mental health problems, with the exception of the national psychiatric in-patient reporting system, which provides information on children admitted to psychiatric hospitals. However, since mental health problems in children rarely require admission, this source of information is of limited value. A highly developed information system is required, in order to underpin approaches to quality assurance and evaluation of mental health prevention and treatment services, to monitor trends in incidence, and to identify risk factors and risk groups¹⁸⁷.”

The lack of centrally published statistics hampers service planning – for instance a Government Working Group noted: “great difficulty in establishing the number of 16-18 year olds currently attending the adult services. Figures are available ... on the number of admissions to adult in-patient facilities. There is however, a lack of information

relating to the number of referrals and non-attendees to out patient clinics. This lack of information made it difficult ... to establish how many ... are currently in receipt of psychiatric service input¹⁸⁸."

As pointed out in Chapter 4, information on the level and quality of service provision is inadequate – other than regarding those admitted to in-patient services, there is no central data collection or reporting system on children's uptake of other mental health services at primary care or on an out-patient basis. Statistics for certain categories of service users, such as those admitted to adult in-patient facilities, do not distinguish those under 18 years. Statistics and research should be also disaggregated not alone by age and gender, but also geographic origin, ethnic group, etc., so that the need for positive actions in respect of marginalized groups can be best assessed, for instance in view of the "right to treatment suited to (a child's) cultural background¹⁸⁹". The UN Committee recommends: "the system of data collection and development of indicators be adjusted to include all children up to the age of 18, with a view to incorporating all the areas covered by the Convention ... with specific emphasis on vulnerable children and children in especially difficult circumstances. Adequate disaggregated data should be gathered and analysed in order to monitor and assess progress achieved in the realisation of children's rights and to help define policies to be adopted to strengthen the implementation of the provisions of the Convention¹⁹⁰." These improvements would also assist in better international and European understanding and evaluation of mental health patterns, and the effectiveness of responses.

(The first step under the second national goal of the National Children's Strategy was the development of the Children's Research Programme, under which are awarded National Children's Strategy Research Awards. The purpose of these research awards is to develop research capacity in relation to children and to support research directly related to the National Children's Strategy. A National Longitudinal Study of children growing up in Ireland is also planned.)

Mental Health Legislation

While the Mental Health Act, 2001 is welcome, Irish legislation should reflect the full range of international human rights standards applicable to the right to the best available mental health care. A planned action in the 2001 Health Strategy to the introduction by the Department of Health and children of new legislation "to provide for clear statutory provisions on entitlement" to health and personal social services". A Bill was to have

been published in 2002, but has not yet been. Whether this Bill, the Mental Health Act, or a separate piece of legislation should deliver this is a matter for the legislature. WHO advises that ensuring legislative provision is also an essential component of a mental health policy: “Mental health legislation should codify and consolidate the fundamental principles, values, goals, and objectives of mental health policy. Such legislation is essential to guarantee that the dignity of patients is preserved and that their fundamental rights are protected¹⁹¹.”

Conclusion & Recommendations

In its 2001 report, 'Mental Health: New Understanding, New Hope', WHO advised States to take serious and meaningful action on the neglected area of mental health. For instance, it recommended that the mental health of the population should be monitored, and more research into biological and psychosocial aspects of mental health was needed¹⁹². It laid down 'Three Scenarios for Action' for states according to their needs and resources. Scenario C is aimed at industrialised countries with a relatively high level of resources, and proposals include improvement in the management of mental disorders in primary health care, individualised care in the community for people with serious mental disorders, community care facilities offering 100 per cent coverage, development of advanced mental health monitoring systems, provision of special facilities in schools and the workplace, and launch of education and awareness campaigns to educate the public about mental illness. Unfortunately, in two years of relative prosperity, insufficient action has been taken by the Irish Government on its key recommendations, particularly in respect of children.

The provision of child mental health services is inadequate, and those available are severely under-resourced in staff, funding and available therapies; adult psychiatric services and facilities are used inappropriately to treat children; and children with behavioural problems and mental health needs are detained in prisons and places of detention without having those needs addressed, contrary to international human rights law. Service planning is hampered by a lack of systems for the collection of data and research on the needs of and provision for children. Geographical inequities exist in the distribution of services; and while funding is generally disproportionately low, in less affluent regions, services are more under-resourced.

In 2001, the World Health Ministers acknowledged that "mental health care has simply not received until now the level of visibility, commitment and resources that is warranted by the magnitude of the mental health burden¹⁹³". This is equally the case in Ireland, and it should strive for full compliance with the CRC, as part of its duty on the world stage: "International cooperation and solidarity should be promoted to support the implementation of the Convention (on the Rights of the Child) and the rights of the child should be a priority in the United Nations system-wide action on human rights¹⁹⁴."

Recommendations

Amnesty International urges the Irish Government to address the following:

- Establish systems and procedures for the collection and compilation of detailed and disaggregated data and conduct regular research into all areas of children's mental health needs and levels of service provision, an essential prerequisite for the development of a quality service. This should be periodically followed up to assess the impact of service developments.
- In the planned review of mental health policy, undertake meaningful consultation with children and their representative organisation, and ensure that emergent policy on children's services meets international human rights standards and best practice in line with WHO guidelines, and promptly implement its outcome.
- Increase revenue and capital funding in children's mental health services, to ensure equitable financial provision for this priority area; and ensure adequate resources for the functioning of the Mental Health Commission.
- Adequately fund the development of innovative community based early intervention services and structured programmes for the identification, assessment and treatment of children with emotional and behavioural problems, as promised in the National Children's Strategy.
- Take immediate steps to ensure the prompt delivery of sufficient and geographically equitable age-appropriate in-patient facilities for all children, in particular those aged 16 years and over, and ensure that children are not placed in adult facilities unless it is considered in their best interests to so place them.
- End the practice of placing non-offending children in facilities for offenders; children with severe emotional or behavioural problems should not be placed in facilities for offenders, whether juvenile justice institutions or the adult prison system.
- Implement the preventive elements of the Children Act 2001 promptly, and prioritise investment of resources in community and statutory services to support these measures.

- Recruit and retain suitable, qualified and experienced staff for children's services, ensure that all staff who work with children are vetted, have received formal training adequate for their posts, and are fully trained in children's rights.
- Develop a national mental health promotion strategy, involving the views and responsive to the experiences of children and young people.
- Introduce a public education and awareness programme emphasising the rights of, and promoting an attitude of dignity and respect towards children with mental ill health.
- Enact rights-based mental health legislation giving full effect to Ireland's international human rights obligations.
- Introduce an effective statutory complaints procedure, and a comprehensive system of personal advocacy to ensure that children with mental illness are assisted in exercising the full range of their rights.
- Provide all necessary resources and services necessary for the full implementation of the Education for Persons with Disabilities Bill, 2002, and expand the National Educational Psychology Service.
- Incorporate the UN Convention on the Rights of the Child into national legislation.

Endnotes

- ¹ 'Caring for children and adolescents with mental disorders: Setting WHO directions', World Health Organisation, Geneva (2003). It observes: "We are well aware of the risks inherent of medicalisation in any discussion of mental health problems of children and adolescents – or worse, its "psychiatrisation" – of problems of normal living and normal psychosocial development. We also aware of the many spurious interests endangering an unbiased, objective approach to normal developmental issues, that tend to unduly put many problems of normal living in the basket of "medical or mental disorders". However, this does not justify ... shunning action that provides adequate and appropriate interventions for children and adolescents with unequivocal mental disorders."
- ² 'Mental Illness: the Neglected Quarter', Amnesty International (Irish Section), Dublin (2003). Reports and information on the campaign are also available at www.amnesty.ie
- ³ See Chapter 1.
- ⁴ 'Mental Health: New Understanding, New Hope', WHO, Geneva (2001).
- ⁵ 'Advocacy for Mental Health', in 'Mental Health Policy and Service Guidance Package', WHO (unpublished at the time of writing).
- ⁶ 'Children's Rights: Creating a Culture of Human Rights', Basic information kit no. 3, Office of the High Commissioner for Human Rights, 1998.
- ⁷ 'Ireland: United Nations Convention on the Rights of the Child – First National Report of Ireland', Department of Foreign Affairs (1996).
- ⁸ 'Concluding observations of the Committee on the Rights of the Child: Ireland', 4 February 1998, UN Doc CRC/C/15/Add.85.
- ⁹ Article 4.
- ¹⁰ 'General Guidelines Regarding the Form and Contents of Initial Reports to be submitted by States Parties Under Article 44, Paragraph 1 (a), of the Convention on the Rights of the Child', CRC/C/5, 15 October 1991.
- ¹¹ 'General Guidelines Regarding the Form and Contents of Periodic Reports to be submitted by States Parties under Article 44, Paragraph 1 (b), of the Convention on the Rights of the Child', CRC/C/58, 20 November 1996.
- ¹² General Assembly Resolution No. 46/119 of 17 December 1991.
- ¹³ MI Principle 2.
- ¹⁴ General Assembly Resolution No. 48/96 of 20 December 1993.
- ¹⁵ General Assembly Resolution No. 2856 (XXVI) of 20 December 1971. While still relevant to people with learning disabilities and mental illness, this Declaration is considered to be quite dated, for example, in that the term "mental retardation" is widely regarded as derogatory, where "intellectual disability" is generally favoured today.
- ¹⁶ General Assembly Resolution No. 3447 (XXX) of 9 December 1975.
- ¹⁷ www.mentalhealthireland.ie/mhi/Information.asp?ID_info=2&
- ¹⁸ Note 1 above.
- ¹⁹ 'The Health of our Children', Second Annual Report of the Chief Medical Officer of the Department of Health and Children (2001). (Also see Fitzpatrick C Prof & Deehan A, 'Competencies and Problems of Irish Children and Adolescents', *European Child & Adolescent Psychiatry*, 8 (1999) 1, 17-23.)
- ²⁰ 'Working Group on Child and Adolescent Psychiatric Services: Second Report', Department of Health and Children (2003).
- ²¹ International studies indicate that the onset of depression is occurring earlier in life than in previous decades. See for example, Klerman GL, Weissman MM, 'Increasing rates of depression', *Journal of the American Medical Association*, 1989; 261: 2229-35.
- ²² For a list of support and advice organisations, see 136.206.204.1/studentsunion/welfare.html web page
- ²³ See Chapter 7, Research and Data.

- ²³ 'Mental Health: New Understanding, New Hope', WHO, Geneva (2001).
- ²⁴ Note 8 above.
- ²⁵ In 2001, 24 per cent of all deaths in Ireland in this age group were recorded as suicide.
- ²⁶ Geaney Dr C, 'Why suicide and alcohol are related in this country', Irish Medical News.
- ²⁷ 'Suicide Prevention: A Resource Handbook for Youth Organisations', National Youth Federation, South Eastern Health Board and National Suicide Review Group (2003).
- ²⁸ 'Preventing Suicide: A Resource for teachers and other school staff', World Health Organisation, Geneva (2000). In 1999 WHO launched SUPRE, its worldwide initiative for the prevention of suicide. This booklet is one of a series of resources prepared as part of SUPRE and addressed to specific social and professional groups that are particularly relevant to the prevention of suicide.
- ²⁹ Department of Health and Children. (1998).
- ³⁰ See for instance, "Dealing with Suicide: Guidelines for youth workers", National Youth Federation (1995); 'Suicide Prevention in Schools: Best practice Guidelines', The Irish Association of Suicidology & National Suicide Review Group (2002); 'Responding to Youth Suicide and Attempted Youth Suicide in Ireland', Barnardos (1999). See also the website of the Government National Suicide Review Group: www.nsrgr.ie Guidelines on sensitive media reporting of suicides have also been developed by several organisations, for example, 'Suicide in the Media', National Union of Journalists & Aware (2002).
- ³¹ 'Suicide In Ireland: A Global Perspective and A National Strategy', Aware (1998).
- ³² 'Get Connected: Developing an Adolescent Friendly Health Service – Reports from Working Groups', National Conjoint Child Health Committee (2001).
- ³³ 'Suicide in Ireland a National Study', Department and Health and Children, on the behalf of the CEO of the Health Boards (2001).
- ³⁴ Article 2(1) CRC.
- ³⁵ Note 8 above.
- ³⁶ 'Mental Illness: The Neglected Quarter – Homelessness'.
- ³⁷ Ivan Mahony, Section Manager, Young Person's Services, Focus Ireland, in 'No homes to go to', Poverty Today, March/April 2000, No. 46, states: "The current state of child homelessness in Ireland is nothing short of a national disgrace. Section 5 of the Child Care Act 1991 conferred a legal duty on health boards to provide accommodation for all homeless children in their area. Yet the number of homeless children re-referred (i.e. those who remain homeless for periods of time) through both health boards and non-statutory services is staggering."
- ³⁸ Kelleher P, Kelleher C & Corbett M, 'Left Out on Their Own: Young People Leaving Care in Ireland', Focus Ireland (2000).
- ³⁹ Note 8 above.
- ⁴⁰ Halpenny AM, Keogh AF & Gilligan R, 'A Place for Children? Children in Families Living in Emergency Accomodation', Children's Research Centre & Trinity College Dublin, submitted to the Homeless Agency (2002). O'Brien J et al, 'The Mental and Physical Health and Well-being of Homeless Families in Dublin: A Pilot Study', Focus Ireland, Mater Hospital and Northern Area Health Board (2000).
- ⁴¹ 'Background Paper 3: Mental Health and Development, National Inquiry into Children in Detention', Australian Commission for Human Rights and Equal Opportunities.
- ⁴² Silove D & Steel Z, 'The Psychological Cost of Seeking and Granting Asylum', Shalev A H, Yehuda R & McFarlane A C (eds), *International Handbook of Human Response to Trauma*, Kluwer Academic/Plenum Publishers, New York, (2000).
- ⁴³ UNHCR Refugee Children: Guidelines on Protection and Care (1994), Geneva, Chapter 4.
- ⁴⁴ Fanning B, Veale A & O'Connor D, 'Beyond the Pale: Asylum-seeking Children and Social Exclusion in Ireland', Irish Refugee Council (2001).
- ⁴⁵ Note 43 above.
- ⁴⁶ See Chapter 4.
- ⁴⁷ See Chapter 5.
- ⁴⁸ 'Implementing Equality for Lesbian, Gays and Bisexuals' (2002).

- ⁴⁹ “US research indicates that up to 30 per cent of suicide attempts and completed suicides are made by young people struggling with their sexual orientation.”
- ⁵⁰ Section E: Children in Care and Child Abuse Cases, ‘Health Statistics 2002’, Department of Health and Children (2003).
- ⁵¹ Ibid.
- ⁵² Irish Times newspaper article, ‘The abused children left at risk by a system in crisis’, 25 March 2003.
- ⁵³ Hennessy E & Heary A, ‘Children’s understanding of ADHD: Perceptions of causes and interventions’, presented at the 17th Biennial Meeting of the International Society for the Study of Behavioral Development, Ottawa, Canada, August 2002.
- ⁵⁴ ‘The Health of our Children’, note 18 above.
- ⁵⁵ Note 1 above.
- ⁵⁶ Note 4 above.
- ⁵⁷ Note 31 above.
- ⁵⁸ Note 4 above.
- ⁵⁹ ‘Prevention and Promotion in Mental Health’, WHO (2002).
- ⁶⁰ Mental Health Ireland website: www.mentalhealthireland.ie/mhi/Information.asp?ID_info=3&
- ⁶¹ ‘Promoting Mental Health and Social Well-being: Cross-Border Opportunities and Challenges’ (2002).
- ⁶² Note 32 above.
- ⁶³ Note 1 above.
- ⁶⁴ Minister for Education and Science in answer to Dail question 5880/03, 27 February 2003.
- ⁶⁵ Speech by Sean Rowley, President, Irish National Teachers’ Organisation, ICTU Conference, Tralee, 2 July 2003.
- ⁶⁶ ‘Scheme for the Commissioning of Individual Psychological Assessments 2002/2003: Information Note’, NEPS, Department of Education and Science.
- ⁶⁷ ‘A Crime Prevention Strategy for Ireland: Tackling the Concerns of Local Communities’, National Crime Council, Dublin (2003). See Chapter 5.
- ⁶⁸ Discussed in Chapter 4, see note 80 below.
- ⁶⁹ CRC General Comment 1, ‘Article 29(1): The Aims of Education’, 21/11/97.
- ⁷⁰ ‘Encouraging Voices: respecting the insights of young people who have been marginalised’, Shevlin M & Rose R Eds, National Disability Authority, Dublin (2003).
- ⁷¹ Education for Persons with Disabilities Bill 2002, ASTI Submission (2003).
- ⁷² Speech by Sean Rowley, President, Irish National Teachers’ Organisation, ICTU Conference, Tralee, 2 July 2003.
- ⁷³ ‘Shortage of quality care undermining service’, 17 November 2000.
- ⁷⁴ Note 80 below.
- ⁷⁵ See Chapter 7.
- ⁷⁶ Note 4 above.
- ⁷⁷ ‘Quality and Fairness: A Health System for You, Health Strategy 2002 – A Year On, The lack of implementation of the Health Strategy on Mental Health’, Irish College of Psychiatrists (2003).
- ⁷⁸ Keogh Dr F, ‘Developments and Challenges in Mental Health Services in Ireland’, ‘Mental Health Commission Annual Report: 2002’, Mental Health Commission, Dublin (2003).
- ⁷⁹ Ibid.
- ⁸⁰ ‘First report of the Working Group on Child and Adolescent Psychiatric Services’, Department of Health and Children (2001).
- ⁸¹ ‘Position statement on child and adolescent psychiatry’.
- ⁸² Note 77 above.
- ⁸³ General Comment No. 4 (2003), ‘Adolescent health and development in the context of the Convention on the Rights of the Child’, CRC/GC/2003/4.
- ⁸⁴ ‘Position Statement on Psychiatric Services for Adolescents’, Irish College of Psychiatrists (2002).
- ⁸⁵ Note 19 above.
- ⁸⁶ See CARI Annual Report 2002.
- ⁸⁷ Irish Examiner newspaper, ‘Abuse therapy group faces cutbacks’, 12 June 2003.
- ⁸⁸ Note 8 above.

- ⁸⁹ 'Summary Report of The Addiction Spoke – May 2002', The Wheel (2002).
- ⁹⁰ 'Position Statement on Psychiatric Services for Adolescents', Irish College of Psychiatrists (2002).
- ⁹¹ MI Principle 7(2).
- ⁹² Daly A & Walsh D, 'Activities of Irish Psychiatric Services 2001', Health Research Board, Dublin (2002). On census night in 2001, there were four children under 16 years adult psychiatric inpatient facilities. (Daly A & Walsh D, 'Irish Psychiatric Hospitals and Units Census 2001', Health Research Board, Dublin (2002).)
- ⁹³ Note 77 above.
- ⁹⁴ MI Principle 8.
- ⁹⁵ In Cork, Galway, Limerick and two in the Dublin area.
- ⁹⁶ Irish Examiner newspaper article, '2,000 mentally ill children wait for assessment', 31 July 2003.
- ⁹⁷ 'Irish Psychiatric Hospitals and Units Census 2001', note 92 above.
- ⁹⁸ Dail Debates, 20 November 2001.
- ⁹⁹ MI principle 13(2).
- ¹⁰⁰ See Chapter 7.
- ¹⁰¹ 'Mental Health Commission response to the Criminal Law (Insanity Bill) 2002', (2003).
- ¹⁰² Personal communication from the Department of Health and Children, 19 August 2003.
- ¹⁰³ See Chapter 5.
- ¹⁰⁴ The Charter is published by Children in Hospital Ireland – European Association for Children in Hospital (EACH) and is available at www.childrenhospital.ie
- ¹⁰⁵ See Chapter 1.
- ¹⁰⁶ Guidelines on periodic reporting, note 10 above.
- ¹⁰⁷ Note 84 above.
- ¹⁰⁸ 'Comments on Mental Health Act 2001', Irish College of Psychiatrists (2001).
- ¹⁰⁹ Quinn P, 'Holding the mirror: how do social workers in adult mental health see themselves?', Social Workers in Adult Mental Health (2003).
- ¹¹⁰ 'Breaking the Silence: Carers' views on the help given during the first episode of psychosis. A European perspective', European Federation of Associations of Families of People with a Mental Illness, Madrid, October 2001.
- ¹¹¹ For example: "The single most important risk factor for development of depressive illness in youth is having at least one parent with a similar depression, particularly one which recurs." Note 31 above.
- ¹¹² Note 2 above.
- ¹¹³ Note 38 above.
- ¹¹⁴ 'Annual Report: Social Services Inspectorate 2002' (2003). The SSI assesses centres against standards set out the 'National Standards for Children's Residential Centres' (2001).
- ¹¹⁵ Children under 18 years who arrive in Ireland without their parents or guardians and seeking to stay in this country are termed unaccompanied asylum seeking minors. See also Chapter 2.
- ¹¹⁶ Personal communication from Maria Corbett, Children's Rights Alliance, August 2003.
- ¹¹⁷ Article 37(b). The provisions of Article 37 are repeated throughout other UN standards on children. For example, the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (1990) states that detention "should be used as a last resort" and "be limited to exceptional cases". The United Nations Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules) (1985) reiterate that any detention should be brief and state this should only occur where the child has committed "a serious act involving violence".
- ¹¹⁸ Article 37(c).
- ¹¹⁹ Note 8 above.
- ¹²⁰ Adopted by General Assembly Resolution 45/113 of 14 December 1990.
- ¹²¹ For a commentary on the 2001 Act, see McDermott & Robinson, 'The Children Act', Roundhall, Dublin (2003).
- ¹²² 'First Annual Report of the Inspector of Prisons and Places of Detention for the Year 2002-2003', Department of Justice, Equality and Law Reform (2003).
- ¹²³ Irish Times, 11 July 2002.
- ¹²⁴ Dooley R & Corbett C, Child Care, Juvenile Justice

and the Children Act, 2001, in Irish Youthwork Scene: A Journal for Youth Workers, Issue 36, National Youth Federation, June 2002.

¹²⁵ Sunday Independent newspaper, 4 March 2001.

¹²⁶ Note 124 above.

¹²⁷ Note 19 above.

¹²⁸ Irish Times newspaper, 15 October 2002.

¹²⁹ Irish Times newspaper, 1 August 2000.

¹³⁰ Kroll L, Rothwell J, Bradley D, Shah P, Bailey S, Harrington R, 'Mental health needs of boys in secure care for serious or persistent offending: a prospective, longitudinal study', The Lancet, Vol 359 (2002).

¹³¹ Note 19 above.

¹³² Casey P & Craven S, 'Psychiatry and the Law' (1999).

¹³³ Kilkenny incest investigation report' (1993).

¹³⁴ Martin F, 'The Politics of Children's Rights', Cork University Press (2000).

¹³⁵ 'Comments on Mental Health Act 2001', Irish College of Psychiatrists (2001).

¹³⁶ Ibid.

¹³⁷ As provided for in paragraphs 6, 7, 8, 13 and 15 thereof.

¹³⁸ "except as provided in paragraphs 12, 13, 14 and 15 below".

¹³⁹ MI Principle 11(7).

¹⁴⁰ 'Mental Health Legislation and Human Rights', in 'Mental Health Policy and Service Guidance Package', WHO (unpublished at the time of writing).

¹⁴¹ MI Principle 22.

¹⁴² MI Principle 2.

¹⁴³ MI Principle 12(2).

¹⁴⁴ MI Principle 12(3).

¹⁴⁵ Note 6 above.

¹⁴⁶ 'Quality and Fairness: A Health System for You', Department of Health and Children (2001).

¹⁴⁷ Note 77 above.

¹⁴⁸ 'Concluding observations of the Committee on Economic, Social and Cultural Rights: Ireland',

17 May 2002, UN Doc No. E/C.12/1/Add.77.

¹⁴⁹ While the Act is not yet in force, the Minister for Health and Children signed a commencement order enacting from 5 April 2002 sections of the Act establishing the Commission, and providing for the appointment of the Inspector of Mental Health Services. Further information on the Commission and the Act is available at www.mhcirl.ie

¹⁵⁰ Note that this provision will not apply to children. See Chapter .

¹⁵¹ 'Chairman's Statement', Mental Health Commission Annual Report: 2002, Mental Health Commission, Dublin (2003).

¹⁵² Kelly Dr B, 'The Mental Health Act 2001', Irish Medical Journal, May 2002, Volume 95 No 5.

¹⁵³ 'The Stark Facts: The Need for a National Mental Health Strategy, as well as Resources', Irish Psychiatric Association (2003).

¹⁵⁴ Press Release: 'Minister announces formation of Expert Group on Mental Health Policy', 4 August 2003, Government Press Office.

¹⁵⁵ 'Submission to the Department of Health and Children and the Expert Group on the Proposed Mental Health Policy Update', July 2003

¹⁵⁶ 'Advocacy for Mental Health' module.

¹⁵⁷ Note 1 above.

¹⁵⁸ McAuley K, Brattman M, 'Hearing Young Voices: Consulting Children and Young People, including those experiencing Poverty or other forms of Social Exclusion, in relation to Public Policy Development in Ireland', Children's Rights Alliance & National Youth Council of Ireland (2002). The Minister of State at the Department of Health and Children with responsibility for children's services has said that he is "fully supportive of these guidelines", and described these as "an excellent and comprehensive set of guidelines" that "will be useful for a wide range of statutory and non-statutory groups who are considering consulting with children and young people". (Answer to Dail question 8198/03)

¹⁵⁹ Note 8 above.

¹⁶⁰ The result of a public consultation process in 1997, and its outline was framed by the then newly

established Commission on the Status of People with Disability.

¹⁶¹ Note 148 above.

¹⁶² 'Toward Equal Citizenship' progress report, December 1999, in reply to recommendations nos. 31, 41, 43, 44 and 45 thereof.

¹⁶³ 'Submission by the Children's Rights Alliance in relation to the National Action Plan against Poverty and Social Exclusion (NAPincl) Ireland – 2003-2005', Children's Rights Alliance (2003).

¹⁶⁴ McKeown K & Sweeney J, 'Family well-being and family policy – a review of research on benefits and costs', Government of Ireland (2001).

¹⁶⁵ Note 148 above.

¹⁶⁶ 'Promoting and Protecting Human Rights in Irish Society, 2003-2006 Plan' (2003).

¹⁶⁷ Note 163 above.

¹⁶⁸ 'National Health Strategy 2001: Submission by the Children's Rights Alliance' (2001).

¹⁶⁹ Note 148 above.

¹⁷⁰ 'Mental Health Financing', in 'Mental Health Policy and Service Guidance Package', WHO (unpublished at the time of writing).

¹⁷¹ Harvey B, 'Rights and Justice Work in Ireland: A New Base Line', The Joseph Rowntree Charitable Trust, York (2002).

¹⁷² Note 2 above.

¹⁷³ Note 151 above.

¹⁷⁴ Ibid.

¹⁷⁵ Note 153 above.

¹⁷⁶ 'Health Service Reform Programme', Department of Health and Children (2003).

¹⁷⁷ Note 170 above. A 'Planning and Budgeting to Deliver Services for Mental Health' module will also be available.

¹⁷⁸ Note 78 above.

¹⁷⁹ UNHCHR, note 6 above.

¹⁸⁰ Note 108 above.

¹⁸¹ Note 1 above.

¹⁸² Ibid.

¹⁸³ Note 77 above.

¹⁸⁴ Note 8 above.

¹⁸⁵ Guidelines on periodic reporting, note 10 above.

¹⁸⁶ This extends more generally to children's needs – for instance, the homeless agency, Focus Ireland "found an absence of an adequate database on young people in the care of health boards and on leaving health board care". (Note 38 above.)

¹⁸⁷ 'The Health of our Children', note 18 above.

¹⁸⁸ Note 19 above.

¹⁸⁹ MI Principle 7.

¹⁹⁰ Note 8 above.

¹⁹¹ Note 4 above.

¹⁹² Note 4 above.

¹⁹³ 'Mental Health: A Call for Action by World Health Ministers', Ministerial Roundtables 2001, 54th World Health Assembly, Geneva, WHO/NMH/MSD/WHA/01.1.

¹⁹⁴ Vienna Declaration and Programme of Action, World Conference on Human Rights, June 1993.

