

NICCY's Response to the Department for Health's Strategy- Protect Life 2

Introduction

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

The current Commissioner has identified child and adolescent mental health as one of her priority areas and therefore the publication of the Department of Health's Protect Life 2 Strategy is of particular interest.

The response includes the view of 37 members of the NICCY youth panel, who fed into NICCY's response to the draft strategy through attending a workshop or completing an online survey. Of those young people that provided demographic information, 21 were female and 8 were male. Those involved were aged between 13-18 years old, with the majority aged between 16-17 years old, and came from across NI. Please note the views of the NICCY Youth Panel are not necessarily representative of all groups of children and young people in NI. We would expect that regional consultation process with children and young on this strategy would ensure that it sought the views of as many groups of children and young people as possible, in particular the more marginalised or lesser heard voices i.e. children with a disability, migrant, younger children (under 16), children involved with the criminal justice system etc.

In the absence of a children and young person accessible version of the draft strategy, NICCY chose a number of key areas to ask the young people to comment on.

1. Do you think the Department of Health should have consulted with children and young people on their proposals?
2. What has your experience been of schools promoting mental health and addressing mental ill health? Do you have some examples of where schools have been good at supporting children and young people? Do you have examples of where schools have been bad?
3. What do you think is missing from existing support that would be helpful for children and young people who have mental health problems?
4. Do you think support for self harm should be provided to 11-18 yr olds?
5. How could we be better at supporting CYP that are bereaved by suicide?
6. What makes the Internet and social networking sites helpful and unhelpful place for CYP with mental health problems?

A summary of young people's comments to each question have been highlighted in grey boxes at points throughout the document. The comments although largely paraphrased, have been kept as close to the young people's own words as possible.

Executive Summary

NICCY has a statutory duty to safeguard and promote the rights and best interests of children and young people, which includes having particular regard to the views of children and young people and to relevant provision of the UNCRC. We have therefore taken a human rights approach to our advice and have highlighted key issues raised and recommendations made for Northern Ireland by the Committee on the Rights of the Child for NI. NICCY engaged with members of its Youth Panel to inform its response to this consultation, their views are included at points throughout the document (NYP) (page 6)

NICCY is extremely concerned that no plans have been made to consult with, or provide a young person accessible version of the draft strategy. This breaches the Department of Health's obligations under Article 12 of the UNCRC, and its statutory duties under Section 75 of the Northern Ireland Act 1998, to consult directly with children and young people on policy formulation and development on all matters which affect their lives. (page 8)

It is very important that this new strategy takes full account of the learning from the lifetime of the previous Protect Life 1 strategy. This includes a very strong steer from organisations who have engaged with the range of consultation processes leading up to the publication of this new draft, and the learning gained for other jurisdictions that have achieved positive impact. As the information collated during the pre-consultation process in 2012 is now relatively old, the draft strategy should be more heavily supplemented with more current statistics and developments including good practice. (page 9)

NICCY strongly believes that the Strategy needs to have a much greater focus on children and young people and does not think that their needs are being adequately addressed within the priority population groups. Only 3 of the 65 actions set out in the Strategy specifically refer to children and young people. We are concerned that the scale of mental health needs for children and young people, and their risk and vulnerability to suicide and self harm has not been more strongly referenced in the draft strategy. (page 10)

NICCY is concerned that the main focus of the actions for children and young people refer solely to the role of schools and further education. The education sector has a critical role in nurturing and protecting the mental and emotional wellbeing of children and young, but in order to fully address the holistic needs of the child, NICCY would strongly suggest that the collaborative role of key sectors / agencies should be more clearly defined in the Strategy, this is particularly critical for children and young people who are presenting with multiple risk factors to suicide. (page 11)

Due to the emphasis placed on the education sector for children and young people, the NYP were asked to comment on their experience of schools in promoting mental health and in address poor mental health. The points they raised included the need for mandatory mental health training for all teachers, training for parents, more mental health awareness and support for primary school age children, greater range of methods of awareness training i.e. peer led, workshop / online based, more regular, including personal experiences, more tailored services for teens and a review of the personal development section of the LLW programme in schools. Young people were supportive of counselling services, but thought that these services should be available in the community as well as schools. GP's weren't perceived as an accessible source of support. (page 18-23)

As the peak years for the onset of mental health problems include adolescence, much more realistic investment and strategic planning and prioritization is needed in order to meet mental health needs of children and young people in order to prevent suicide in both adolescence and young adult hood. (page 11)

NICCY strongly believe that the strategy must include a comprehensive response to the rising prevalence of self harm within the under 18 age group, particularly, the higher incidence of self harm by girls, and by increasingly younger children is a serious public health concern. The NYP thought that self harm needed to be taken more seriously, that self-harming behaviours needed to be addressed earlier through counselling, and that careful use of social media can be an effective awareness raising and support medium. (page 13)

The Department for Health, as the lead duty bearer in setting out the strategic direction for mental health services in NI, needs to lay out a clear policy response on how it will support children and young people who have developed mental health problems, as well as providing effective prevention and early intervention support. The draft Strategy references the need to ensure that children and young people get good access to self harm services and CAMHS in order to prevent suicide¹. However, the action plan itself seems to focus solely on prevention and mental health promotion with respect to children and young people. (page 16)

NICCY agrees that the 10 overarching objectives outlined in the Strategy are important, however, the actions to be set out under these need to include the full range of *specific* needs and considerations for children and young people with respect to self harm and suicide prevention. Generic actions tend to be ineffective as they do not properly consider or address the specific needs of children and young people. (page 17)

¹ Draft Protect Life 2 Strategy- pg 36, para. 2

NICCY would strongly recommend that sufficient investment is put into tailored, children and young people centred and accessible training for all services that have a role in the mental, emotional wellbeing of children and young people – this includes staff in schools, higher education institutions, specialist NGO groups and personnel working across the health system. There is also a need to ensure that a range of primary / acute and community based services are provided to support children and young people with a range of emotional and/or mental health problems. (page 18 & 23)

There continue to be very significant health inequality gaps in relation to mental health. Wide ranging environmental factors, within the context of family, school, community, friendship groups, are significant factors (root causes) of poor mental health and wellbeing. For the suicide strategy to be successful lead agencies on these wide ranging policy areas must work very closely together. The final Strategy should clearly outline how the monitoring and implementation mechanisms will ensure that this cross departmental working will happen. This focus will also help Departments and their agencies to meet the reporting requirements as set out in the Childrens Service Co-operation Act. (page 24)

Service users, carers and their families should be given the opportunity to influence developments within mental health services based on their own experiences. This commitment should be set out as one of the principles at the beginning of the draft strategy and followed through as a key action from it. (page 27)

The pending Children and Young People's Strategy must be viewed as the overarching framework for delivery for children across government and its agencies. All other strategies and action plans, including the Protect Life 2 Strategy must therefore flow from it. Furthermore, the Children's Services Co-operation Act (NI) 2015 provides a legislative basis for the strategy and places a statutory duty on departments and their agencies to work together to deliver on the eight 'wellbeing' outcomes for children and to report on the progress that has been made.²NICCY recommends that the department clearly outlines how it intends to comply with these duties in the implementation of the Protect Life 2 Strategy. (page 27)

The NYP provided a range of comments on the need for greater awareness raising on the mental health needs. This included ideas on how this could be done. (page 28)

This strategy provides an opportunity to improve the NI Government's response to children and young people's mental health and wellbeing. In the absence of a comprehensive mental health strategy for NI, this new suicide prevention strategy provides a very important policy framework.(page 29)

² <http://www.legislation.gov.uk/nia/2015/10/contents/enacted>

Background & Context

UNCRC and other international human rights instruments

As a signatory of the UNCRC, NI as a devolved nation of the UK, has ratified all articles of the UNCRC. These articles are based on the fundamental agreement that children and young people are entitled to ‘*special care and assistance*’, due to their innate vulnerability because of their age and evolving capacity. All of the articles of the UNCRC are relevant to the discussion of the operation of a Suicide prevention Strategy for Northern Ireland. In particular Article 24 which builds on the fundamental right to life articulated in Article 6, and sets out the right of every child “*to the highest attainable standard of health and for facilities for the treatment of illness and rehabilitation of health. And that “States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.”* (Article 24 (1))³ General Comment 15 which provides further guidance to duty bearers in the interpretation and practical considerations for the implementation of Article 24, sets out the broad scope of Article 24 to include the timely and appropriate prevention, health promotion, curative, rehabilitative services⁴.

Furthermore, the CRC reminds all State Parties that in developing and implementing policy, practice and services, a number of overarching general principles need to be applied - these are: to protect the rights of all children not to be discriminated against (Article 2); to have their best interests upheld (Article 3); to be supported to develop to their maximum potential (Article 6); and that they are able to meaningfully participate in all aspects of their lives (Article 12). In understanding the relevance of international human rights principles in the development of the NI suicide prevention strategy, there is also a very clear link with Articles 2 and 3 of the European Convention on Human Rights as incorporated by the Human Rights Act 1998 – the right to life and the right to live free from torture, inhuman and degrading treatment.

Following the 2015 examination of the implementation of the UNCRC in the UK, the UN Committee expressed its concern in relation to youth suicide rates in NI and made a comprehensive range of recommendations in relation to mental health and health and health services more generally⁵. The full text is set out below.

Mental Health

³ <http://www.ohchr.org/Documents/ProfessionalInterest/crc.pdf>

⁴ General Comment 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health CRC/C/GC/15.

⁵ Para 60 & 58, CRC/C/GBR/CO/5

60. The Committee recommends that the State party:

- (a) Regularly collect comprehensive data on child mental health, disaggregated across the life course of the child, with due attention to children in vulnerable situations, and covering key underlying determinants;
- (b) Rigorously invest in child and adolescent mental health services and develop strategies at national and devolved levels, with clear time frames, targets, measurable indicators, effective monitoring mechanisms and sufficient human, technical and financial resources. Such strategy should include measures to ensure availability, accessibility, acceptability, quality and stability of such services, with particular attention to children at greater risk, including children living in poverty, children in care and children in contact with the criminal justice system;
- (c) Expedite the prohibition of placement of children with mental health needs in adult psychiatric wards or police stations, while ensuring provision of age-appropriate mental health services and facilities;
- (d) Support and develop therapeutic community-based services for children with mental health conditions;
- (e) Review current legislation on mental health to ensure that the best interests and the views of the child are taken duly into account in cases of mental health treatment of children below the age of 16, in particular with regard to hospitalization and treatment without consent.

Health and health services

58. With reference to its General Comment 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health, the Committee recommends that the State party, the governments of devolved administrations, Overseas Territories and Crown Dependencies develop comprehensive and multi-sectoral strategies on child health:

- (a) With allocation of the maximum extent of available resources and a robust monitoring mechanism;
- (b) With a strong focus on eliminating inequalities in health outcome as well as in access to health services;
- (c) Addressing underlying social determinants of health.

General Comments

Consultation and EQIA Process

NICCY is extremely concerned that no plans have been made to consult with, or provide a young person accessible version of the draft strategy. This is despite the fact that the Health

Minister on publishing the draft strategy highlighted the need for the widest range of stakeholders to take part in the process - *“Suicide prevention is a huge challenge to our society and I want to see a consultation process that is meaningful and engages everyone⁶.”*

As you know we have written directly to the Department of Health and copied in the Equality Commission for NI about this specific matter⁷. In short we would reiterate again the Department of Health’s obligations under Article 12 of the UNCRC, and its statutory duties under Section 75 of the Northern Ireland Act 1998, to consult directly with children and young people on policy formulation and development on all matters which affect their lives. In our correspondence to you we have requested the expedient production of a child accessible version of the strategy document and information on an engagement plan for consulting with children and young people.

Views of NICCY Youth Panel

Do you think the Department of Health should have consulted with children and young people on their proposals?

All the young people consulted with agreed that the widest range of children and young people should have been consulted on the strategy proposals. In summary, the young people believed that they have a right to be listened to and felt that they had something valuable to say. They felt that only by listening to them directly could their views be fully understood as the issues being addressed in the strategy were relevant to them and therefore should have included their input. They felt that by not sufficiently consulting with them, the government were losing out on the views of a particularly vulnerable group within society.

“If they are not reaching out to children and young people, they aren't sufficiently providing support for a particularly vulnerable age group”

“ As children and young people are a group at increasing risk of having their mental health overlooked until it reaches extreme levels. Their involvement in this issue will ensure they get the help and services they need as they can inform the government on this.”

“We are directly involved in this issue, it is our right to be heard and what we have to say is valuable.”

⁶ Minister for Health Statement (11 October 2016)- We must work together to reduce suicide rate – O’Neill
<https://www.health-ni.gov.uk/news/we-must-work-together-reduce-suicide-rate-oneill>

⁷ NICCY letter dated 6 October.

It is very important that this new strategy takes full account of the learning from the lifetime of the previous Protect Life 1 strategy. This includes a very strong steer from organisations that have fed into the evaluation of the first strategy and those who have engaged with the range of consultation processes leading up to the publication of this new draft. From reading the consultation document it would be useful if there was a clearer outline of how this information has been reflected in the new strategy. We also note that the information from the evaluation and pre-consultation process is now relatively old and therefore should be heavily supplemented with more current statistics and developments including good practice.

Increasing prevalence of mental health problems of children and young people

We are concerned that the scale of mental health needs for children and young people, and their risk and vulnerability to suicide and self harm has not been more strongly referenced in the draft strategy. This is despite the fact that the draft strategy itself acknowledges that *“suicide is one of the main causes of mortality in young people.”* (pg35)

There is a growing body of evidence which is highlighting the increasing prevalence of mental ill health of children and young people in Northern Ireland, both in terms of the scale and complexity of mental health needs. For example, there is an upward trend being reported in the numbers of children and young people being prescribed anti-depressants. In 2014-15, 550 under 16s and 5,500 16-19 yr olds were prescribed anti-depressants / anti-anxiety drugs, representing a year on year increase from 2012⁸. On the face of it, these statistics are alarming as they indicate an increasing number of children and young people who have serious mental health problems, and depression is the most common condition contributing to suicide.⁹

It has been reported that 26% (rising to 27.5% in 2011 results) of 16 year olds had experienced serious personal, emotional or mental health problems but only 9% had sought professional help.¹⁰ And that one in ten children (age 11-13 years) had never been or were seldom happy with the way they were, with only half of children aged 13-16 years old feeling that they were always dealing with problems well and 18% feeling they never dealt well with problems¹¹. We know that responding effectively to poor mental health reduces the risk of self harm, substance misuse and suicide.

⁸ Assembly Written Question 52569/11-16.

⁹ Common mental health problems: identification and pathways to care. Clinical Guidance (CG 123) May 2011 <https://www.nice.org.uk/guidance/cg123/chapter/introduction>

¹⁰ Schubotz D. and McMullan G. (2010) Mental and emotional health of 16-year olds <http://www.ark.ac.uk/publications/updates/update67.pdf>

¹¹ NISRA (2014) Young Persons' Behaviour and Attitudes Survey Bulletin, Belfast: NISRA

Q.1-3 NICCY agrees with the overall purpose, aims and principles of the strategy.

Q. 4 Are there any other groups that are particularly at risk that have not been included in this list? (page 34)

NICCY strongly believes that the Strategy needs to have a much greater focus on children and young people and does not think that their needs are being adequately addressed within the priority population groups. Only 3 of the 65 actions set out in the Strategy specifically refer to children and young people.

Producing a list of priority population groups for suicide prevention (box 3), can exclude other high risk groups. We acknowledge the specific focus on ‘looked after and care experienced children and young people’ and agree that this group of young people are at higher risk of poor mental health, however, to be complete, this list should also include a number of other groups of children and young people. The Committee on the rights of the child in its recent examination drew attention to the need for the State Party to specifically consider the needs of children in care but also made reference to children living in poverty, and children in contact with the criminal justice system¹². Furthermore, there is evidence of other groups of children and young people at higher risk of experiencing poor mental health and discrimination in access to health services - this includes children affected by the conflict (directly or indirectly because of the affect on parents / main carers), young carers, those with long-term disability or illness, those exposed to parental mental ill health, Roma, Gypsy and Traveller children, children belonging to ethnic minorities, migrant children and LGBTQIA children. We believe for the strategy to be exclusionary in this way underestimates the true extent of the children and young people who are at risk and does not fully address needs with regard to suicide prevention.

The Department for Health in its draft strategy does recognise that children and young people who have suicidal thoughts and behaviours have ‘*different needs in terms of support and care*’¹³, however, unfortunately we do not feel this very important point is reflected in the amount of specific attention given to this group in the vision for the strategy or the draft action plan.

The draft strategy states that “*children are not a specific high risk group for suicide*”; and that “*the rates of suicide in those aged under 18 years of age is low compared to other age groups*”.¹⁴

¹² Para 60, CRC/C/GBR/CO/5

¹³ Pg 35- Protect Life 2: A draft strategy for suicide prevention in the north of Ireland.

¹⁴ Pg 34- Protect Life 2: A draft strategy for suicide prevention in the north of Ireland.

Although we acknowledge numbers of under 18s dying by suicide is lower than other age groups; rates have been increasing steadily over the last 10 years. Furthermore, rates of suicide within under 18s is disproportionately higher in NI compared to other parts of the UK. In 2012, the suicide rate for 15 to 19 year olds was 4 times higher in NI, than for England and Wales. For 10 to 14 year olds, rates were 10 times higher.¹⁵ This increase needs to be more fully addressed through government strategy¹⁶. The fact that suicide rates are consistently higher for males under 19 yrs old compared to females, also requires urgent attention - in 2014, 15 of the 18 registered deaths by under 19 yrs olds were by males. These statistics represent serious public health issues with underlying layers of health inequalities which we would expect the Strategy to have referred to and addressed.

A recent UK review of evidence on youth mental health has stated that mental health difficulties increase during teenage years (11-15 yrs old), with 20% of 16-25 year olds experiencing a diagnosable mental health problem¹⁷. Those aged 20- 34 years of age are the most high risk group for suicide, however, current evidence states that there is an average 10 year delay between young people presenting first symptoms and getting help¹⁸. **As the peak years for the onset of mental health problems include adolescence, much more realistic investment and strategic planning and prioritization is needed in order to meet mental health needs of children and young people in order to prevent suicide in both adolescence and young adult hood.**

Q.5 We have identified a number of gaps in services that need to be enhanced. Do you agree with these? Are there any gaps that you think need to be addressed? (p56-58)

NICCY is concerned that based on our reading of the draft strategy the main focus of the actions for children and young people only refer to the role of schools and further education.

The education sector has a critical role in nurturing and protecting the mental and emotional wellbeing of children and young, including identifying a pattern of cumulative risk and 'final straw' stresses that are critical to suicide prevention i.e. relationship problems or exams¹⁹. **In order to fully address the holistic needs of the child, including the multiple and chronic**

¹⁵ Safeguarding Board for Northern Ireland (2014) Annual Report for the period to 31 March 2014 & CYPSP Monitoring Outcomes Report 2014-2015

¹⁶ Para 60(b), CRC/C/GBR/CO/5

¹⁷ Missed Opportunities: A review of recent evidence into children and young people's mental health, Centre for Mental Health 2016

¹⁸ Ibid.

¹⁹ National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2016) Suicide by children and young people in England, pg 16

adversities that are highly correlated with suicide, other departments and their agencies also have an important role. The draft strategy very importantly references the National Confidential Inquiry's recommendation on the role of key agencies, such as health and social care, youth justice in addition to the education sectors.²⁰ Although we recognise that a range of departments have been included as lead organisations in the action plan for the delivery of this strategy, we are not confident that the specific needs of children and young people will be effectively considered or addressed unless they are specifically referenced (also see answer to Q.6- Do you agree with the stated objectives and action plan of the Strategy?).

Professionals who work with children and young people describe their frustration with the lack of co-ordination, communication and integration within and between children's services, leading to services not picking up on need or not tailoring their services to the needs of the child²¹. Research produced by NICCY in 2012, focused on how experiences of multiple and enduring adversities affect young people's resilience in their teenage years, and increases their risk to suicide and accidental death in adolescence²². It set out a number of recommendations to support statutory agencies in fulfilling their duties to safeguard vulnerable children and young people, and we would expect these recommendations to be reflected in the Protect Life 2 Strategy and Action Plan.

These recommendations were:

- improving assessments by developing a decision making tool to assess both the immediate and underlying needs of children and young people;
- improving the co-ordination of case planning by appointing a lead professional to all children who are involved with multiple agencies (not just LAC or on the child protection register as is currently the case);
- ensuring that suicide prevention training addresses the need to identify and respond to adolescent depression; and
- reducing the impact of adversity by addressing both the immediate and longer term needs of a child or young person.

NICCY would strongly suggest that in order to ensure the best possible outcomes for children and young people, the collaborative role of key sectors / agencies should be more clearly defined in the Strategy, this is particularly critical for children and young people who are presenting with multiple risk factors to suicide.

²⁰ Pg 15, para 6-7.

²¹ Section A- pg. 16 para 4, <http://www.niccy.org/about-us/news/latest-news/2016/july/19/niccy-advice-on-children-and-young-peoples-strategy/>

²² NICCY (2012) Still Vulnerable Chapter 8, pg 77 <http://www.niccy.org/publications/2012/november/12/adolescent-suicide-and-accidental-death/>

NICCY welcomes the passing of the Children's Services Co-operation Act (Northern Ireland) 2015 and believes that it will provide the necessary focus for Government departments and their agencies to work more collaboratively together. The Act places a **statutory obligation** on all 'children's authorities' and 'other children service providers' to work together to improve the well being of children and young people and to report on the progress that has been made at defined intervals.²³ **NICCY recommends that the department clearly outlines how it intends to comply with these duties in the implementation of the Protect Life 2 Strategy.** (See response to Q8. for further comments on the relevance of the CSCA).

Self harm by children and young people

The draft strategy draws attention to the link between self harm and increasing risk of suicide, which we very much welcome, and specific reference is made to incidence of presentations to A&E due to self harm (Fig 5, pg 23), however, the policy setting context did not state that those aged 15-29 years old account for almost half (44%) of all self harm presentations in 2013/ 14, with 15% of these presentations being made by 15-19 years olds. We would also draw your attention to the fact that between 2012/13 and 2013/14 there was a 14% increase in under 16s presenting to A&E due to self harm²⁴. Furthermore, the EQIA screening document, dated 2012, only considers that an *"opportunity exists to consider the extension of the Self Harm Intervention Programme for those aged 11-18 years of age."*²⁵

In light of these statistics, NICCY strongly believe that the strategy must include a comprehensive response to this need. The rising prevalence of self harm within the under 18 age group, particularly, the higher incidence of self harm by girls, and by increasingly younger children is a serious public health concern.

Furthermore, the self harm registry only records the numbers of people presenting at A&E, therefore the numbers of young people self harming will be much higher than this, it is important to have a more complete picture of the scale of the issue and therefore we strongly agree with the feedback from the pre-consultation engagement workshops that it is important to roll out the self harm registry to include primary care and voluntary and community groups. It is not clear from the action plan that this will be the case; therefore we would recommend that this is included as an action in the final document (cited on pg 58 of draft strategy).

²³ <http://www.legislation.gov.uk/ni/2015/10/contents/enacted>

²⁴ Self Harm Registry 2013-14, <http://www.publichealth.hscni.net/publications/northern-ireland-registry-self-harm-annual-report-201314>

²⁵ Pg 29, Equality Screening, Disability Duties and Human Rights Assessment Template, Department of Health, October 2012

The self harm symposium report from 2015²⁶ has been referenced in the draft strategy, ‘under evidence of what works in terms of self harm’ on page 53, but we note a comment from part of the evaluation process which stated that; *“I felt that young people were largely absent throughout the day. I was surprised by the lack of specific discussion in this regard and that CAMHS weren’t present at the MH service workshop. Also the entire focus was on adults presenting at ED. I work with young people who largely keep their SH private and confidential.”*

In accordance with international human rights obligations under the UNCRC and Section 75 duties of the Northern Ireland Act 1998, there is a need to ensure that any policy and practice which is relevant to children and young people, and which will / or is likely to have an impact on them, is shaped by the needs of children and young people. This includes taking account of their views, experiences, and those of their carers and advocates.

Views of the NICCY Youth Panel

Do you think support for self harm should be provided to 11-18 yr olds?

There was unanimous support for any self harm programme being extended to 11-18 year olds. The young people felt very strongly that due to how common it is, there was a need for better awareness and support, and for self harm to be taken seriously by society. They felt it would be useful to have support for self harm available in schools and the community. The young people highlighted excellent practices in West Belfast where self harm is talked about from an early age in both schools and youth clubs.

Like mental health awareness more generally, young people felt that self harm awareness raising and training was something that could be more effective if delivered in small group workshops and as part of a peer education programme.

Social media, including facebook, instagram and snapchat were highlighted as a way of promoting awareness and support for self harm. Young people talked about the negative aspects of social media in encouraging self harm. They felt that social media providers can be slow to react, as can ‘celebs’ whose identity is falsely used to promote self harm.

Young people thought that there should be a campaign for self harm like the 1, 2, 3 stroke campaign, to identify or help someone who does it, and provide young people with coping techniques to help them to stop. They also thought that there should be up to date resources / films etc. that are interesting to look at.

²⁶ Public Health Agency (2015) self harm symposium conference report (pg 179)
<http://www.publichealth.hscni.net/publications/public-health-agency-self-harm-symposium-conference-report>

If self harm is discussed in school, the Teachers need to address the issue fully as part of the awareness raising. It needs to include what self harm is and the reasons for it. Some young people felt that self-harm shouldn't always be associated with serious mental health issues or suicide as this can add to the stigma felt by those doing it.

General awareness raising of self harm was thought to be useful in helping young people's peers to understand it and be more empathetic towards those that self harm.

Young people also thought that counselling needs to be provided to young people who self harm as early as possible, before it gets worse, and for the counselling to get to the root of the problem.

CAMHS Provision- Mental Health Recovery and Rehabilitation

The draft Strategy references the need to ensure that children and young people get good access to self harm services and CAMHS in order to prevent suicide²⁷ However, the action plan itself seems to focus solely on prevention and mental health promotion with respect to children and young people.

We very much welcome and acknowledge the need for the strategy to have a prevention and early intervention focus for children and young people²⁸. There is good evidence that intervening early in the course of mental illnesses can reduce impairment that could lead to serious mental ill health and suicidal ideation.

The current CAMHS system is under significant pressure and under-resourcing, NICCY is concerned about the quality and responsiveness of mental health services for children and young people, this includes the fact that although adolescence is the peak years for the onset of mental health problems, there is an average 10 year delay between young people presenting first symptoms and getting help.²⁹ Incomplete and fragmented implementation of the regional stepped care model of CAMHS is prolonging unequal access to high quality primary / acute and community based Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland. A lack of clear transparent information on CAMHS is also a major concern and raises very serious questions about the health system's ability to plan and develop

²⁷ Draft Protect Life 2 Strategy- pg 36, para. 2

²⁸ Missed Opportunities: A review of recent evidence into children and young people's mental health, Centre for Mental Health 2016

²⁹ UK based research has reported that 3/4 of parents of children and young people with mental health problems seek help, but only a 1/4 receive any support- Missed Opportunities: A review of recent evidence into children and young people's mental health, Centre for Mental Health 2016

services that are evidence based and effectively meeting need. A robust monitoring and evaluation system of CAMHS which includes primary / acute care and community care is vital.

Ensuring that high quality, effective child and adolescent mental health services, including self harm services are available to every child that needs it is vital to tackling suicide and self harm. This is particularly vital for those children and young people who are facing multiple adversities and therefore require the support and interventions of a range of statutory and non-statutory agencies. The National Confidential Inquiry into suicide and homicide by people with mental illness has recently published a report on suicide by children and young people, in which it states that *“Improved services for self-harm and access to CAMHS are crucial to addressing suicide and there is vital role for school, primary care, social services and youth justice”*³⁰.

The Department for Health, as the lead duty bearer in setting out the strategic direction for mental health services in NI, needs to lay out a clear policy response on how it will support children and young people who have developed mental health problems. We are concerned that the draft strategy states that *‘mental health services are not delivered under the umbrella of Protect Life, (but are intrinsic to suicide prevention)’*.³¹ NICCY cannot emphasize enough the critical role that the suicide prevention strategy has in setting out the key role of departments, agencies and frontline services (statutory and non-statutory). This includes the responsibility that the Department for Health and the Public Health Agency has in holding these bodies to account by providing robust oversight and monitoring delivery mechanisms. The Protect Life 2 Strategy will be a very important policy framework on mental health which will support the delivery of the broader NI Executive Children and Young People’s Strategy³². The latter must be viewed as the overarching framework for delivery for children across government and its agencies. The Children’s Services Co-operation Act (NI) 2015³³ (CSCA) provides a legislative basis for the strategy and places a statutory duty on government departments and their agencies to work together to deliver on the eight ‘wellbeing’ outcomes for children, one of which is physical and mental health. Furthermore, we reiterate the importance of the learning from the previous suicide prevention strategy to inform and shape the new implementation, governance and monitoring arrangements.

Q. 6 Do you agree with the stated objectives and action plan of the Strategy?

³⁰ National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2016) Suicide by children and young people in England.

³¹ Draft Protect Life 2 Strategy- pg42, para 2.

³² <https://www.executiveoffice-ni.gov.uk/publications/ten-year-strategy-children-and-young-people-northern-ireland-2006-2016>

³³ <http://www.legislation.gov.uk/nia/2015/10/contents/enacted>

NICCY agrees that the 10 overarching objectives outlined in the Strategy are important, however, the actions to be set out under these need to include the full range of *specific* needs and considerations for children and young people with respect to self harm and suicide prevention. Generic actions tend to be ineffective as they do not effectively consider or address the specific needs of children and young people.

Question 7: We would invite your views on the draft action plan and welcome suggestions on additional actions.

NICCY has provided comments below on Objectives 3, 4 and 6.

Objective 3- Improve the understanding and identification of suicidal and self harming behaviour, awareness of self harm and suicide prevention services and the uptake of these services by people who need them.

There are two specific actions under objective 3 for children and young people:

One is an action for the Department for Education- To *‘develop and implement policies, guidance and resources for schools to include positive mental health; protecting life and the management of critical incidents’*.

The second is for the Department for the Economy- *‘Encourage universities, colleges and training organisations to promote, via their pastoral care arrangements, a culture of help seeking behaviour and suicide awareness particularly among young people’*.

We agree that both of these actions are important - the training of personnel on mental health promotion, as well as identifying, assessing and addressing poor mental health, is critical if they are to be effective. Although, not specifically references in the draft consultation, we note and welcome a statement made by the Minister for Health that the Department of Education will be developing a self-assessment audit tool, to assist schools assess progress on promoting and supporting the emotional health and wellbeing of pupils³⁴.

Children and young people tell us that adults don’t talk to them about mental health. CAMHS professionals have told us that many non-CAMHS professionals who come into contact with children and young people are afraid to address mental health issues with young people and are potentially too quick to refer on to specialist support without first attempting to provide their own intervention. Avoidance of the subject and over-escalating the response to a child when

³⁴ Minister for Health Statement (11 October 2016)- We must work together to reduce suicide rate – O’Neill
<https://www.health-ni.gov.uk/news/we-must-work-together-reduce-suicide-rate-oneill>

they do talk about problems, only helps to reinforce the stigma around mental health for children and young people and may contribute to them not talking about their mental health or seeking help. **There is a need for an age appropriate, child friendly response to children and young people and one which respects and actively listens. NICCY would strongly recommend that sufficient investment is put into tailored, children and young people centred and accessible training for all services who have a role in the mental, emotional wellbeing of children and young people – this includes staff in schools, higher education institutions, specialist NGO groups and personnel working across the health system.** Furthermore, NICCY would strongly recommend that key requirements are set on the numbers and range of staff personnel that must complete this training and for this to be evaluated and monitored as part of the Strategy. NICCY strongly endorses the development of a mental health promotion action plan.

Due to the emphasis that has been placed within the draft strategy on schools with respect to awareness raising and support, NICCY asked its youth panel to give their experiences of schools promoting mental well being and addressing mental ill health. They also made a range of comments on the helpful and helpful aspects of the internet and social media.

Views from the NICCY Youth Panel

What has your experience been of schools promoting mental health and addressing mental ill health? Do you have some examples of where schools have been good at supporting children and young people? Do you have examples of where schools have been bad?

What do you think is missing from existing support that would be helpful for children and young people who have mental health problems?

Mental Health Awareness and support in school

There was a very mixed picture in terms of the availability and quality of mental health awareness and support in schools from the young people NICCY spoke to. Some felt their school was very supportive of their mental health, whilst others felt that counselling and pastoral support could be promoted more. Young people also felt that they received mixed messages from teachers about the importance of mental health- on the one hand talking about your mental health is important but on the other hand your feelings of stress and anxiety around school work is dismissed as normal.

Primary School Age Children

Young people felt that mental health awareness should be provided from primary school age and should not be left until 5th year. Primary school children should be encouraged to understand and express their feelings. Very young children don't have the skills to search for

information on their phones like teenagers can. The recent case of the young boy who accidentally killed himself after having an argument with his parents was understood as being caused because the young person didn't understand the consequences of their actions.

Older Young People - Teens

It was felt that some teenagers don't have the mental health literacy to seek help when they need it. This was felt to be a bigger issue for boys than girls, as culturally boys aren't expected to talk about their feelings.

Young people felt that there needed to be specific support services for teenagers i.e. mid teens to 21. They also talked about not identifying with childline as they don't associate with being a child anymore, and that they needed something like childline for teens.

Training for Teachers

There should be government approved mandatory training on mental health for all teachers not just pastoral support. At the very least all schools should have a pastoral lead for each year. Not all young people we consulted knew if the teachers in their school received training on mental health.

Methods of training / support on mental health

There needs to be dedicated workshops that fully address the issues being raised. There should be tailored workshops to different year groups. It isn't sufficient to cover it in assembly and for this to only happen once a year, it should be more regular. It was felt that these sessions could be more effective if you can talk to someone that has had personal experience of a mental health problem. The link between physical and mental health should be made.

Peer led training

Young people should be trained to co-facilitate or lead on mental health workshops. The peer facilitators should be a similar age to the young people they are speaking to, as it can be easier to identify with them. Some young people thought that peer support could also be provided through online live chat. A school in Mid Ulster that offered a student leadership programme which promoted counselling and trained pupils as peer supporters was discussed as an example of good practice.

Out-sourced support

FASA was provided as an example where stress relief and relaxation was discussed, and pupils would have liked this to be a permanent fixture.

Training for parents

Some young people thought they would feel uncomfortable talking to their parents about their mental health. However, they agreed that there should be more information for parents on how to identify and respond to poor mental health in their child, as parents can be an important source of support. Evening classes on young people mental health awareness should be made available to parent. These could be offered in youth centres and school facilities.

Views on Learning for Life and Work (LLW)

The LLW sessions on personal development could be improved, they are not practical enough, they cover the obvious information and don't go into enough detail, teachers don't see them as serious subjects and pupils don't value them wither- it is perceived as a filler subject. LLW sections never get finished, they are too short and sessions aren't regular enough. They should do fewer session really well, rather than covering too many. LLW is more focussed on work / career preparedness. LLW isn't available in all schools- in some schools pupils can choose if they do them. It can also be based on age. It is often offered as an add-on to P.E as there is more capacity to do it.

Views of the NICCY Youth Panel

What makes the Internet and social networking sites helpful and unhelpful place for CYP with mental health problems?

It should be compulsory to do e-safety classes from primary school. Parents need to be aware of safety filtering settings for different ages. Everyone should have access to this sort of awareness raising training; this includes how to report things that they don't like on social media. There should also be more monitoring of online material so that negative posts and website can be taken down quickly. Awareness raising classes for children and young people should include peers telling their own stories, it shouldn't just rely on videos.

The young people talked about the negative aspects of social media. This included social media being cruel and mocking of mental health problems or romanticizing negative / harmful thoughts or behaviours. Young people also felt that social media can add to young people's stress and negatively affect their self worth i.e. cyber bullying, how many likes being used as a barometers of how popular or liked you are.

They also talk about the peer pressure to be on social media and to use it and share personal information. Yong people should be made aware of the benefits of coming off social media for a period of time if they felt it was causing them stress or making them feel bad about themselves- 'social media detoxing'.

The young people talked about the positive aspects of social media as a platform of support for people with mental health problems- including online support, and the increasing number of body positive and mental health positive pages online and range of websites for support. They also felt that the anonymous nature of social media might help some young people to open up and to talk freely.

Objective 4- Enhance the initial response to, and care and recovery of people who are experiencing suicidal behaviour and to those who self harm.

School counselling for post primary schools (mainstream and special schools)

There are one specific actions under objective 4 for children and young people:

Department for Education – *‘To provide support to post primary schools and the post primary cohort in special schools through the Independent Counselling Service’.*

We support the focus on continuing to provide counselling services in post primary school. This is a vital service and one which is reporting an increase in the number of children experiencing self harm, mental health, alongside other issues such as neglect³⁵.

We note the lack of information within the strategy about counselling for primary school age children. A range of sources report increasing numbers of younger children with mental or emotional health problems, statistics for the last 2 years from the Family Support Hub programme³⁶ report that 5-10 year olds have consistently been the highest referral age group with emotional and behavioural support being the main reason for referral. Between 2014/15 and 2015/16 there has been an increase of 115% (from 512 to 1103) for primary school age and an increase of 44% (from 458 to 660) for post primary school age. We also know that support hubs are finding it increasingly difficult to meet demand, and therefore the introduction of universal government funded primary school counselling would help to address growing need and alleviate pressure on existing services.

Views of NICCY Youth Panel School Counselling

³⁵ Cited in ICSS report to Marshall K. (2014) Independent Inquiry into Child Sexual Exploitation in Northern Ireland, Belfast: RQIA

³⁶ Family Support Hubs- Annual report card for 15/16 <http://www.cypsp.org/family-support-hubs/#ffs-tabbed-12>

School counsellors aren't always that visible- they should go around the different classes and introduce themselves to pupils. Unless you make an approach for counselling you are not offered it but some young people don't realise that they need it.

School counselling should be at lunch time or after school so that young people don't have to miss class- missing class can add to a young person's stress.

Young people felt there was still a lot of stigma around going to counselling, especially if you live a rural community and are a boy.

Using the box for making a counselling appointment wasn't felt to work very well, young people thought that it would be better if they could email the counsellor to make an appointment.

The extent of the counselling is limited- in terms of the time the counsellor is available in the school and in the depth of discussion that can be covered during the set number of sessions. You get a certain number of sessions and then you are finished, if you go again the same sort of stuff is covered again.

Schools are a key place for providing counselling and mental and emotional support , however, the school environment can often be the main cause or contributor to a child anxiety, stress etc. for example, bullying, exam stress and school pressure has been identified as contributory factor in child suicide, in particular because these things can be a 'final straw stress' coming from an accumulation or build up of multiple stresses³⁷. For this reason we strongly suggest that the Strategy puts some focus on the need for community based counselling as well as school based counselling. We are aware that there are currently long waiting times for some community based counselling due to increasing demand and reduced capacity due to funding cuts.

There is a need to ensure that a range of community based services are provided to support children and young people with a range of emotional and/or mental health problems. These services need to have adequate long term funding to meet need, whilst also acknowledging the necessity to monitor and evaluate the effectiveness of provision.

Views of NICCY Youth Panel

Mental health awareness and support in places other than school

³⁷ National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2016) Suicide by children and young people in England.

Schools aren't always the most approachable places for young people to open up about their mental health. This is especially the case if a young person has issues with school i.e. doesn't trust or get on with teachers or if school is contributing to their stress.

Young people thought that counselling should be offered in the community as well as schools- possible places included church based counselling services and drop in counselling services at libraries. A youth service like Cadets was also highlighted as an example of a good network to access counselling services.

In general, young people felt that it was difficult to talk to anyone about their mental health- this was deemed to be easier where they had a trusting relationship with someone in which they felt understood. Young people fear that adults will 'over-react' if they share personal feelings on their mental health. Young people felt strongly that mental health issues, no matter how small, should be addressed at the earliest point to stop them from escalating into something bigger and which can extend into adulthood.

GPs weren't perceived to be an accessible source of support; young people thought that GP's wouldn't understand as they have more experience of physical problems, that they would see your mental health problem as a medical problem and use medical language. The lack of confidentiality between a young person and their GP was also raised as a potential barrier to talking to a GP. Some of the young people we talked to didn't like the idea of the App in which GP's can track a patient's social media activity, as it might send false alarms and because you feel like you were being watched all the time.

Rural Need

In general, we would agree that incidents of self harm or mental health problems are likely to be higher than indicative statistics would suggest; this includes rural areas, where stigma might be felt more acutely and where there is a lack of mental health services. Farming communities is currently as far as the scope of the draft strategy goes in relation to rural communities; we would suggest that rural communities, more broadly, is given a greater focus.

Standards for the provision of mental and emotional wellbeing and suicide prevention services

NICCY very much welcomes the further development of standards for the provision of mental and emotional wellbeing and suicide prevention services (obj. 4, pg 71). NICCY would call for a specific child rights compliant standard for children and young people.

Addressing Health Inequalities

There continue to be very significant health inequality gaps in relation to mental health, with rates of suicide and self-harm admissions in the most deprived areas three or four times higher than rates in the least deprived areas.³⁸ Furthermore, we know that children and young people who have experienced persistent poverty have 3 times (30%) more likelihood of having a mental health problem by the age of 11yrs old, compared to those that have never experienced it (10%)³⁹. This is a significant concern in NI where statistics are showing increasing numbers of children and young people living in poverty with mental ill health (28% for the period 2014/15)⁴⁰. We understand from page 87 of the draft strategy that identifying and addressing wider ranging social determinants of health will be largely addressed in other pieces of work, including the Public Health Strategic Framework “Making life Better” and cross-departmental strategies on poverty and children and young people. Environmental factors, particularly within the context of family, school, community, friendship groups, are such significant factors (root causes) of poor mental health and wellbeing that for the suicide strategy to be successful these other policy areas must work very closely together. The final Strategy should clearly outline how the monitoring and implementation mechanisms will ensure that this cross departmental working will happen.

Objective 6: Ensure the provision of effective and timely information and support for individuals and families bereaved by suicide.’

Bereaved by Suicide

NICCY welcomes the focus on supporting those bereaved by suicide; however it is unclear as to what the plans are for supporting children and young people. There is significant need in NI for this type of specialist support - statistics provided by Cruse NI, report that in 2015, up 30,000 children in Northern Ireland were directly affected by the death of someone close to them. They also report that amongst youth referrals to Cruse in NI, suicide accounts for 17% of bereavements (compared to 7.5% in UK).⁴¹

Views of the NICCY Youth Panel

How could we be better at supporting CYP that are bereaved by suicide?

Treat people bereaved by suicide in the same way as you would treat any other bereavement.

³⁸ Health Inequalities – Regional Report <https://www.health-ni.gov.uk/news/health-inequalities-regional-report-2016>

³⁹ The Lancet (2016) Child poverty continues to rise in the UK, Vol 388, pp.747 (report of findings from Millennium Cohort Study, which includes NI)

⁴⁰ NI Poverty Bulletin 2014-15 <https://www.communities-ni.gov.uk/publications/northern-ireland-poverty-bulletin-2014-2015>

⁴¹ Presentation by Cruse Bereavement Care- Young Cruse Project to NICCY- 17 August 2016.

Bereavement counselling should always be offered to children and young people who have some connection with a person who has died, assumptions shouldn't be made about potential impact. A range of options for counselling should be offered, examples provided by the young people were online, face to face, support group and family therapy. Peer support is also very important and schools should be open to this and allow a bereaved person to be accompanied to the funeral or counselling by a friend.

Schools should have protocols/ best practice guidelines on how to deal with bereavement. Support should be age appropriate. Schools should make sure that time off is allowed for bereavement and to make it easy to catch up with school work when ready i.e. send work home, virtual learning environment, powerpoint or video of class.

Young people involved in the criminal justice system

There are a number of actions under objective 3, 4 and 5 which specifically refer to prisoners. These actions cover access to services, adaptations to the environment for those held in custody and the development and implementation of a suicide and self harm strategy to cover NIPS and a review of 'Supporting Prisoners at Risk'. In general, people who are detained in the criminal justice system are much more likely to have one or more mental health problems compared to those in the general population and young offenders are no exception. In NI, almost all (95%) of the 15-21 year olds in the criminal justice system have at least one mental health problem.⁴² In the recent Department of Justice / Department for Health consultation on improving health within the criminal justice system, it was acknowledged that research shows that a 'very large proportion of imprisoned young people have one of the following conditions: personality disorder, psychosis, neurotic disorders or substance misuse.' It also reports that 'young adults have higher rates of self harm and suicide than older prisoners and are more likely than older prisoners to have been in the care system'⁴³. Continuity of healthcare services is vital, as is ensuring that there is equitable access to services for children and young people.

It is very important that this Strategy aligns itself with the actions for children and young people that will come from the new joint Department of Justice / Department for Health Strategy and that careful consideration is given to how it can complement targets and actions coming from other policy work. CJI's inspection of the JJC noted that healthcare staff face particular challenges in linking children effectively with community based CAMHS as the children who need these services are often highly mobile and known to more than one agency. Therefore, consideration should be given within the draft strategy as to how this problem can be

⁴² CJNI (2010)- Not a marginalised Issue- Mental Health and the Criminal Justice System in NI

⁴³ DOJ / DHSSPS (2016) Improving health within the criminal justice system: A draft strategy and action plan to ensure that children, young people and adults in contact with the criminal justice system are healthier, safer and less likely to be involved in offending behaviour (pg 20).

overcome. In order to ensure this cohort of young people have continued access to the appropriate services following both admission and release, justice and health agencies must work together⁴⁴. Leading up to a young person's release there must be appropriate transition planning so that the necessary referrals are made in time and the services can be accessed immediately upon release.

The Legacy of the Conflict

There is a growing recognition of the impact of parental / carers' mental ill health on their children. With respect to the conflict, it is estimated that over 40% of children are living with parents who have high or moderate experience of the conflict, which can impact on wellbeing of younger generations - 'trans-generational impact'.⁴⁵ The acknowledgment of 'trans-generational' trauma, has been included in the Minister's foreword; however, the issue doesn't appear to be addressed in the main body of the strategy nor is the specific issue included in the action plan. Furthermore, the development of a mental health trauma service should be developed as a matter of urgency and is a basic requirement of any post-conflict society, which is committed to providing the best mental health support for its citizens.

Chapter 5: Strategic Direction for Improving Suicide and Self Harm Prevention

NICCY agrees that it is important for the new suicide prevention strategy to be shaped by up to date research and evaluation of the most effective programmes and interventions. In the draft Strategy it is reported that the Regulation and Quality Improvement Authority (RQIA) plan to carry out a review of suicide prevention services within their 2018/ 2021 programme. However, we understand that RQIA are currently carrying out the review and it should be published in late 2016/early 2017, therefore we would expect at the very least, the emerging findings / learning from it will be built into the final Strategy and delivery plans.

Data Collection and Analysis

The DHSSPS and the PHA during a Health Committee⁴⁶ session hearing acknowledged that Scotland has had a more positive impact on suicide rates than NI has during the same time period and whilst applying a similar policy response and budget. However, what was deemed to have made the difference was Scotland having better awareness raising and training targets

⁴⁴ see recommendations at para 2.70 and 2.71 CJI, 'Report on an Unannounced Inspection of Hydebank Wood Secure College', October 2016

⁴⁵ Commission for Victims and Survivors (2015) Towards a Better Future (pg 36)

⁴⁶ Protect life update to health committee on 3/3/16.

and better analytical tools to understand what the data means. There is therefore a pressing need to carry out much more detailed analysis of data on suicide and self harm through current databases i.e. self harm registry, sudden death notification process, NCISH and the General Registrar Office. Equally importantly is the need to address issues with poor recording, and analysis of qualitative information (pg47). We strongly endorse the plans to improve data collection and analysis of self harm and suicide. There also needs to be greater transparency and easier access to information on how much money is spent, where it is spent and why, or what difference services are making to children and young people.

Chapter 8: Implementation Governance and Monitoring

Participation of children and young people

Service users, carers and their families should be given the opportunity to influence developments within mental health services based on their own experiences. We welcome the current Health Minister's commitment to 'co-production' and co-design' by establishing effective mechanisms for listening to those with experience of using the health system and to use that information to shape services that meet their needs and expectations⁴⁷. **This commitment should be set out as one of the principles at the beginning of the document and followed through as a key action from the strategy.** There is real opportunity to embed, strengthen and promote the involvement of children and young people in decision making during the reform of the health care system, including in the roll out of the Protect Life 2 Strategy. The Office of the Children's Commissioner in England has produced a report on this area, which includes good practice on involvement of children and young people in health service design and delivery⁴⁸.

Q8. Views on how best to monitor and assess the impact of the Strategy over time.

Children & Young People's Strategy 2017-2027 / CSCA / PfG

This new Children and Young People's Strategy will be the most important strategic development for children and young people for the next 10 years. The Children's Strategy must be viewed as the overarching framework for delivery for children across government and its agencies and all other strategies and action plans, including the Protect Life 2 Strategy must therefore flow from it. The Children's Services Co-operation Act (NI) 2015 (CSCA) provides a legislative basis for the children and young people's strategy and places a statutory duty on government departments and their agencies to work together and with 'other children

⁴⁷ Health and Wellbeing 2026- Delivering Together, Department for Health, October 2016.

⁴⁸ Available from OCCE website.

service providers⁴⁹ to deliver on the eight ‘wellbeing’ outcomes for children⁵⁰. (see diagram at Appendix 1).

Monitoring and evaluation of the Protect Life 2 Strategy needs to include the outcomes for individuals accessing services. It is noted that this action under objective 4 of the draft strategy only goes as far as stating that an exploration of the ‘feasibility of developing a system to monitor and evaluate outcomes for individuals accessing services’ (pg 71). Under the CSCA, all government departments and their agencies are required to demonstrate how they have contributed to key aspects of children and young people’s health and wellbeing, therefore a robust monitoring framework will be essential. Monitoring of the delivery on Protect Life 2 Strategy should be included in the overall departmental plan. Delivery by the Department for Health in an outcomes based accountability approach as proposed in the current Programme for Government necessitates ‘read across’ to the Children’s and Young People’s Strategy and monitoring of indicators / measures to achieve the desired outcomes.

Q9. We would welcome your views on how best to raise public awareness of suicide, suicidal ideation, suicidal behaviour and self harm.

Views from NICCY Youth Panel

Publicity on mental health that is specific to CYP

Young people felt that there needed to be a lot more targeted publicity and support on child and adolescent mental health.

Young people should be given support and information to understand the mental health problems of their peers and to equip them to reach out to other young people who are exhibiting mental health issues. A number of examples were given of the stigma around mental health and attending counselling being more strongly felt between pupils than between pupils and teachers. The ‘Helping Others’ strand of wider ‘Change Your Mind’ campaign was mentioned as a great idea and young people thought it should include equipping young people to be able to support their own family or friends to deal with a mental health problem.

In the publicity provided on youth mental health, normalise the issue by getting across the message that they can get help, that you are not weird to feel the way you do and that mental health is equal to physical health.

⁴⁹ Defined in the Act as any person or body, of whatever nature, who provides a children’s service or is engaged in activities which contribute to the well-being of children or young persons.

⁵⁰ With regard to whom the duties under the CSCA apply, this can be found in section 2 of the Act but includes statutory and non statutory agencies and bodies that provide services to children.
<http://www.legislation.gov.uk/niu/2015/10/contents/enacted>

Youth friendly posters in school are useful but it might also be useful to put information into the back of school diaries (post primary), develop web page for younger children and have more videos targeted as children and young people.

There isn't enough information on where young people can get help- this includes a lack of awareness of CAMHS. World Mental Health Day was given as an example of a day in which services like CAMHS could be promoted and normalise their services by linking with celebs. One young person had a positive experience of someone from CAMHS coming to their school to talk about what it was.

Perception of youth mental health that needs to be challenged through public awareness

Society doesn't take the emotional and mental health of young people seriously; young people's problems are seen as 'typical teenage problems'.

Society thinks that young people or anyone with mental health problems can change how you feel easily- but you can't, you feel stuck- you can't control it.

Communication about mental health needs to be done in a calm way, so not to panic people or over-react about their mental health- it needs to be normalised for young people to open up.

Conclusion

This strategy provides an opportunity to improve the NI Government's response to children and young people's mental health and wellbeing. This includes mental health promotion but also the responsiveness of services and effectiveness of care for those presenting with emotional, behavioural difficulties or specific diagnosed mental health problems. In the absence of a comprehensive mental health strategy for NI, this new suicide prevention strategy provides a very important policy framework. Lastly we would reiterate the relevance of the Children's Strategy and how it must be viewed as the overarching framework for delivery for children across government and its agencies and all other strategies and action plans, including the Protect Life 2 Strategy must therefore flow from it. As well as the significance the Children's Services Co-operation Act (Northern Ireland) Act as it places a statutory obligation on all 'children's authorities' and 'other children service providers' to work together to improve the well being of children and young people and to report on the progress that has been made at defined intervals.⁵¹ NICCY recommends that the department clearly outlines how it intends to comply with these duties in the implementation of the Protect Life 2 Strategy.

⁵¹ <http://www.legislation.gov.uk/nia/2015/10/contents/enacted>

Programme for Government 2016-21

