

# A System at a Crossroads

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An Assessment of the Strategic Design and Delivery of Children's Mental Health Services Through a Child's Rights-based Approach.

February 2026

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## Foreword by Chris Quinn, NI Commissioner for Children and Young People

It should not be the case that children and young people’s mental health services in Northern Ireland (“NI”) becomes the subject of headline news. However, regrettably and alarmingly, this has occurred repeatedly in recent years, signalling serious and systemic failings that demand urgent attention.

Since I assumed the role of Commissioner in Autumn 2023, I have heard from children, young people, and their families as to the difficulties they have faced in seeking support for their mental and emotional health and wellbeing. I have been informed about many of the challenges in accessing services; from general practice to a variety of CAMHS steps, issues of children and young people not feeling “heard” or “seen” when entering services, and not having opportunities to be involved in decision-making relevant to their care. I am also aware of the barriers caused by the matter of prolonged waiting lists, particularly in seeking first-time appointments, and the corresponding delay in treatment and management this causes. Challenges facing CAMHS are also acute within a regional service context, as well as increasing referral rates, including children being referred for support at increasingly younger ages.



I am deeply conscious that behind these news stories, and statistical datasets, there are the critical, untold stories – the stories of children and young people experiencing mental distress, needing support for their emotional health and well-being, waiting on accessing support services, and fundamentally, struggling to access and invoke their right to health as guaranteed by international law. This has raised questions as to the operation and direction of strategic planning and delivery of children and young people’s mental health services.

The office of the NI Commissioner for Children and Young People (“NICCY”) has formally investigated the adequacy of children and young people’s mental health services in NI. In 2018, this office published the “Still Waiting: A Rights Based Review of Mental Health Services and Support for Children and Young People in NI”. This report discovered a mental health system under significant pressure, struggling to respond to both the scale of need, and the complexity of issues which young people presented with. The report revealed that young people were experiencing issues in accessing services and seeking early intervention and support and did not feel that they were being taken seriously nor involved in decision-making for their care and treatment. A troubling revelation was how young people felt that their mental health needed to deteriorate before they would be seen and taken seriously. The report further presented recommendations to the Department of Health, the then-Health and Social Care Board, and other relevant agencies, and work was undertaken to produce an Action Plan, which pulled together the recommendations into key objectives which government could progress.

NICCY formally concluded its monitoring of the Still Waiting report in 2023. Since that time, several political and policy developments have taken place. This included the return of the

devolved institutions, and the continued implementation of the Mental Health Strategy and the Early Intervention and Prevention Action Plan, and the broader Transformation Agenda, including new Reset frameworks. These policy frameworks interact and overlap, with the advancement of one framework connected to the advancement of another. This does, however, create the impression of an overly saturated policy framework which is starting to fall upon itself. It further raises concern in the context of sustained and adequate funding allocations – and it is apparent this is not being met. At the time of writing, only £12.3mn has been allocated to 14 actions within the Mental Health Strategy, equating to only 16% of the necessary funding for its implementation during that timeframe. Future progression of the Mental Health Strategy is dependent on the allocation of additional funding. This is deeply concerning.

In light of these concerns, my office has undertaken a periodic review of the strategic design and delivery of children and young people’s mental health services in NI. The purpose of this review is to better understand the operational status of children and adolescent mental health services, including drawing out any challenges faced by services. The review seeks to gain an understanding of the delivery of key strategic policy frameworks, particularly in the context of funding pressures and corresponding challenges for progression of these frameworks.

This report sets out an evidence-based and research-informed approach to understanding the mental health landscape faced by our children and young people, and the human rights context, specifically, understanding the obligation to ensure the highest attainable standard of health for children and young people as outlined within Article 24 of the UN Convention on the Rights of the Child (“UNCRC”). It assesses the status of implementation of the Still Waiting report recommendations, contextualising the strategic focus of government. Through the collection and collation of CAMHS data, the report provides an analysis of the status of CAMHS and provides analysis of the delivery of key strategic policy frameworks.

In selecting the title for this report, *A System At A Crossroads?*, NICCY is seeking to convey how there are challenges facing the operation of children and young people’s mental health services are both systematic and systemic, arising within the design and delivery of the strategic policy frameworks designated as the drivers of change with the healthcare system. The findings present a system facing combined pressures of limited policy progression, uncertainty as to future delivery, and constrained financial support. This situation is to the detriment of the rights and best interests of children and young people, and it cannot continue. This report suggests we now stand at an opportune moment to institute radical change in system approaches for the benefit of all infants, children, and young people.

The Department of Health has outlined that progression of key strategic policy frameworks such as the Mental Health Strategy has been undertaken in a challenging financial context, and that resources are limited.<sup>1</sup> It is vital that every possible effort to progress these strategies, and advance the child’s right to health, is made within available resources. International law could not be clearer: governments cannot justify a failure to respect and uphold their obligations under international law because of a lack of resources, but rather, must guarantee the right to health to the maximum of their available resources, irrespective of financial pressures. The

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<sup>1</sup> See Department of Health. (9 October 2025). “Publication of NI Mental Health Strategy: A Review of the Deliverability of the Strategy’s Actions 2026-2029.”

need to incorporate a comprehensive and robust child rights-based approach into governmental budgeting processes in NI, as recommended by the UN Committee on the Rights of the Child, has never been more pressing.<sup>2</sup>

The landscape faced by children and young people’s mental health services presents a clear argument as to the importance of securing the full and direct incorporation of the standards and norms of the UNCRC into domestic law in NI, and I will continue to advocate for this to ensure that all children and young people can have timely access to efficient, supportive, and rights-based mental health services.

For my office, this review has demonstrated that, whilst some important steps have been taken since the publication of *Still Waiting*, progress has been uneven and, in key areas, insufficient. For too many children and young people, timely access to appropriate mental health support remains out of reach. This cannot be explained away by complexity or constrained budgets alone. The obligation to realise children’s right to the highest attainable standard of health is a continuing one.

Nonetheless, our report also makes clear that change is both possible and within reach. The evidence set out here provides a recognition of trends in children and young people’s mental health, a clear basis for action, grounded in children’s rights, informed by data and experience, and directed towards practical improvement. With sustained commitment, transparency and meaningful engagement with children and young people, NI can build a mental health system which better meets need, respects rights, and provides early, effective support. My office will continue to advocate for the action that children and young people are entitled to expect.



**Northern Ireland Commissioner for Children and Young People**  
**February 2026**

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<sup>2</sup> See UN Committee on the Rights of the Child. (2023). “Concluding observations on the combined 6th and 7th periodic reports of the United Kingdom of Great Britain and Northern Ireland: Committee on the Rights of the Child’ at para 11.

## Executive Summary

The following report represents the culmination of a Periodic Review of children and young people’s mental health services, and the governing key strategic documents underpinning and driving same, conducted by NICCY, in accordance with its functions under Article 7(2) and 7(3) of The Commissioner for Children and Young People (NI) Order 2003. The aim of the Periodic Review was to assess the strategic design and delivery of children’s mental health services through a child’s rights-based approach. There were three strands within the Periodic Review, whereby NICCY sought to understand the:

- Operational provision of existing children and adolescent mental health services (“CAMHS”) between the timeframe 2021-2024;
- Challenges / issues arising within the provision of these services; and
- Implications of the Department’s 2024/2025 Budget on operation of services, through assessment of impact upon delivery of the Mental Health Strategy, and other associated strategies / frameworks.

Several information requests were submitted to key relevant authorities to ascertain the operation of children and young people’s mental health services, as well as the current status of the delivery of the Mental Health Strategy, and the Still Waiting report recommendations and the Still Waiting Action Plan (“SWAP”) actions. Information returns were reviewed and collated and analysed accordingly. A traffic light grading system was then used to assess the progress of implementation of the Mental Health Strategy and the SWAP actions.

This report presents an evaluation of the status of the strategic design and delivery of mental health services, including an assessment of the current operation of CAMHS, and the status of the SWAP. The report firstly seeks to understand the mental health landscape faced by children and young people in NI within the global context and scale of mental health challenges faced by young people, identifying key trends on critical issues (Chapter 2). It presents an examination of mental health within the international human rights framework governing the obligation to ensure the highest attainable standard of health for children and young people provided by Article 24 of the UNCRC (Chapter 3). The report assessed the status of implementation of the Still Waiting report recommendations, reviewing NICCY’s previous monitoring of the SWAP actions (Chapter 4) and updating this monitoring process through an evaluation of the status of the SWAP (Chapter 6). Through the collection and collation of CAMHS data, the report provides an analysis of the status of CAMHS (Chapter 7). Further, the report analyses the delivery of key strategic frameworks, namely the Mental Health Strategy (Chapters 8 and 9). Concluding observations and recommendations are outlined at Chapter 10.

## Key findings

### Status of the SWAP: updates

Of the 32 SWAP Actions which were subject to information returns, **19 have been identified as remaining in the same status / progress since 2023.**<sup>3</sup>

**10 SWAP Actions were marked as completed;** these were actions which had previously been confirmed as having been completed in 2023, indicating no further/additional progress has been made. These included Action 2.4 (Development of an App to assist young people requiring help and support with health and social wellbeing) and Action 2.5 (review of CAMHS appointment systems to consider the viability and practical implications and to fully implement CAMHS care pathway across NI).

**For three of the Actions,** there are discrepancies arising between the updates provided in 2023 and the updates provided in 2025 in that they had been categorised as in progress in 2023, but in 2025 NICCY was informed that they had been completed prior to 2023. This includes: Action 1.9-Establishment of a fully implemented and operational Managed Care Network, which NICCY was advised had been completed in 2022; 2.1- Scope what supports are currently on offer for children and young people awaiting appointments or in between appointments, which NICCY was advised had been completed in 2022; and 2.3 - Review Integrated Elective Access Protocol to ensure fit for purpose for children and young people (which NICCY was advised had been completed in 2021).

*The full review can be found in Appendix 1, “Review of the Still Waiting Action Plan February 2023 – February 2025”.*

### Status of the SWAP: analysis

Of the 32 SWAP Actions which were subject to information returns, six actions were coded as red. NICCY is concerned as to the status of progression of these actions, and considers these as actions requiring urgent attention. Only four actions were coded as green. Whilst NICCY welcomes the efforts made in these specific areas, it is concerned at the pace of progress for the SWAP more generally. A summary of the status of the SWAP actions with NICCY’s progress coding is below:

Objective	Action	NICCY’s Progress Coding
<b>Sustainable investment in CAMHS</b>	1.3 Create a fund map of spending in children and adolescent mental health and emotional wellbeing services.	Yellow
	1.4 Increase funding for CAMHS.	Red
<b>Collect better information more regularly</b>	1.5 Full implementation of CAMHS dataset.	Yellow

<sup>3</sup> Where an action is categorised as ‘same status/progress since 2023’, it means that it has been identified as remaining in the same status in both 2023 and as of 2025 in the information returns.

	1.6 Development of Encompass across the HSCT to provide a system of recording and reporting on patient data and trends.	
	1.8 On an annual basis trusts, along with SPPG will reflect back on referral trends to identify changes in referrals patterns and undertake specific awareness rising activities as required.	
<b>Joined up working between services</b>	1.9 Establishment of a fully implemented and operational Managed Care Network (MCN).	
	1.10 Develop MH Liaison Service (for 16+), CAIT and acute care pathways for children and young people. REPLACED with 1.10 Create a regional mental health crisis service that will meet the needs of children and young people.	
	1.11 CAMHS referral pathways will be kept under review.	
<b>Removing barriers that stop young people accessing services</b>	2.1 Scope what supports are currently on offer for children and young people awaiting appointments or in between appointments. Analyse any resource and practical implications for implementing this.	
	2.2 Consider creation of a Mental Health Passport Scheme, through existing portals.	
	2.3 Review Integrated Elective Access Protocol (IEAP) to ensure fit for purpose for children and young people.	
<b>Greater Flexibility and choice in how young people engage with services.</b>	2.4 Develop an APP that will assist young people requiring help and support with health and social wellbeing or who may have difficulty in engaging with CAMHS	
	2.5 Review CAMHS appointment systems in relation to recommendation 8 to consider the viability and practical implications. Fully implement CAMHS care pathway across NI, including gap analysis and where additional resources should be deployed.	
<b>Mental health training for all professionals who work with young people</b>	3.1 Roll out at Trust level of short course programme on the CAMHS Care pathway to GPs and other children services.	
<b>Integrated working across the system to strengthen children and young people's emotional and mental wellbeing</b>	3.2 Implement primary care Multi Disciplinary Teams (MDTs) with a mental health practitioner attached to all GPs across the region. The role of the MHP within the MDT is to provide mental health support across a whole life approach.	

	<p>3.3 Establishment and launch of additional specialist mental health support available for schools, delivered through the Emotional Health and Wellbeing in Education Framework:</p> <ul style="list-style-type: none"> <li>-Text a Nurse (Post primary)</li> <li>-Expanded rise provision (Primary)</li> <li>-CAMHS school service (Primary and Post Primary).</li> <li>-Extension of Abbey School Nursing pilot.</li> </ul>	
<b>Greater range of community based mental health support</b>	4.1 Provide greater opportunities for mental health support community and voluntary sector organisations to apply for funding from the Department of Health's core grant funding scheme, through introducing an open call for applications to the scheme.	
	4.2 Provide a greater range of self-help support for young people.	
<b>Needs led support and treatment in mental health hospitals</b>	4.4 Fully implement psychological therapies in CAMHS, as per the existing 2010 Psychological Therapies Strategy.	
	4.5 Evaluate and analyse the need for Psychiatric Intensive Care provisions in Northern Ireland and make decision on the future need.	
<b>Children and Young People on Adult wards</b>	4.7 Ensure suitable protocols exist for children who are admitted to adult wards.	
	4.9 Review the Card Before You Leave (CBYL) Scheme for children and young people.	
<b>Implement and monitor minimum care standards in A&amp;E</b>	4.10 Create a regional crisis service for children and young people.	
<b>Transition planning from CAMHS to post-18</b>	5.1 Develop proposals for transitions between CAMHS and adult mental health services, engaging widely with all relevant stakeholders	
<b>Provide clear information on service standards and how to make a complaint and feedback</b>	6.1 Audit of existing complaints process across trust and review complaints made within 2 years for baseline. Consult with existing Service User groups re: appropriateness of current arrangements.	
<b>Strengthen involvement of young people in decisions about their care and how services are delivered</b>	6.2 Scope children and young people involvement in service evaluation and development. Consider development of an action plan and setting up a mental health youth forum in each trust to support this action.	

<b>Equal access for young people with a learning disability to services and support</b>	8.1 Understand current provision of ID CAMHS across all trusts through undertaking scoping exercise of existing pathways.	
	8.2 Establish a regional board with SPPG/lveagh and 5 trusts to strengthen operating procedures within lveagh to prevent delayed discharges as well as keep focus of plans to discharge.	
	8.3 Development of the Children and Young People Emotional Health and Wellbeing Framework including scoping a regional ADHD service.	
	8.4 Carry out a review of community based emotional, mental and behavioural support services for children and young people.	
<b>Access to services to address mental health and substance use problems at the same time</b>	8.5 Establish a service that will provide support and care for young people with co-occurring drug and/or alcohol and mental health problems.	
	8.6 The SPPG and the PHA will review services available for children and young people, particularly looking at the transition of young people from children to adult services, and ensure this is incorporated into the new outcomes-focused strategic plan being developed to replace the Alcohol and Drugs Services Commissioning Framework.	

*The full review can be found in Appendix 1, “Review of the Still Waiting Action Plan February 2023 – February 2025”.*

### Status of CAMHS

- A trend of decreasing referrals to CAMHS between 2021/2022 to 2023/2024 was identified.
- As of March 2024, there were 1,990 total CAMHS waiters.
- Whilst there has been some fluctuation in CAMHS waiting lists during 2021/2022 to 2023/2024, those waiting beyond the targeted nine weeks has increased to 51.5% (1,026) - the highest figure for this category within the period under assessment.
- For 2023/2024, there were 6,573 accepted referrals, and referral categories were at the lowest levels recorded within the period under assessment.
- Girls have consistently been the majority of overall referrals for CAMHS service use compared to boys; this includes Step 2 and Step 3 CAMHS.
- Girls are the majority users of Eating Disorder services, and boys are the dominant users of Addiction Services - but the composition of girls relative to the total referrals to the

system has increased, now forming the highest levels of referrals in the period under assessment.

- Overall, girls comprised the majority of referrals to Crisis services: boys had slightly edged out girls for referrals within the 5-11 age band in 2021/2022 and 2022/2023, but by 2023/2024, girls were the dominant figures across all age bands.
- The percentage of discharges within Step 2 and Step 3 CAMHS made on the basis of the identified goal having been achieved has decreased each year, and the rates for 2023/2024 are the lowest within the period under assessment (at 51.4% and 60.3% respectively). Conversely, the percentage of discharges within Step 2 and Step 3 made on the basis of the identified goal having not been achieved has increased each year, and the rates for 2023/2024 are the highest within the period under assessment (at 5.1% and 3.0% respectively).
- The percentage of discharges within Addictions services made on the basis of the identified goal having been achieved has fluctuated, initially increasing (from 37.8% in 2021/2022 to 57.1% in 2022/2023) before decreasing (to 48.9% in 2023/2024).
- The percentage of discharges within Step 2 made on the basis of the identified goal having been partially achieved has increased each year, and the rate for 2023/2024 is the highest within the period under assessment (at 16.1%);
- The percentage of discharges within Step 3 made on the basis of the identified goal having been partially achieved has fluctuated, initially increasing (from 8.8% in 2021/2022 to 13.6% in 2022/2023) before decreasing (at 11.1% in 2023/2024); and
- The percentage of discharges within Eating Disorder services made on the basis of the identified goal having been partially achieved has fluctuated, initially increasing (from 9.7% in 2021/2022 to 13.8% in 2022/2023) before decreasing sharply (at 6.6% in 2023/2024).
- There has been a steady decline in the number of regional active clients recorded within CAMHS (Step 2, Step 3, Eating Disorders services, Addictions services, and Crisis) during the period under assessment. In March 2022, 6,485 total active clients were recorded. By March 2023, this had decreased to 6,168. As of March 2024, 5,749 total active clients were recorded.

*The full CAMHS data set can be found in Appendix 2, “CAMHS Data 2021/22; 2022/23; 2023/24”.*

### **Status of the Mental Health Strategy: analysis**

Of the four Actions which were subject to information returns, three actions were coded as red, outlined below. NICCY is concerned as to the status of progression of these actions and considers these as actions requiring urgent attention.

Action	NICCY's Progress Coding
10. Increase the funding for CAMHS to 10% of adult mental health funding and improve the delivery of the stepped care model to ensure it meets the needs of young people, their families and their support networks.	
11. Ensure that the needs of infants are met in mental health services, and meet the needs of vulnerable children and young people when developing and improving CAMHS, putting in place a 'no wrong door' approach.	
12. Create clear and regionally consistent urgent, emergency and crisis services for children and young people that will work together with crisis services for adult mental health.	
13. Develop proposals for transitions between CAMHS and adult mental health services, engaging widely with all relevant stakeholders.	

The updates provided for Actions 10, 12, and 13 were limited, lacking information such as clear timeframes and targets for full implementation. This is particularly concerning in the context of Actions 12 and 13, given their importance to CAMHS system reform and response to immediate need. The updates provided for Actions 10, 12, and 13 advised generally that they “should be” completed. NICCY is mindful of the financial constraints experienced by the Department, and the uncertainty this generates for future planning and delivery. However, it is concerning that general comments are provided in relation to critical actions which are needed to ensure much-needed systematic and operational reform of CAMHS. This is particularly in the context of addressing the prolonged issue of transitions from CAMHS to adult mental health services which has been well-documented, and which has repercussions for safeguarding the future mental health of young people.

NICCY is concerned by the limited progress made in relation to Action 11, and by the wider fragmented focus made in respect of protection and promotion of infant mental health. This is particularly given its importance to early intervention and prevention, and for ensuring the best possible start in life for children.

Analysis of identified actions for 2025/2026 provided by the Department is difficult due to the limitations of the information provided, and the Department’s own guidance that the required

additional funding to progress Actions 10, 12, and 13 is contingent on additional funding being received to the Department.

*The full review can be found in Appendix 3, “Review of the Mental Health Strategy”.*

### Status of the Transformation Agenda analysis

Efforts have been made to advance the vision of *Delivering Together*, but progress has been fragmented to date, hampered by political instability and funding uncertainty. The omission of specific actions to address mental health challenges within the NI population, including the omission of any comprehensive indicators, targets, and timeframes for progression of items pertaining to mental health services, has restricted a clear direction of travel for reform of mental health services. This is particularly apparent in the context of children and young people’s mental health services.

The Mental Health Strategy being included as a lynchpin of the Transformation Agenda is welcome; however given the issues facing the future progression of the Mental Health Strategy, its role as a driver of change may be hampered – with detrimental impact for the reform and change of issues within CAMHS.

NICCY believes that transformation and reconfiguration of the health and social care system in NI should be perceived as a critical moment for the progression of children’s health, insofar as working to ensure timely access to adequate health infrastructure for all children and young people, including within the prevention and early intervention context for their mental health. For the Transformation Agenda to be truly radical, the adoption of a CRBA for the future design and delivery of healthcare reform is required.

### Recommendations

This report identifies 31 recommendations to support the transformation of children and young people’s mental health services.

#### NICCY recommends:

- 1. The Department, in conjunction with the Public Health Agency, review and clarify its adopted definition of “early intervention” within children and young people’s mental health policy. This review should be grounded on the principle that early intervention is recognised as a lifelong approach - which covers infancy, early childhood, school-based supports and community provision, as well as specialist services. This principle should be embedded within the development of mental health policy including the Early Intervention and Prevention Action Plan, as well as associated funding allocation and workforce design. Public health messaging should also adopt this principle to better address the scale and complexity of mental health and wellbeing issues faced by children and young people.**
- 2. Recognising the need for improvements in the accessibility and quality of disaggregated, basic operational mental health data, the Department and the SPPG should undertake and publish a review of the rollout of the Encompass system and**

illustrate the progress made towards the standardisation of data collected and utilised by HSCTs for the purposes of planning, commissioning, and delivering CAMHS.

3. The Department examines the potential for a mental health dashboard, as considered by the Scottish Government's commitment, which is grounded on performance, targets, and indicators.
4. Understanding the mental health landscape for children and young people in NI, that the Department, in conjunction with relevant authorities and stakeholders, commits to developing a mechanism to build capacity and facilitate engagement with children and young people on an ongoing basis, ensuring delivery is based on actual need not presumed need. This mechanism should be designed in accordance with a child rights-model of participation such as the Lundy Model and should reflect the Participation Principles as agreed by all Government Departments.
5. The Department and the SPPG commit to ensuring that child- and young person-friendly, accessible information is made publicly available in order to engage young people in an effective and meaningful way on mental health policy and service planning.
6. The Department incorporates clear and direct reference to Article 24 of the UNCRC within future strategic documents governing the design and operation of children and young people's mental health services. This should include clearly outlining how these Strategic documents provide for establishment and implementation of a rights-based approach to the design and delivery of children and young people's mental health services.
7. The Department should include child public health as a specific, individual category within its strategic policymaking, and should incorporate a Child Public Health Approach model which upholds children's rights in public health awareness and prevention measures.
8. The Department utilises the Childs' Rights-Based Approach framework within the design and delivery of future strategic documents governing the design and operation of children and young people's mental health services. This should include consideration of workforce capacity, resources, recruitment, retention, and safe working environments.
9. The NI Executive incorporates a Childs' Rights-Based Approach into its Departmental budgeting processes. This should include the undertaking of Child Rights Impact Assessments by all Departments and corresponding agencies in addition to EQIAs, to ensure that all due consideration as to how budgetary decisions will affect children and young people. This is especially critical in the context of continued budgetary pressures.
10. The establishment of an information-exchange system which will enable communication between the Department and NICCY on the status of the Still Waiting recommendations and SWAP actions. This should include the provision of bi-annual updates from the Department on the progression of all outstanding SWAP Actions to enable comprehensive engagement and accountability, and NICCY's engagement within the implementation process.
11. The establishment of a dialogue / monitoring mechanism, involving representatives of the CVS, which will enable the continued monitoring of progress

and impact arising from the continued implementation of the SWAP actions. This should include the provision of engagement from the Department, the SPPG, and the HSCTs.

12. The Department clarifies how the SWAP has been incorporated into the Mental Health Strategy, and further clarifies what is meant by its comments that the “intent” of the Still Waiting report is being “met” through the governance and accountability arrangements of the Mental Health Strategy.
13. The Department undertake and publish a mapping exercise which demonstrates the precise incorporation of relevant SWAP Actions within the Mental Health Strategy. This mapping exercise should also detail the exact status of progress of the identified SWAP Actions within the development of their corresponding Mental Health Strategy Actions, and identify actions for future progression within the 2026/2027 financial year.
14. The Department undertakes a robust, refreshed mapping exercise which produces a refreshed funding map for CAMHS services, as well as ascertaining the existing need among the CVS in the mental health support sector, recognising increasing demand on CVS support services.
15. Funding for CAMHS is increased by the Department to sit at 10% of mental health services allocations.
16. The Department, the SPPG, and the HSCTs undertake an internal review of existing referral pathways, which assesses the current design and operation of referral pathways using a CRBA, including recognition of waiting lists and waiting times for access. The review should include the design and application of relevant indicators as an assessment framework. This review should be published within one year, and subsequent review should be undertaken using the same CRBA, including Child Rights-based indicators.
17. That reviews of the pilot programmes undertaken under SWAP Action 3.3 are published, with evidence of learning and recognition of best practice and opportunities for design improvement identified. These reviews should comply with Article 12 of the UNCRC and participation of those engaged in services provided by the pilot programmes, including in the design of recommendations for future work.
18. The Departments of Health and Education in accordance with the Children’s Services Co-Operation (NI) Act 2015, produce a comprehensive action plan for the future design and delivery of specialist mental health support services within schools and educational settings. This action plan should be framed within a CRBA and identify opportunities for collaboration and cooperation across all relevant services, including between the Emotional Health and Wellbeing in Education Framework and the Emotional Health and Wellbeing Framework (when finalised).
19. The Department engage in a stakeholder consultation exercise to understand the needs of the CVS, and to work alongside the CVS to ensure sufficient funding is provided in order to realise the ambitions of the Mental Health Strategy, and the role identified for the CVS within this, as well as the (draft) Emotional Health and Wellbeing Framework.
20. The Regional Mental Health Crisis Service is rolled out as a matter of urgency.
21. The Department advises of the status of implementation of recommendations made within the 2024 GIRFT review report, “The Emergency Departments of NI” and

particularly in relation to those made in respect of the Royal Belfast Hospital for Sick Children, and further, confirms what work has been undertaken within the Belfast HSCT region to progress on ensuring a safe ED environment for children and young people experiencing mental health crisis and/or requiring CAMHS assessment.

22. The development of a clear, regionally consistent, and child rights-based transitions pathway is upgraded to a priority by the Department, and undertaken as a matter of urgency.
23. The Department undertakes a robust, refreshed mapping exercise which produces a refreshed funding map for CAMHS services, as well as ascertaining the existing need among the CVS in the mental health support sector, recognising increasing demand on CVS support services.
24. Funding for CAMHS is increased to sit at the identified 10% of mental health services.
25. The Regional Mental Health Crisis Service is rolled out as a matter of urgency.
26. The development of a clear, regionally consistent, and Child Rights-based transitions pathway is upgraded to a priority by the Department, and undertaken as a matter of urgency.
27. The refreshed Infant Mental Health Framework is published by the Public Health Agency without further delay.
28. The Department to consider producing updates to its 2025 Deliverability Review within each financial year.
29. The Department undertakes a mapping exercise to ascertain the positioning of infants, children, and young people within the design and delivery of the Transformation Agenda to date.
30. The Department demonstrates its awareness and understanding of intersectionality within its strategic policy-making, indicating how it is designing mental health services in recognition of specific issues and barriers faced by communities such as LGBTQIA+ young people, disabled young people, ethnic minority young people, neurodiverse young people, rural communities, carers within their families etc.
31. The Department adopts a mainstreaming approach towards the design and delivery of future strategic developments associated with the Transformation Agenda, whereby children's rights and specifically, the standards and norms associated with Article 24 of the UNCRC, are actively incorporated within strategic frameworks.

## 1. Introduction

Monitoring the status and operation of children and young people’s mental health services in NI has been a focus area for NICCY in recent years. NICCY is acutely aware of stories relating to: waiting lists within CAMHS, increasing referrals, the decreasing age ranges of children being referred and challenges facing regional CAMHS and specific services.<sup>4</sup> These stories, alongside our casework, demonstrate that there are children and young people experiencing mental distress, needing support for their emotional health and well-being, waiting on accessing support services, and fundamentally, struggling to access and invoke their right to health as guaranteed by international law.

In 2018, NICCY published “Still Waiting: A Rights Based Review Based Review of Mental Health Services and Support for Children and Young People in NI” (“the Still Waiting report”). The aim of this Review was to assess the adequacy of mental health services and support for children and young people, utilising a children’s rights framework. Alongside providing a comprehensive overview of children and young people’s experiences of accessing and using mental health services or support, the Review also examined service activity, and budgeting data relating to mental health services, producing a range of recommendations for improving services that are grounded in the collated evidence. The Still Waiting report, its 50 recommendations, and subsequent Action Plan (“the SWAP”) have utilised the incorporation of human rights-based indicators to develop a comprehensive understanding of the status of mental health service provision, including within the context of intervention and prevention for children and young people.

NICCY committed to monitoring the progression of Still Waiting and the SWAP, publishing four monitoring reports between 2020 and 2023. By the conclusion of this monitoring exercise, it was found that:

*“...the pandemic, cost of living crisis and lack of functioning Government are just some of the key external factors that has made it extremely challenging to progress the plans set out in the SWAP and which have also exacerbated poor mental health and wellbeing of children and young people...”<sup>5</sup>*

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<sup>4</sup> Gray, K. (14 October 2025). “Waiting times for mental health services ‘unacceptable’”. *Armagh I.*; Reid, K. (6 May 2025). “More than 5,700 waiting in NI for first mental health appointment”. *Belfast Telegraph.*; Hargan, G. (8 February 2024). “Mental health waiting times ‘unacceptable’ as 10,000 NI children seek support in 2023” *Belfast Telegraph*; McGinty, C. (1 March 2025). “Challenges facing child mental health service”. *Derry Now.*; McLaughlin, T. (7 February 2023). “Rise in mental health referrals for children and young people across NI”. *UTV News.*; Patterson, H. (16 October 2025). “One hundred children under four referred to mental health services in four years”. *The Irish News.*; Smyth, L. (11 February 2020). “Northern Ireland GP reveals children as young as nine being referred to mental health services”. *Belfast Telegraph.*; see the issues within the Knowing Our Identity service at the Belfast Health and Social Care Trust, see Meredith, R. and McCormack, J. (16 December 2022). “Gender identity: Belfast Trust apologises for ‘excessive delays’ at clinic” *BBC News*; and see concerns relating to safety and care at Beechcroft, see Winters, R. (16 March 2022). “Report finds “very worrying” failings at children’s mental health hospital” *The Detail*.

<sup>5</sup> NICCY. (February 2023). “Still Waiting- Implementation NICCY Progress Update Monitoring Report 4 February 2023”.

This complex and entangled relationship – the non-progression of the SWAP, the ramifications for a system under pressure, and the negative consequences for the mental health of children and young people – has persisted since 2023 and looks set to continue.

It has been a matter of deep concern for NICCY that since the restoration of devolved government in NI in 2024, infants, children and young people’s healthcare services have been marginalised within political and policy developments. This theme has continued with the design and commencement of key strategic documents, including the NI Executive’s Programme for Government 2024-2027 (“PfG”). We were troubled by the omission to recognise and address mental health, and especially in the context of CAMHS, within both the draft and final PfG, and advised as such.<sup>6</sup> We are also concerned about the use of specific terminology within strategic health policy frameworks which suggests that mental health, and mental health disorders, are “problems”.<sup>7</sup> Juxtaposed with the relative absence of clear, specific objectives and commitments in respect of children and young people’s mental health services, we are facing a policy landscape which appears to be both disengaged and disconcerting.<sup>8</sup>

In June 2023, the UN Committee on the Rights of the Child (“the UN Committee”) published its latest Concluding Observations on the UK’s compliance with its obligations under the UNCRC.<sup>9</sup> Several areas of concern relating to the protection and promotion of children’s health were identified, similar to its 2016 recommendations, advising Government to:

- Ensure the availability of quality, child-sensitive and age-appropriate paediatric primary and specialist health-care services to all children;
- Ensure that children’s perspectives are included in the development and implementation of all health-care services, health and social-care commissioning policies, and policy and practice reviews; and
- Develop a strategy to address health inequalities, including the underlying causes, in particular in respect of children in disadvantaged situations, including children with disabilities, children belonging to ethnic minorities, socioeconomically disadvantaged children, children living in rural areas, and transgender children.

NICCY is concerned by the status of progress on the Committee’s recommendations in general in NI, which has relevance for the design and delivery of children and young people’s mental health services. Paediatrics has a vital role in the mental development of the child through all life stages. Healthcare professionals working across the sub-fields of paediatrics are responsible for monitoring and promoting various aspects that are vital to a child’s cognitive,

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<sup>6</sup> See the Executive Office. (2024). “Draft Programme for Government 2024-2027 ‘Our Plan: Doing What Matters Most’ Public Consultation”.

<sup>7</sup> See for example, Department of Health. (June 2025). “Health and Social Care NI Reset Plan” at page 16.

<sup>8</sup> There was no clear and specific reference, objective, target, or commitment made in respect of CAMHS with the Reset Plan 2025, see Department of Health. (June 2025). “Health and Social Care NI Reset Plan”. Whilst reference was made to mental health within the Three Year Plan 2024, notably at page 20, and commitments made, there was no clear and specific reference, objective, target, or commitment made in respect of CAMHS, see Department of Health. (10 December 2024) “Health and Social Care NI A three year plan to: stabilise reform deliver”.

<sup>9</sup> UN Committee on the Rights of the Child. (2023). “Concluding observations on the combined 6th and 7th periodic reports of the United Kingdom of Great Britain and Northern Ireland: Committee on the Rights of the Child”.

emotional, and social growth. The role of paediatrics is even more critical in the context of vulnerable children, such as those with chronic illnesses, neurodevelopmental disorders, or adverse early life experiences, where timely and targeted paediatric interventions can significantly influence long-term outcomes.<sup>10</sup> When paediatric services are under pressure, the detrimental impact upon children’s health, including long-term implications must be recognised.<sup>11</sup>

As this report demonstrates, there are systematic issues impacting the mental health system which raise concerns regarding delays in ensuring appropriate services and supports for children and young people. This raises concern as to the recognition, protection, and promotion of the child’s right to health as affirmed by Article 24 of the UNCRC. Whilst the Department of Health (“the Department”) has recently sought to acknowledge child-centred healthcare within its vision of children and young people’s mental health services, the current financial landscape and how this will affect the operation of children’s mental health services is worrying.<sup>12</sup>

New proposed policy interventions such as the draft Emotional Health and Wellbeing Framework aim to work in conjunction with the Mental Health Strategy 2021-2031 (“the Mental Health Strategy”) yet ongoing and allocated funding continues to not be aligned with the projections identified in the Mental Health Strategy Funding Plan.<sup>13</sup> The Department itself has identified this troubling situation within other overarching strategic plans and policy frameworks, and has stated that [it] “needs to continue to prioritise the actions that can be delivered, with delivery being taken forward by way of Annual Delivery Plans which set out agreed actions which can be taken forward year-on-year.”<sup>14</sup>

The Deliverability Review of the Mental Health Strategy was published in October 2025.<sup>15</sup> It confirmed that as of the year end of 2024/25, only £12.3mn has been allocated to 14 actions, equating to only 16% of the necessary funding for its implementation during that timeframe. Of the Mental Health Strategy’s 35 actions, only 20 have commenced with partial funding, both recurrent and non-recurrent. The Department has noted that since the commencement of the Mental Health Strategy, its delivery has been taking place within an “extremely challenging financial context”.<sup>16</sup> The Review proposes a prioritisation model for future progression of actions; it is concerning that actions relating to children and young people have not been identified as a high priority under this model.

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<sup>10</sup> See Suppiej, A., Longo, I. and Pettoello-Mantovani, M. (2025). “The pivotal role of mental health in child and adolescent development” *Global Pediatrics*, Volume 13, 100277.

<sup>11</sup> See RCPCH. (June 2025). Collaborative Healthcare in Northern Ireland: Delivering the services children need in the community” and (April 2024). *Worried and waiting: A review of paediatric waiting times in Northern Ireland 2024*.

<sup>12</sup> Department of Health. (2025). “Children and Young People’s Emotional Health and Wellbeing Framework Consultation Draft May 2025”.

<sup>13</sup> See Department of Health. (2021). “Mental Health Strategy 2021-2031 Funding Plan”.

<sup>14</sup> Department of Health, (10 December 2024), “Health and Social Care NI A three year plan to: stabilise reform deliver”, at page 20.

<sup>15</sup> Department of Health. (2025). *The Northern Ireland Mental Health Strategy A Review of the deliverability of the Strategy’s Actions 2026-2029*.

<sup>16</sup> Department of Health. (9 October 2025). “Publication of NI Mental Health Strategy: A Review of the Deliverability of the Strategy’s Actions 2026-2029.”

The conceptualisation of the right to health generally under international law is clear: States are expected to make every possible effort, within available resources, to realise the right to health and advance it without delay. States cannot justify a failure to respect and uphold their obligations under international law because of a lack of resources but rather must guarantee the right to health to the maximum of their available resources, irrespective of financial strain.<sup>17</sup> Moreover, the UN Committee has recommended the incorporation of a child rights-based approach into governmental budgeting processes in all jurisdictions of the UK, including NI.<sup>18</sup> The Committee further advised that government should:

- (a) Implement a tracking system for the allocation, use and monitoring of resources for children, with a view to eliminating disparities and ensuring equitability, and assess how investments in all sectors serve the best interests of children;
- (b) Introduce budgetary allocations for children in disadvantaged situations and ensure that children are not affected by austerity measures;
- (c) Ensure that, in situations of economic crisis, regressive measures are not taken without meeting the requirements set out in paragraph 31 of the Committee’s general comment No. 19 (2016) on public budgeting for the realization of children’s rights, including that children participate in the decision-making process relating to such measures.

NICCY has robustly advised each Department on the need to protect children and young people from the devastating budget cuts over the last number of years, and the importance of ensuring funding provision on a multi-year basis.<sup>19</sup>

It is evident that more must be done to demonstrate appropriate financial investment will be made on a proactive, and sustained, basis to ensure the full realisation and protection of the child’s right to health within children and young people’s mental health services, notwithstanding financial constraints.

This report represents the culmination of a Periodic Review of children and young people’s mental health services, and the governing key strategic documents underpinning and driving same, conducted by NICCY. The aim of the Periodic Review was to assess the strategic design and delivery of children’s mental health services through a child’s rights-based approach. There were three strands to the Periodic Review, with NICCY seeking to understand the:

- Operational provision of existing CAHMS between the timeframe 2021-2024;
- Challenges / issues arising within the provision of these services; and

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<sup>17</sup> See for example as outlined in Office of the United Nations High Commissioner for Human Rights and the World Health Organisation, “The Right to Health Factsheet No 31”.

<sup>18</sup> UN Committee on the Rights of the Child. (2023). “Concluding observations on the combined 6th and 7th periodic reports of the United Kingdom of Great Britain and Northern Ireland: Committee on the Rights of the Child’ at para 11.

<sup>19</sup> This has included proactive advice letters to Permanent Secretaries and responses submitted to EQIAs; see NICCY. (November 2024). Response to draft Programme for Government.

- Implications of the Department’s 2024/2025 Budget on operation of services, through assessment of impact upon delivery of the Mental Health Strategy, and other associated strategies / frameworks.

Considering the identified issues within the children and young people’s mental health services in NI, this report aimed to present an evaluation of the status of the strategic design and delivery of mental health services, including an assessment of the current operation of CAMHS, and the status of the SWAP, through:

- Providing an evidence-based and research-informed approach to understanding the mental health landscape faced by children and young people in NI in Chapter 3, which examines the global context and scale of mental health challenges faced by young people, identifying key trends on critical issues, and documents the statistical evidence pertaining to the specific mental health challenges in NI.
- Examining mental health within the international human rights framework governing the obligation to ensure the highest attainable standard of health for children and young people as outlined within Article 24 of the UNCRC in Chapter 4.
- Assessing the status of implementation of the Still Waiting report recommendations, reviewing NICCY’s previous monitoring of the SWAP and contextualising the strategic focus of government in Chapter 5, and updating this this monitoring process through an evaluation of the current status of the SWAP at Chapter 6.
- Reviewing collected and collated CAMHS data to provide an analysis of the status of CAMHS, identifying relevant trends, at Chapter 7.
- Analysing the delivery of key strategic policy frameworks, namely the Mental Health Strategy and the Transformation Agenda documents, within Chapters 8 and 9.

Through this review, NICCY has aimed to convey that the challenges facing the operation of children and young people’s mental health services are not only systematic, but also systemic, present within the design and delivery of the strategic policy frameworks serving as the architects for change with the healthcare system in NI.

## 2. The Mental Health Landscape for Children and Young People

### 2.1. Introduction

In June 2025, the KidsRights Index 2025 (“the Index”) was published. It documented the ongoing global children’s mental health crisis, finding that 14% of children and adolescents (aged 10-19 years) globally are reportedly facing mental health concerns.<sup>20</sup> This is further exacerbated by their vulnerabilities owing to factors such as experiences of conflicts, poverty, exclusion, discrimination, and/or displacement.<sup>21</sup> Girls and older adolescents, for example, are at a greater risk of being impacted by mental health concerns.<sup>22</sup>

The Index also highlighted that due to lack of adequate safeguards in the digital environment, including social media platforms, children and young people’s mental health has been put at risk. Recent technological advancements present both challenges and opportunities for the child’s right to health in the context of mental health. The digital environment, which can be a vital means for enhancing access to mental health care services and information for children and young people, can also expose them to risks of bullying, sexual exploitation and abuse, trafficking, gender-based violence, cyber-aggression, cyberattacks and information warfare.<sup>23</sup> There are increasing issues of problematic social media use.<sup>24</sup> According to the World Health Organisation (“WHO”), between 2018 and 2022, this use has increased among children aged 11, 13 and 15 across Europe, Central Asia, and Canada increased from 7% to 11%.<sup>25</sup>

The linkages between mental health concerns and suicides have been well-documented.<sup>26</sup> The global average suicide rate now identified as being 6 per 100,000 among young people aged 15 to 19 years old.<sup>27</sup> The WHO reported suicide as the third leading cause of death among those aged 15 to 29.<sup>28</sup> A troubling trend is the global underreporting of suicides due to various factors, including stigma, misclassification, and a general lack of appropriate reporting mechanisms on deaths.<sup>29</sup> This demonstrates the necessity for data collection, and monitoring by

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<sup>20</sup> KidsRights. (6 June 2025). “KidsRights Index 2025: ‘Global children’s rights crisis deepens as mental health emergency reaches tipping point’”.

<sup>21</sup> See Committee on the Rights of the Child. (2016). General Comment No. 20 (2016) on the Implementation of the Rights of the Child During Adolescence at para 58.

<sup>22</sup> See World Health Organization Regional Office for Europe and UNICEF. (2024). “Child and Adolescent Health in the WHO European Region: Adolescent Mental Health Fact Sheet”.

<sup>23</sup> Committee on the Rights of the Child. (2021). General Comment No. 25 (2021) on Children’s Rights in Relation to the Digital Environment at paras 82 and 93.

<sup>24</sup> The term “problematic social media use” is broadly used to refer to a compulsive and addictive usage of social media that adversely impacts the users’ everyday functioning, see O’Day, E. and Heimberg, R. (2021). “Social Media Use, Social Anxiety, and Loneliness: A Systematic Review” *Computers in Human Behavior Reports* Vol. 3.

<sup>25</sup> World Health Organization Regional Office for Europe. (25 September 2024). “Teens, Screens and Mental Health”.

<sup>26</sup> Bertolote, J. M., and Fleischmann, A. (2002). “Suicide and Psychiatric Diagnosis: A Worldwide Perspective” *World Psychiatry* 1(3). 181–185; Nock, M., et al. (2009). “Cross-national Analysis of the Associations Among Mental Disorders and Suicidal Behavior: Findings from the WHO World Mental Health Surveys” *PLoS Medicine* 6(8).

<sup>27</sup> World Health Organization. (2021). “Mortality and Global Health Estimates: ‘Suicide Rates’ The Global Health Observatory.

<sup>28</sup> World Health Organization. (2021). “Global Health Estimates 2021: Deaths by Cause, Age, Sex, by Country and by Region, 2000-2021”; World Health Organization (10 October 2024). “Mental Health of Adolescents”.

<sup>29</sup> See Dattani, S. et al. (2023). “Suicides” OurWorldinData.org.

government. The UN Committee has recognised that adolescents are at greater risk of suicides, and has stressed the importance of States providing the necessary support services to address concerns relating to violence, abuse, bullying, and high expectations, amongst other factors. States are obligated to ensure the availability of mental health care services and facilities that are suitable for children and young people and implementing other measures necessary to promote their mental health; such obligations are underpinned by the role and purpose of data.<sup>30</sup>

In the last decade, there has been increasing awareness of the mental ill-health among children and young people globally, as well as the need for disaggregated, basic operational data required to plan, commission and deliver mental health services specifically for children and young people. This has influenced the evolution of the understanding of the right to health in international law. In 2013, through General Comment No. 13, the UN Committee expressed concern about the increase in mental ill-health among children and adolescents, acknowledging how there is growing recognition of the need for increased attention for behavioural and social issues that undermine children’s mental health, psychosocial wellbeing and emotional development.<sup>31</sup> It warned against over-medicalisation and institutionalisation, urging for States to address mental ill-health through a public health and psychosocial support approach, including investment in primary care approaches which facilitate the early detection and treatment of psychosocial, emotional and mental problems.

Vital to the undertaking of these approaches is the requirement for the collection, analysis, and monitoring of operational data to inform the design and delivery of mental health services, supports, and broader governing strategic frameworks. The Index however has argued that mental health is one of the aspects of children’s lives where detailed information and data is “grossly lacking” and emphasised the need for improved data infrastructure.<sup>32</sup> Mapping data transforms it into a narrative which can flag differences in mental health and support service planning and interventions- particularly pertinent for NI.

## **2.2. Collection of operational Data**

Data collection, including the use of targets and indicators, is an important pillar for the protection and promotion of the health of infants, children, and young people. The UN Committee’s 2023 Concluding Observations made recommendations as to the improvement of data collection, analysis and use, including in the mental health context.<sup>33</sup> This follows, and reaffirms, prior recommendations made in terms of data collection and use of targets and

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30 Committee on the Rights of the Child. (2003). General Comment No. 4 (2003) on Adolescent Health and Development in the Context of the Convention on the Rights of the Child at paras 22 and 39.

31 Committee on the Rights of the Child. (2013). General Comment No. 15 (2013) on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health’ at para 38.

32 KidsRights. (6 June 2025). “KidsRights Index 2025: ‘Global children’s rights crisis deepens as mental health emergency reaches tipping point’”.

33 UN Committee on the Rights of the Child. (2023). “Concluding observations on the combined 6th and 7th periodic reports of the United Kingdom of Great Britain and Northern Ireland: Committee on the Rights of the Child’ at para 12.

indicators, and specifically to “regularly collect comprehensive data on child mental health”.<sup>34</sup> The progression of these recommendations in NI have been limited.

In undertaking of the Still Waiting report, NICCY reviewed operational data and expressed its surprise with the lack of basic operational data collected regionally on children and young people accessing, or trying to access, CAMHS. NICCY found alarming gaps in the collation of vital disaggregated, basic operational data required to efficiently plan, commission, and deliver CAMHS:

*“Data was not available on the demographic make-up of children in contact with statutory services, their presenting need or diagnosis, the types of treatments received, or the outcomes from these... Very little data is currently in the public domain, the new datasets must be made publicly available.”*<sup>35</sup>

The Still Waiting report identified three recommendations in respect of data and monitoring:

1. The CAMHS Dataset should be fully implemented across each Health and Social Care Trust (HSCT);
2. Adequate resources should be provided to establish and maintain the system; and
3. Data should be published on a regular basis, in line with other health statistical reporting and this should be augmented to include additional basic information and data, required to monitor services and effectively plan CAMHS.

By the time of its final monitoring report in February 2023, it was NICCY’s opinion that improvement in the accessibility, quality, and use of mental health data was still required. In respect of the progression of the SWAP, it was recognised that a Task and Finish Group had been established to determine the appropriate level of data to be published, and it was anticipated that a “limited range of data”, initially relating to waiting times, would be published on the Department’s website in early 2023. NICCY had welcomed this development as a first step but reiterated it was still essential that the full CAMHS dataset was published.

The limited access to, and limitations of, existing mental health data in NI has repercussions for the collation, publication, and analysis of mental health statistics. In turn, this raises questions as to the efficiency and efficacy of governmental and statutory agency planning, especially with regards to the design and delivery of key strategic policy interventions. The Office for Statistics Regulation (“OSR”), as part of its exploratory work on understanding the public value of mental health statistics in the UK, published a review of NI mental health statistics in 2021.<sup>36</sup> The OSR recognised, and welcomed, the introduction of significant policy interventions in respect of mental health services, such the Mental Health Strategy 2021, but acknowledged:

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<sup>34</sup> CRC/C/GBR/CO/5. (12 July 2016). UN Committee on the Rights of the Child Concluding Observations on the Fifth Periodic Report of the UK of Great Britain and NI at para 60 (a) and (b).

<sup>35</sup> NICCY. (2018). “Still Waiting: A Rights Based Review Based Review of Mental Health Services and Support for Children and Young People in NI” at page 15.

<sup>36</sup> Office for Statistics Regulation. (2021). *Systemic Review Programme Review of mental health statistics in Northern Ireland*.

*“Statistics serve the public good when they enable a range of statistics users to answer key important questions on a particular topic. Mental health statistics [in NI]... are currently not fully serving this vision.”*

The OSR identified significant issues regarding statistics and their use in mental health services in NI, as well as corresponding pressing challenges.<sup>37</sup>

There was a scarcity of robust mental health data.

This meant the development of official statistics was hindered, resulting in significant and fundamental data gaps.

The hindrance of official statistics created a situation which meant statistics could not precisely indicate or inform how many people were accessing mental health services.

Statistics could also not enable, from a health assessment perspective, whether service users' needs were being met.

It was difficult to assess and evaluate the delivery of mental health services in NI, and to understand the outcomes for individuals.

It was also difficult to understand the outcomes for individuals, as well as any challenges or barriers faced in accessing services and appropriate supports.

Mental health data was collected in silos by each of the five HSCTs.

As a result, there was no accurate regional picture of mental health in NI.

It was challenging to obtain clear standardised data:

- There were inconsistent data definitions.
- The fragmented IT infrastructure had led to poor data comparability due to the operation of different localised IT systems within and across HSCTs.
- There was no single point of access to official statistics on mental health, and users encountered difficulties when attempting to locate official statistics and data across a “dispersed landscape of information”.

Overall, the OSR Review painted a bleak picture of the statistical landscape for mental health in NI, prompting questions as to how exactly data is collected, stored, disseminated, and utilised by officials – particularly in the design and delivery of important strategic policy interventions. That these questions remain relevant in the contemporary context is disconcerting.

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<sup>37</sup> As above at page 5.

In 2024, the NI Assembly’s Public Accounts Committee (“PAC”) published its Report on Mental Health Services in NI. The report stated the provision of data on mental health services was unacceptable and needed urgent improvement. Whilst recognising the Department’s future work to achieve better, fuller data, the PAC recognised this was dependent on the successful implementation of the new Encompass system and therefore “full implementation remains some distance away”.<sup>38</sup> Further, it was suggested the digitalisation of records and the broader new digital landscape operating within the health and social care system through Encompass will partially, but not fully, address all identified issues affecting the collection, analysis, and use of mental health data in NI.

The Department’s own evidence did not allay the PAC’s concerns. Given the design, and commencement of the implementation of the Mental Health Strategy at the time of its inquiry, the PAC also outlined its concern that the Department had developed a substantial, cost-intensive strategy based flawed or incomplete information due to poor quality data”. The PAC was also critical about the (non)presence of data, the belated uptake of work relating to data presence and use, and that the Department’s own baseline was “incredibly low”.

Further, the PAC advised that data on the performance of mental health services should be published, to support transparency and accountability: it was essential for the Department to outline how it would publish mental health data to bring transparency to the services.<sup>39</sup> Whilst investment in mental health services was needed, so too was increased, and improved, data to enable a better understanding of what service impact.

As this report outlines, the full realisation of the SWAP objective in respect of data remains an issue – and thereby raises questions as to the current effectiveness of collection and retention of the disaggregated, basic operational data which is needed to ensure the efficient design and delivery of mental health services specifically for children and young people, as required by the UN Committee.

### **2.3 Mental health rates of children and young people in NI**

#### *General observations*

Young people in high income countries are in the midst of a mental health crisis.<sup>40</sup> International evidence documents a decline in wellbeing in young people in the West over the last decade.<sup>41</sup> Whilst there is not a complete overlap between well-being and mental ill-health, research does

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<sup>38</sup> Public Accounts Committee. (June 2024). *Report on Mental Health Services in Northern Ireland*. NI Assembly. At para 74.

<sup>39</sup> At para 77. The PAC acknowledged the Scottish Government’s commitment to the development of a mental health dashboard, and posited this could be the template for the Department, encouraging it to introduce a publishable database which demonstrates performance against a set of indicators.

<sup>40</sup> Brown, H., Gao, N., Song, W. (2024). “Regional trends in mental health inequalities in young people aged 16–25 in the UK and the role of cuts to local government expenditure: Repeated cross-sectional analysis using the British household panel Survey/UK household longitudinal survey”. *Social Science & Medicine* 353.

<sup>41</sup> See Blanchflower, D.G., Bryson, A, Xu X. (2025). “The declining mental health of the young and the global disappearance of the unhappiness hump shape in age.” *PLoS One*. 27;20(8); Marquez, J., Long, E. A. (2021). “Global Decline in Adolescents' Subjective Well-Being: a Comparative Study Exploring Patterns of Change in the Life Satisfaction of 15-Year-Old Students in 46 Countries.” *Child Indic Res*. 4.

illustrate that these are related, and a robust evidence base now demonstrates changes in these measures among children and young people in the last 20 years.<sup>42</sup> In the UK, an increase in poor well-being and mental ill-health among young people has been identified in different studies.<sup>43</sup> Non-suicidal self-harm, which is now increasingly reported among children and young people as a means of coping with unpleasant feelings of anger, tension, anxiety, or depression, almost tripled in England between 2000 and 2014 with the sharpest increase in the use of non-suicidal self-harm has been observed among women aged 16–24.<sup>44</sup> Similar findings have been found across studies in countries such as Germany, Sweden, Finland, Norway, and New Zealand.<sup>45</sup> The global nature of rising, and complex, mental ill-health among children and young people is clear. Equally clear are the repercussions of the trend of declining wellbeing and increasing mental ill-health.

Evidence confirms self-reported mental health is “intricately linked with physical health”.<sup>46</sup> Deterioration in mental health is known to be a major cause of increasing hospital admissions among young people, and declining mental health has been linked to rising suicide rates.<sup>47</sup> Recent evidence from the European Commission has shown a rise in suicide rates of young people aged between 15–19 in 12 EU countries between 2011 and 2022.<sup>48</sup>

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<sup>42</sup> See The Children’s Society UK. (2019). *The Good Childhood Report 2019*; Twenge, J.M., Joiner, T.E., Rogers, M.L., et al. (2017). “Increases in depressive symptoms, suicide-related outcomes, and suicide rates among U.S. adolescents after 2010 and links to increased new media screen time.” *Clinical Psychological Science*. 6:3–17; Twenge, J.M., Martin, G.N., Campbell, W.K. (2018). “Decreases in psychological well-being among American adolescents after 2012 and links to screen time during the rise of smartphone technology.” *Emotion*. 18(6):765–780.

<sup>43</sup> See Patalay, P., Fitzsimons, E. (2017). *Mental ill-health among children of the new century: Trends across childhood with a focus on age 14*. Centre for Longitudinal Studies (London); Earl, J. (2016). Children and young people’s mental health. BMA.; Frith, E. (2016). CentreForum Commission on Children and Young People’s Mental Health: State of the Nation. CentreForum.

<sup>44</sup> McManus, S., Gunnell, D., Cooper, C., et al. (2019). “Prevalence of non-suicidal self-harm and service contact in England, 2000–14: repeated cross-sectional surveys of the general population.” *The Lancet Psychiatry*. 6(7):573–581.

<sup>45</sup> See Brailovskaia, J., Margraf, J. (2020). “Decrease of well-being and increase of online media use: Cohort trends in German university freshmen between 2016 and 2019.” *Psychiatry Research*. 290; Potrebny, T., Wiium, N., Haugstvedt, A. et al. (2019). “Health complaints among adolescents in Norway: A twenty-year perspective on trends.” *PLoS One*. 14; Kim, Y, Hagquist, C. (2018). “Trends in adolescent mental health during economic upturns and downturns: A multilevel analysis of Swedish data 1988–2008.” *Journal of Epidemiology and Community Health*. 72; Mishina, K., Tiiri, E., Lempinen, L., et al. (2018). “Time trends of Finnish adolescents’ mental health and use of alcohol and cigarettes from 1998 to 2014.” *Eur Child Adolesc Psychiatry*. 27; Brann, E., Chaplin, J.E., Agelii, M.L., et al. (2017). “Declining Well-Being in Young Swedes Born in 1990 Versus 1974.” *Journal of Adolescent Health*. 60(3):306–312; Potrebny, T., Wiium, N., Lundegya, et al. (2017). “Temporal trends in adolescents’ self-reported psychosomatic health complaints from 1980–2016: A systematic review and meta-analysis.” *PLoS One*. 12; Fleming, T.M., Clark, T., Denny, S., et al. (2014). “Stability and change in the mental health of New Zealand secondary school students 2007–2012: Results from the national adolescent health surveys.” *Austral N Zeal J Psychiatry*. 48:472–480.

<sup>46</sup> This extends to delayed healing of injuries for example: anxiety and depression slow the rate of wound healing: research has found that patients who scored in the top 50% of the Hospital Anxiety and Depression Scale were four times more likely to have delayed healing than those scoring in the bottom 50%; see Cole-King, A., Harding, K.G. (2001). “Psychological factors and delayed healing in chronic wounds.” *Psychosom Med*. 63(2):216–20.

<sup>47</sup> Daw, J.R., MacCallum-Bridges, C.L., Admon, L.K. (2025). “Trends and disparities in maternal self-reported mental and physical health.” *JAMA Int Med*.

<sup>48</sup> See Eurostat. “Suicide death rate by age group”.

Higher rates of depression result in higher usage of anti-depressant drugs, suggesting self-reports are accurate.<sup>49</sup> Anti-depressant prescribing to children aged 12–17 in the UK, for example, was found to have doubled between 2005 and 2017.<sup>50</sup> In NI, formerly described as “one of the world’s highest prescription rates for antidepressant medicines”, prescription levels were found to be higher than other UK regions with a similar economic profile, or with similar or higher rates of depression and determined to be higher than levels present in 23 countries featured in a 2014 global study.<sup>51</sup> Trends of increased prescribing to children and young people have been described as “worrying”.<sup>52</sup>

Deteriorating mental health is a major contributor to both school absenteeism and student difficulties with learning, with evidence suggesting that school absence is increasingly related to mental health difficulties.<sup>53</sup> There is increasing concern about rates of school refusal, and how recognised factors such as bullying, adversity at home, and poverty are impacting the mental health of school-age children in particular.<sup>54</sup> In the UK, children aged between 8–16 with a probable mental disorder were seven times more likely to have missed 15 days of school in 2022 than children without a mental disorder. NI appears to have higher rates of school absence compared to other UK regions.<sup>55</sup>

Finally, poor mental health increasingly contributes to difficulties in engaging in employment and the labour market, demonstrating the economic consequences of deteriorating mental health and the importance of robust mental health services designed to respond to need.<sup>56</sup>

Evidence demonstrates since the emergence of the COVID-19 pandemic in the UK, 62,000 more young people have become economically inactive, representing an increase of 2%. Between 2019 and 2022, there was a 29% increase in economic inactivity among those aged between 16–24, and a 42% increase among those aged between 25–34.<sup>57</sup> Among these age

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<sup>49</sup> See Chua, K., Volerman, A., Zhang, *et al.* (2024). “Antidepressant dispensing to US adolescents and young adults: 2016–2022”. *Pediatrics*.153(3).

<sup>50</sup> See NIHR. “Antidepressants for Children and Teenagers: What Works for Anxiety and Depression.”

<sup>51</sup> See McClure, J. (2014) *The Script Report* (a report produced for *The Detail*) as cited in McClure, J. (17 November 2014). “New data shows Northern Ireland is a world leader in prescription drug use” *The Detail*.

<sup>52</sup> O’Neill, S. and Rooney, N. (2018). “Mental health in Northern Ireland: an urgent situation”. *The Lancet Psychiatry* Volume 5, Issue 12, 965 – 966.

<sup>53</sup> In the United States, a sharp rise in chronic absenteeism (defined as students missing 10 percent or more of the school year) has been documented, increasing from 17.6% in 2017 to 29.6% in 2021. 69% of high school teachers in the United States in a 2024 Pew survey stated that anxiety and depression in their school was a major problem; 61% said the same about chronic absenteeism; see Saavedra, A., Polikoff, A., Silver, D. (2024). “Parents are not fully aware of, or concerned about, their children’s school attendance. Brookings Institute and Lim, L., Parker, K., Horowitz, J. (2024). “What’s it like to be a teacher in America today?” Pew Research Center. See also Adams, R. (14 June 2024). “Mental health is main cause of rising absences in England, say headteachers.” *The Guardian*.

<sup>54</sup> Bottomley, H. and Shafan-Azhar, Z. (2024). *Not in school: The mental health barriers to school attendance*. London: Centre for Mental Health.

<sup>55</sup> See NHS England. (2023). “Mental Health of Children and Young People in England, 2023 - wave 4 follow up to the 2017 survey”; Kooth and Centre for Mental Health. (November 2024). *Mapping the Mental Health of the UK’s Young People Key Findings*. At page 7.

<sup>56</sup> Blanchflower, D.G., Bryson, A, Xu X. (2025). “The declining mental health of the young and the global disappearance of the unhappiness hump shape in age.” *PLoS One*. 27;20(8).

<sup>57</sup> Buchanan, I. (2023). “Why are young people leaving the labour market?” Insight Briefing of the House of Commons Library.

groups, the largest overall increase in people with long-term sickness was due to mental illness, which rose by around 20,000, an increase of 24%. Research published in 2022 by the Mental Health Foundation found there were 10.3mn recorded instances of mental ill-health across the UK in 2019, and the third most common cause of disability was depression.<sup>58</sup> The annual economic cost of mental health problems for the UK was estimated at £117.8bn.<sup>59</sup>

The prevalence of mental ill-health, and mental health difficulties for children and young people in the UK, has increased for most age groups and, in all locations, has been recognised as being at a level to necessitate concern.<sup>60</sup> Studies show that these changes indicate an overall upwards trend across the UK, and provide evidence that mental health and wellbeing is a significant and growing issue for young people.

For young people aged between 17–19, the prevalence of a likely mental disorder rose from 10.1% in 2017 to 17.7% in 2020.

For children and young people aged between 7-16 years old, the prevalence of a likely mental health disorder rose from 12.1% in 2017 to 16.7% in 2020.

Comparative analysis from 2020 and 2023 demonstrates the scale of mental ill-health and mental health difficulties across the UK.<sup>61</sup> This analysis, presented below in Table 3, shows that the prevalence of mental illness within NI's youth population is broadly similar to that of other UK regions. It suggests that young people, particularly those entering their teenage and young adult years, are experiencing mental health difficulties at higher rates than other age groups. Evidence related to circumstances and inequalities which affect children and young people's mental health across all UK regions are documented, spanning poverty, adverse childhood experiences (ACEs), bullying and loneliness, social, racial, and economic inequalities, particularly affecting ethnic minority, disabled, and LGBTQIA+ children and young people.<sup>62</sup>

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<sup>58</sup> McDaid, D. and Park, A. (February 2022). *The economic case for investing in the prevention of mental health conditions in the UK*. Mental Health Foundation; London School of Economics and Political Science, Queen's University Belfast. At page 39.

<sup>59</sup> See above at page 42.

<sup>60</sup> NHS England. (22 November 2022). "Mental Health of Children and Young People in England 2022 - wave 3 follow up to the 2017 survey."

<sup>61</sup> In NI, Scotland and Wales, there are different approaches and different methods of data collection within mental health and health more broadly; direct comparative analysis is not always possible.

<sup>62</sup> See Kooth and Centre for Mental Health. (November 2024). *Mapping the Mental Health of the UK's Young People Key Findings*.

Table 1: Children and young people experiencing mental health difficulties across England, NI, Wales, and Scotland by approximate age ranges.<sup>63</sup>

Country	Younger child age range	Older child to young person age range	Older teenage or young person age range
England	<b>8-10 years</b>	<b>11-16 years</b>	<b>17-19 years</b>
	Mental health difficulties: <b>157 in 1,000 children</b> (2023)	Mental health difficulties: <b>226 in 1,000 children</b> (2023)	Mental health difficulties: <b>233 in 1,000 young people</b> (2023)
Northern Ireland	<b>5-10 years</b>	<b>11-15 years</b>	<b>16-19 years</b>
	Any mental health diagnosis: <b>128 in 1,000 children</b> (2020)	Any mental health diagnosis: <b>143 in 1,000 children</b> (2020)	Any mental health diagnosis: <b>186 in 1,000 young people</b> (2020)
Wales	<b>7-11 years</b>	<b>11-16 years</b>	-
	Clinically significant emotional difficulties: <b>130 in 1,000 children</b> (2022/23)	Scoring 'very high' on mental health difficulties questionnaire: <b>240 in 1,000 children</b> (2017-2021)	-
Scotland	<b>4-12 years</b>	<b>11-16 years</b>	<b>16-24 years</b>
	Scoring 'very high' on mental health difficulties questionnaire: <b>100 in 1,000 children</b> (2017-2021)	Scoring 'very high' on mental health difficulties questionnaire: <b>170 in 1,000 children</b> (2015-17)	Scoring 'very high' on mental health difficulties questionnaire: <b>350 in 1,000 young people</b> (2022)

In the NI context, consideration must also be given to the legacy of the conflict, exposure to paramilitary groups, and associated violence on the mental health of young people.<sup>64</sup> The continued impact of the Troubles has prompted the UN Committee to express its concern for children and young people, urging that they are protected from paramilitary activities.<sup>65</sup>

Further, the continued rise of racism within NI must be recognised as a driver of future mental ill-health among children and young people as the number of reported racist incidents is now higher than sectarian incidents.<sup>66</sup> The NI Life and Times Survey 2017 found that participants aged between 18-24 years old worryingly demonstrated greater racial intolerance than other age ranges.<sup>67</sup> Research has revealed that children and young people from ethnic, religious, and/or cultural minority backgrounds have experienced racism and racist bullying in school

<sup>63</sup> Table taken from Kooth and Centre for Mental Health. (November 2024). *Mapping the Mental Health of the UK's Young People Key Findings*.

<sup>64</sup> See NI Executive, Programme on Paramilitarism and Organised Crime (EPPOC). (July 2024). "The connection between paramilitarism and mental health in Northern Ireland Research from the Executive Programme on Paramilitarism and Organised Crime"; Rogers, P. and McAlister, S. (2019). "Paramilitary violence as a children's rights issue". *QPOL*.

<sup>65</sup> UN Committee on the Rights of the Child. (2023). Concluding observations on the combined 6th and 7th periodic reports of the United Kingdom of Great Britain and Northern Ireland: Committee on the Rights of the Child' at para 34(b).

<sup>66</sup> Amnesty International NI. (17 May 2024). "Northern Ireland: Race hate incidents at all time high".

<sup>67</sup> NILT. (2018). *Northern Ireland Life and Times Survey 2017*.

and have felt excluded at school due to their background.<sup>68</sup> Racist bullying has been found to have a profoundly negative effect on children: parents have highlighted the worrying impact of racist bullying on children’s mental and physical health.<sup>69</sup>

The impact of the COVID-19 pandemic must also be recognised. Data demonstrates that post-pandemic, the rates of poor mental health in young people in other UK regions increased, with the rates of probable mental health disorders rising to 16.7% in England, compared to 12.8% in 2017.<sup>70</sup> There is however, an absence of comparable, detailed post-COVID data available in NI. Data obtained via the Mental Health Foundation NI did however discover that 39% of young people (aged 18–24 years old) reported that anxiety had affected their day-to-day life to a great or moderate extent.<sup>71</sup> The proportion of respondents with anxiety was higher in males (34%) compared with females (27%), and rates were also higher in respondents with a long-term health condition (51%).

The multifaceted and interdependent risk factors for poor mental health among children and young people are clear across the UK, and so too is the need to prioritise policies which address the root causes of such risk factors. It is therefore essential to meet the needs of young people at risk of poor mental health.<sup>72</sup> Studies have indicated that approximately 75% of adults with a diagnosable mental health condition experienced their first onset of poor mental health during adolescence and young adulthood. It is estimated that on average, children and young people with mental health difficulties will experience a ten year wait between becoming unwell and getting any help.<sup>73</sup>

Children and young people experiencing poor mental health are at increased risk of facing challenging situations such as social exclusion, discrimination, stigma, poor educational outcomes, risk-taking behaviour, and poor physical health. This has the potential to detrimentally impact the life course of a child, increasing the likelihood of socio-economic inequalities.<sup>74</sup> It is in this context that the landscape faced by children and young people in NI should be understood.

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<sup>68</sup> “Children described having racist things said to them, being pushed or hit, or reported that other pupils had said unkind things about their schoolwork or their English (if they were learning English)”; see Queen’s University Belfast, Nuffield Foundation. (2023). “Migrant and ethnic minority children and young people’s views of education in Northern Ireland”. At page 15.

<sup>69</sup> Children have reported that “they felt ‘scared’, had begun to ‘hate’ school, did not want to attend school or wished to change schools”; see Queen’s University Belfast, Nuffield Foundation. (2023). “Experiences of education among minority ethnic groups in Northern Ireland” at page 37.

<sup>70</sup> Bond, N. and O’Neill, S. (2023). *Factors Affecting Mental Health and Wellbeing in Children and Young People in Northern Ireland. Mental Health Champion*. At page 2.

<sup>71</sup> Mental Health Foundation NI; Mental Health Awareness Week. (2023). “Mental Health Awareness Week 15 to 21 May 2023 Uncertain Times: The impact of anxiety in Northern Ireland and how to tackle it”.

<sup>72</sup> World Health Organization. (1 September 2025). *Mental health of adolescents*.

<sup>73</sup> Khan, L. (June 2016). “Missed opportunities A review of recent evidence into children and young people’s mental health”. *Centre for Mental Health*.

<sup>74</sup> McGorry, P.D., Purcell, R., Hickie, I.B., Jorm, A.F. (2007). “Investing in youth mental health is a best buy”. *Med. J. Aust.* 187 (S7) S5-S7.

## The NI Context

NI has the highest prevalence of mental illness in the UK, and it is estimated that mental health problems cost the NI economy at least £3.4bn annually.<sup>75</sup> Around 72% of this stems from the lost productivity of people living with mental health conditions, and the costs incurred by unpaid informal carers providing mental health support within their families and/or their communities.<sup>76</sup> This is a staggering figure, especially in the context of the specific nature of mental ill-health - a substantial proportion of these illnesses are preventable and treatable.

Analysis, however, suggests that only 29% of people with depression or anxiety disorders will have their needs met.<sup>77</sup> Moreover, suicide is acknowledged as a preventable death, but with around 300 deaths a year, NI has the highest suicide rate of the UK regions.<sup>78</sup> The gender and age dimensions of suicide in NI are outlined below.<sup>79</sup>

Gender ratios for suicides are 3:1 - 77% male to 23% female.

Of these, gender proportions were similar in those under 19 years old (9.3% and 7.9% respectively). Males demonstrated somewhat higher rates aged between 20 and 39 years.

79.3% (230) of the total deaths by suicide registered in 2024 were men.

20.7% (60) were women.

Of the 290 deaths by suicide in NI in 2024, 12 were under 20 years old.

11 of these individuals were men.

Whilst studies show that the rates of mental illness in people who die by suicide is over 90%, in NI only 57.6% of those who died had a recorded mental illness. It may be surmised that many people who die by suicide in NI therefore have an undiagnosed, or unreported, mental illness.

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<sup>75</sup>NI Audit Office. (2023). *Mental Health Services in Northern Ireland*.

<sup>76</sup> McDaid, D. and Park, A. (February 2022). *The economic case for investing in the prevention of mental health conditions in the UK*. Mental Health Foundation; London School of Economics and Political Science, Queen's University Belfast.

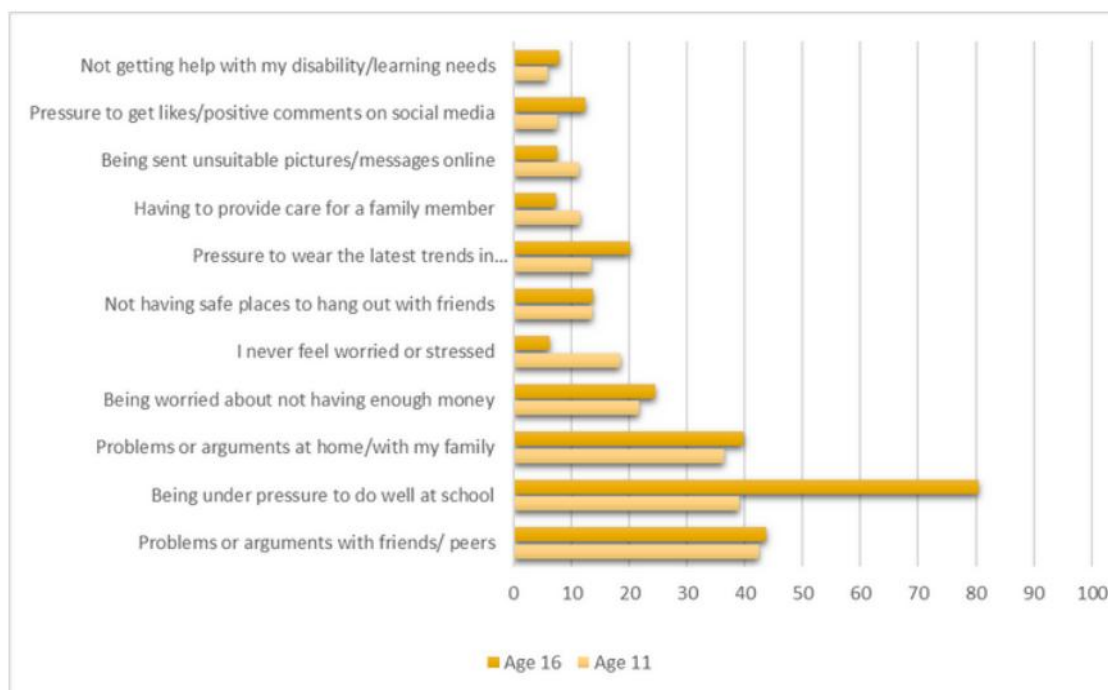
<sup>77</sup> McConnell, P., Bebbington, P., McClelland, R., et al. (2002). "Prevalence of psychiatric disorder and the need for psychiatric care in Northern Ireland. Population study in the District of Derry." *Br J Psychiatry*. 181:214-9.

<sup>78</sup> O'Neill, S. (2018). "Policy and Practice Briefing 01 Suicide prevention in Northern Ireland: results from studies of suicide and suicidal behaviour" Ulster University.

<sup>79</sup> Data was obtained from the following sources: O'Neill, S. (2015). "Understanding suicide and suicidal behaviour in Northern Ireland". *NI Assembly Knowledge Exchange Seminar Series*; NISRA. (2024). Northern Ireland Suicide Statistics, 2024; O'Neill, S., Corry, C., Murphy, S., et al. (2014). "Characteristics of deaths by suicide in Northern Ireland from 2005 to 2011 and use of health services prior to death". *J Affect Disord* 168, 466-471.

Mental illness can commence through experiencing issues or challenges which instigate feelings of worry and/or stress.<sup>80</sup> A 2023 survey undertaken by the Mental Health Champion asked young people to indicate which, if any, issues outlined in a list caused them worry or stress. It discovered a variety of sources for feelings of worry and stress, as outlined in Table 2 below. The most common concerns for young people at both ages were identified as being: problems or arguments with friends (age 11, 42.4%; age 16, 43.8%); problems or arguments at home (age 11, 36.4%; age 16, 39.8%); and pressure to do well at school (age 11, 39.1%; age 16, 80.4%).

Table 2: Causes of worry and stress for young people in NI.<sup>81</sup>



The 2020 NI Youth Wellbeing Survey measured the mental health of children and young people in NI, including rates of common mood and anxiety disorders, and their association with personal, familial, and social risk factors.<sup>82</sup> Findings showed that the majority of children and young people did not meet the criteria for a mental health disorder, but rates of anxiety and depression were about 25% higher than the figure for the UK in general.<sup>83</sup> The 2020 Survey found that 12.6% of children and young people experience common mood disorders such as anxiety and depression, which again, is approximately 25% higher than in other UK regions.<sup>84</sup> It has further been suggested that one in eight children in NI have a probable mental illness, with

<sup>80</sup> “The patterns of feelings and behaviours that characterise mental illness result from the individual’s response to stress or distress over time. The amount or intensity of stress (the allostatic load) required to trigger the onset of a mental disorder, varies between individuals and is dependent on that person’s vulnerabilities”; see Bond, N. and O’Neill, S. (2023). *Factors Affecting Mental Health and Wellbeing in Children and Young People in Northern Ireland*. Mental Health Champion. At page 2.

<sup>81</sup> Table taken from Source: Bond, N. and O’Neill, S. (2023). *Factors Affecting Mental Health and Wellbeing in Children and Young People in Northern Ireland*. Mental Health Champion.

<sup>82</sup> Bunting, L., McCartan, C., Davidson, G., et al. (2020). *The Mental Health of Children and Parents in Northern Ireland*. Health & Social Care Board.

<sup>83</sup> See Anand, A. (August 2024). “ARK Policy Brief The Mental Health of People in Northern Ireland”. ARK.

<sup>84</sup> HSCNI. Youth Wellbeing Prevalence Survey 2020. (2020).

those living in the most deprived areas are more likely to have a probable mental illness compared to those in least deprived areas with poverty as a key contributor.<sup>85</sup> Unreported mental ill-health for children and young people in NI is well documented. Around two-thirds of children and young people who do have mental health concerns do not seek help, with the majority of same feeling they could handle things on their own.<sup>86</sup>

There are a number of observations to be made about specific mental health issues faced by children and young people in NI including severe mental illness, substance use, experiences of children who are LGBTQIA+, dual diagnoses, and ACEs.

### *Severe mental illnesses*

Severe mental illnesses such as psychotic disorders can be experienced at a younger age: according to the Youth Wellbeing Prevalence Survey 2020, almost 19% of young people aged between 11-19 met the threshold for psychotic-like experiences.<sup>87</sup> Yet awareness of psychosis among young people is limited: fewer than 1 in 5 (17%) young people would be confident in spotting early signs of psychosis, with 1 in 4 having never heard of it.<sup>88</sup> Around three in 100 people however will experience an episode of psychosis in their lifetime, with the first episode most likely to happen between ages of 18-24.<sup>89</sup> The 2020 NI Youth Wellbeing Survey therefore called for opportunities for prevention and early intervention, including “screening for psychotic-like symptoms that can indicate a higher risk of developing mental health problems”.<sup>90</sup>

### *LGBTQIA+ children and young people*

LGBTQIA+ children and young people in NI disproportionately experience mental ill-health. 82% of LGBTQIA+ young people aged between 11-18 years old in NI have experienced suicidal thoughts and feelings compared to 23% of their peers.<sup>91</sup> LGBTQIA+ young people NI are more likely to have experienced suicidal thoughts and feelings than their peers in England (67%); Wales (73%); and Scotland (79%).

Delays in accessing gender-affirming healthcare, particularly in attending an initial appointment and commencing a medical pathway such as medication, including puberty blockers, have been identified as a factor in the mental health distresses experienced by transgender and non-binary young people. LGBTQIA+ young people NI faced increasing mental ill-health due to the COVID-19 pandemic.

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<sup>85</sup> Mental Health Foundation, Mental Health Champion. (2023). *Mental Health in Northern Ireland: Fundamental Facts 2023*.

<sup>86</sup> Anand, A. (August 2024). “ARK Policy Brief The Mental Health of People in Northern Ireland”. ARK.

<sup>87</sup> HSCNI. Youth Wellbeing Prevalence Survey 2020. (2020).

<sup>88</sup> Rethink Mental Illness. ‘Young people and psychosis: Our new research says they are unaware of warning signs despite being most at risk’.

<sup>89</sup> See: National Institute of Mental Health. ‘Understanding Psychosis’; and Rethink Mental Illness. ‘Young people and psychosis: Our new research says they are unaware of warning signs despite being most at risk’.

<sup>90</sup> HSCNI. Youth Wellbeing Prevalence Survey 2020. (2020).

<sup>91</sup> See BeLong To Youth Services. (June 2021). LGBTI+ Life in Lockdown: 1 Year Later Key Findings.

Over 75% of transgender youth identified lengthy waiting times to access gender-affirming healthcare as a cause of their mental ill-health in 2021.

### *Substance use*

Drug supply chain imperils children at each stage, from production to use. This is acute in the NI context, considering the impact of exposure to paramilitary and organised crime groups, exploitation, and associated violence on the mental health of young people.<sup>92</sup> Children are harmed through drug use, parental drug dependence, drug-related violence, exploitation, and trafficking. Children and young people have the right to protection from drugs and exploitation in the drug trade under Article 33 of the UNCRC, and their best interests must be a primary consideration in drug laws, policies, and practices. The UN Committee has consistently made recommendations on drug-related issues to States and across General Comments, from adolescent health to children in street situations to children’s right to health.<sup>93</sup> In particular, General Comment No. 15 outlines that States should protect children from illicit substances, and act to reduce their use among children.<sup>94</sup>

The age when substances are first used by young people in NI slightly differs dependent on the substance, and the gender of the young person. The Substance Misuse Database 2024/2025 found that the median age for when alcohol was first used was 15 years old for males and 16 years old for females, whereas the median age for drug use was 17 years old for males and 19 years old for females.<sup>95</sup>

There are worrying health and wellbeing issues posed by substance use in NI, documented below:

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<sup>92</sup> See NI Executive, Programme on Paramilitarism and Organised Crime (EPPOC). (July 2024). “The connection between paramilitarism and mental health in Northern Ireland Research from the Executive Programme on Paramilitarism and Organised Crime”.; Rogers, P. and McAlister, S. (2019). “Paramilitary violence as a children’s rights issue”. *QPOL*.

<sup>93</sup> See Committee on the Rights of the Child, General Comment No. 25: Children’s Rights in relation to the Digital Environment, UN Doc. CRC/C/GC/25 (2021), paras. 97, 114; Committee on the Rights of the Child, General Comment No. 21: Children in Street Situations, UN Doc. CRC/C/GC/21 (2017), para. 53; Committee on the Rights of the Child, General Comment No. 15: The Right of the Child to the Highest Attainable Standard of Health, UN Doc. CRC/C/GC/15 (2013), para. 66; Committee on the Rights of the Child, General Comment No. 3: HIV/AIDS and the Rights of the Child, UN Doc. CRC/GC/2003/3 (2003), para. 39; Committee on the Rights of the Child, General Comment No. 20: Implementation of the Rights of the Child during Adolescence, UN Doc. CRC/C/GC/20 (2016), para. 64.

<sup>94</sup> Committee on the Rights of the Child, General Comment No. 15: The Right of the Child to the Highest Attainable Standard of Health, UN Doc. CRC/C/GC/15 (2013), para. 65-66.

<sup>95</sup> See Department of Health. (2025). “Statistics from the Northern Ireland Substance Misuse Database: 1 April 2024 – 31 March 2025 Official statistics in development”.

Substance use	Issue
<i>Vaping</i>	<ul style="list-style-type: none"> <li>• Rise of vaping among young people is a pressing public health concern.</li> <li>• Evidence suggests increasing prevalence of vaping across age frames: findings from a 2025 report confirm that 15% of young people in NI currently vape.<sup>96</sup></li> <li>• Young people in the upper school year groups were considerably more likely to be current vapers than those in the lower year groups (Year 14 pupils are found to be 10 times more likely to be current vapers than those in Year 8).</li> <li>• The prevalence of current vape use has been found to increase through school year groups: from 4% among Year 8 pupils, to 46% among Year 14 pupils.</li> <li>• There is a link between vaping, and experimentation with tobacco, with 33% of respondents to a PHA survey who had never smoked before vaping confirming that they have since experimented with cigarettes.<sup>97</sup></li> <li>• Increasing use of vaping equipment for the consumption of illicit and harmful substances such as spice is a child public health concern.<sup>98</sup></li> </ul>
<i>E-cigarettes</i>	<ul style="list-style-type: none"> <li>• The majority of young people in NI aged 11-16 (95%) have heard of e-cigarettes, with 21% having used an e-cigarette on one occasion.<sup>99</sup></li> <li>• Those in the older school year groups are more likely to report having used an e-cigarette, with findings ranging from 6% of those in Year 8 to 44% in Year 14 pupils.</li> </ul>
<i>Alcohol</i>	<ul style="list-style-type: none"> <li>• 31% of young people reported having drunk alcohol.</li> <li>• 46% of young people that reported drinking alcohol indicated they had been drunk at least once.<sup>100</sup></li> </ul>
<i>Cannabis</i>	<ul style="list-style-type: none"> <li>• Frequent cannabis use in young people can be associated with negative mental health experiences such as depression, anxiety and even psychosis.<sup>101</sup></li> </ul>
<i>Injectable drug use</i>	<ul style="list-style-type: none"> <li>• In 2023, of the 6,353 new clients registered with the PHA's Needle and Syringe Exchange Service, approximately 400 (6.2%) were aged between 18 to 24 years old.<sup>102</sup></li> </ul>

Children with ADHD have a higher likelihood of developing problems with substance abuse, particularly alcohol and there is a growing body of research which demonstrates the developmental relationship between ADHD and the development of substance abuse

<sup>96</sup> PHA. (2025). 'Behavioural insights into youth vaping in Northern Ireland'.

<sup>97</sup> See above.

<sup>98</sup> See Higgins, K. Percy, A., and Mc Crystal, P. (2004). "Secular Trends in Substance Use: The Conflict and Young People in Northern Ireland". *The Journal of Social Issues*. 60(3), 485-506; PHA. (11 April 2024). "Parents urged to talk to young people about vaping Spice dangers"; and (13 May 2021). "Call to alert young people to dangers of 'spice'".

<sup>99</sup> See Department of Health. (September 2023). *Young Persons Behaviour & Attitudes Survey 2022: Substance Use (Smoking, Alcohol & Drugs)*.

<sup>100</sup> See above.

<sup>101</sup> See Royal College of Paediatrics and Child Health. (2020). *State of Child Health 2020*.

<sup>102</sup> PHA. (2023). *Annual Report for Needle Exchange for 2023*.

disorders, with ADHD symptoms such as impulsive behaviours recognised as important risk factors.<sup>103</sup>

### *Dual Diagnosis*

Lack of access to services for individuals who have co-occurring mental ill-health and substance use health issues, often called “dual diagnosis”, is an ongoing issue.<sup>104</sup> This is especially concerning given the evidence of the prevalence of dual diagnosis among young people, with young men identified as particularly at risk.<sup>105</sup> Mental ill health and substance misuse have been found to influence premature mortality among multiple and complex needs groups.<sup>106</sup>

For some individuals, their drug use and mental health issues are interrelated: both general mental ill-health and symptoms associated with psychological trauma can lead people to self-medicate with alcohol and drugs. However, such use can, in turn, result in an exacerbation of mental ill-health conditions. Individuals with a dual diagnosis may be overlooked or passed between services – with neither mental health nor substance misuse services taking overall responsibility for care. Barriers like stigma or stringent service criteria can be exclusionary, resulting in high levels of unmet need.<sup>107</sup> People with dual diagnosis disorders can experience some of the worst health, wellbeing and social outcomes. Many of those individuals with a dual diagnosis in NI would be young – research notes that between 64% and 88% of young people with substance use disorders have at least one co-existing mental disorder.<sup>108</sup> Young people are particularly at risk with a dual diagnosis disorder, and more likely to experience poorer health, wellbeing and social outcomes.<sup>109</sup> For example, early onset of substance misuse is linked with higher rates of major depressive disorders, and it is estimated that a third of

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<sup>103</sup> See Young, S., Abbasian, C., Al-Attar, Z., *et al.* (2023). “Identification and treatment of individuals with attention-deficit/hyperactivity disorder and substance use disorder: An expert consensus statement.” *World J Psychiatry*. 19;13(3):84-112.; Zulauf, C.A., Sprich, S.E., *et al.* (2014). “The complicated relationship between attention deficit/hyperactivity disorder and substance use disorders”. *Curr Psychiatry Rep*. 16(3); Lee, S.S., Humphreys, K.L., Flory, K., *et al.* (2011). “Prospective association of childhood attention-deficit/hyperactivity disorder (ADHD) and substance use and abuse/dependence: a meta-analytic review. *Clin Psychol Rev*. 31(3):328-41; Wilens, T.E. and Morrison, N.R. (2011). “The intersection of attention-deficit/hyperactivity disorder and substance abuse.” *Curr Opin Psychiatry*. 24(4):280-5; Sundquist, J., Ohlsson, H., Sundquist, K., and Kendler, K.S. (2015). “Attention-deficit/hyperactivity disorder and risk for drug use disorder: a population-based follow-up and co-relative study.” *Psychol Med*. 45(5):977-83.

<sup>104</sup> “Dual Diagnosis” is used to describe the co-occurrence of a mental (psychiatric) disorder alongside substance misuse. Mental disorders include a variety of illnesses such as depression, bipolar disorder, schizophrenia and other psychoses. Substance misuse is the use of alcohol, illicit drugs, or over-the-counter and/or prescription medicines in a way that can cause harm.

<sup>105</sup> See Tomáš, J., & Lenka, Š. (2023). “Prevalence of Dual Diagnoses among Children and Adolescents with Mental Health Conditions.” *Children* 10(2), 293.

<sup>106</sup> Perry, R., Adams, E.A., Harland, J., *et al.* (2021). “Exploring high mortality rates among people with multiple and complex needs: a qualitative study using peer research methods.” *BMJ Open*. 3;11(6).

<sup>107</sup> Black, L.A. (23 March 2021). “Mental ill health and substance misuse: Dual Diagnosis” NI Assembly Research and Information Service Research Paper at page 7.

<sup>108</sup> The reference to young people is for those aged 10 to 19 years old in this context. See: Brewer, S. *et al.* (2017). “Treating mental health and substance use disorders in adolescents: What is on the menu?” and Black, L.A. (23 March 2021). “Mental ill health and substance misuse: Dual Diagnosis” NI Assembly Research and Information Service Research Paper.

<sup>109</sup> See NICE, “NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE Guideline scope Severe mental illness and substance misuse (dual diagnosis): community health and social care services”.

young people seeking to take their lives by suicide are intoxicated with alcohol at the time of their death.<sup>110</sup>

Children and young people are facing significant challenges to their mental and emotional health and wellbeing in NI. Exposure to issues triggering stress and worry can be an instigating force; so too are chronically stressful situations such as poverty, domestic violence, and substance use within the home. Exposure to these situations can lead to negative impacts which can commence in early childhood and throughout adolescence, and last into adulthood. These situations, ACEs, are often associated with, and can have, damaging and long-term impact on mental health and wellbeing, including poorer outcomes across the lifespan in terms of educational attainment, employment, involvement in crime, family breakdown, and a range of other health and wellbeing measures.<sup>111</sup>

An estimated 32% of the NI population have endured ACEs.

People who have experienced ACEs and who also had psychological difficulties, were 15 times more likely to engage in suicidal behaviour than those who experienced low levels of trauma.

An estimated 60% of adults have experienced at least one ACE, and 17.6% experienced four or more ACEs (which is recognised as a critical threshold for elevated risk).

In terms of childhood impact:

- Higher ACE exposure was found to have correlated with poorer educational outcomes, including increased school exclusions and special educational needs.
- Elevated ACE exposure was associated with higher rates of excessive alcohol consumption, previous year illicit drug use, smoking, and reduced physical activity, all contributing to long-term health difficulties.

Adults with 4+ ACEs were found to be 5 times more likely to report chronic health issues, 14.8 times more likely to experience PTSD, and nearly 10 times more likely to have a diagnosed mental health condition.

## 2.4 Conclusion

The KidsRights Index provides an accessible, general, and comparative overview of State performance on selected children's rights. It ranks the performance records of state parties to the UNCRC in relation to the most fundamental aspects of children's lives where there is available global and comparable data. The Index scores for five "Domains", including assessing how states are positioned in creating the conditions needed for the realisation of children's rights, and/or for the design and delivery of children's rights policies.

<sup>110</sup> Black, L.A. (23 March 2021. "Mental ill health and substance misuse: Dual Diagnosis" NI Assembly Research and Information Service Research Paper at page 7.

<sup>111</sup> See Safeguarding Board for NI. "What are ACES?"

The assessment of the UK was concerning, raising questions as to the environment for the effective realisation of children’s rights at a time of pressing mental health challenges increasing in their scale and complexity. In the overall Global ranks for 2025, which consider multiple ‘domains’ of children’s rights and health, the UK was placed 130 out of 194 countries, and in last place in the ranking for Western Europe. Whilst it cannot be ascertained precisely as to the role played by each UK jurisdiction towards these findings, it can be concluded that there are difficulties and challenges within and across the UK in respect of creating and maintaining those conditions needed for the full realisation of children’s rights, and/or for the design and delivery of children’s rights policies, and this evidently extends to NI.

Addressing the mental health conditions of children and young people and meeting the needs of those young people at risk of poor mental health is critical. The consequences of failing to do so extend to adulthood, impairing both physical and mental health, and limiting opportunities to lead fulfilling lives as adults. Service providers in the HSCTs, and in the community and voluntary sector, are trying to deliver evidence-based mental health services in NI. However, the demand continues to increase, and issues of data, planning, and strategic design and delivery persist. The role of disaggregated, basic operational data required to efficiently plan, commission, and deliver CAMHS, as well as design and implement key strategic policy interventions is paramount – and a fundamental pillar of the human rights-based approach to child health.

**NICCY recommends:**

- 1. The Department, in conjunction with the Public Health Agency, review and clarify its adopted definition of “early intervention” within children and young people’s mental health policy. This review should be grounded on the principle that early intervention is recognised as a lifelong approach - which covers infancy, early childhood, school-based supports and community provision, as well as specialist services. This principle should be embedded within the development of mental health policy including the Early Intervention and Prevention Action Plan, as well as associated funding allocation and workforce design. Public health messaging should also adopt this principle to better address the scale and complexity of mental health and wellbeing issues faced by children and young people.**
- 2. Recognising the need for improvements in the accessibility and quality of disaggregated, basic operational mental health data, the Department and the SPPG should undertake and publish a review of the rollout of the Encompass system and illustrate the progress made towards the standardisation of data collected and utilised by HSCTs for the purposes of planning, commissioning, and delivering CAMHS.**
- 3. The Department examines the potential for a mental health dashboard, as considered by the Scottish Government’s commitment, which is grounded on performance, targets, and indicators.**
- 4. Understanding the mental health landscape for children and young people in NI, that the Department, in conjunction with relevant authorities and stakeholders, commits to developing a mechanism to build capacity and facilitate engagement with children and young people on an ongoing basis, ensuring delivery is based on actual need not presumed need. This mechanism should be designed in**

**accordance with a child rights-model of participation such as the Lundy Model and should reflect the Participation Principles as agreed by all Government Departments.**

- 5. The Department and the SPPG commit to ensuring that child- and young person-friendly, accessible information is made publicly available in order to engage young people in an effective and meaningful way on mental health policy and service planning.**

## 3. The Children’s Rights Framework

### 3.1 Introduction

There has not been any specific, clear understanding as to the application of the right to health within the context of emotional health, wellbeing, and mental health of children and young people, including within delivery of public services within key strategic documents governing the design and delivery of mental health services in NI to date.<sup>112</sup> Understanding of subsequent responsibilities upon government and relevant statutory authorities and agencies to recognise, protect, and promote the child’s right to health, or any identified commitments proposing how to deliver on such responsibilities appears limited. This is a glaring omission, not least because the NI Executive’s Children and Young People’s Strategy 2020-2030 (“the CYPS”) specifically recognises Articles 23 and 24 of the UNCRC.<sup>113</sup> Within the CYPS, the Department is clearly identified as a key authority for the purposes of progressing and achieving the outcome, “Children and young people are physically and mentally healthy”. The CYPS indicates the advancement of outcomes relating to child health, including mental health, is underpinned by the standards associated with the child’s right to health as outlined at Article 24 of the UNCRC. However, the acknowledgement of the requirement to give effect to the Department’s role under the CYPS has been limited: for example, the Department initially did not recognise it as a policy with bearing on its assessment in producing the Equality Impact Assessment for the 2024/2025 Departmental Budget.<sup>114</sup>

That the vision encapsulated by the CYPS has not yet been advanced is disappointing; it is also detrimental to the design and delivery of children and young people’s mental health services. Without full consideration as to the scale of the international human rights dimensions or incorporating relevant human rights standards and norms within key strategies that are identified as specific drivers of change within mental health services in NI, implementing the other actions of such strategies will be inadequate and unsustainable, with cost implications in the long-term. A child’s right to health is intrinsically connected to the principles of protection, promotion, and participation within healthcare services, and strategic frameworks for the design and delivery of mental health services in NI should serve as a foundational pillar for the future systematic approach to supporting the mental health of children and young people.

Challenges to and barriers within children’s health in NI are grounded in social and environmental determinants. The UNCRC clearly outlines the rights and standards required to

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<sup>112</sup> There is no reference to the right to health, including the child’s right to health, within the Mental Health Strategy or any of its associated documents, nor is there any reference within the Department of Health’s Transformation Agenda document series; see Department of Health. (2016). “Health and Wellbeing 2026 – Delivering Together 2026.”; Department of Health. (10 December 2024). “Health and Social Care NI A three year plan to: stabilise reform deliver”.; and Department of Health. (June 2025). “Health and Social Care NI Reset Plan”. Further, there is also no reference made to the child’s right to health within the Department’s draft Emotional Health and Wellbeing Framework; see Department of Health. (2025). “Children and Young People’s Emotional Health and Wellbeing Framework Consultation Draft May 2025”.

<sup>113</sup> See the Executive Office. (2020). *Children & Young People’s Strategy 2020-2030*. At page 10.

<sup>114</sup> See Department of Health. (2024). Equality Impact Assessment of the 2024-25 Budget Outcome. NICCY had advised the Department it had failed to identify the 2020 Strategy within paragraph 2.4 as a policy with bearing on its assessment; see NICCY. (2024). “Advice on the Department of Health Budget EQIA 2024-2025”.

address these civil-political, social, economic and cultural determinants of child well-being. The principles of child rights – universality, interdependence and accountability - define the tenets of the social justice and health equity required to ensure all rights are accessible to all children, and the responsibilities and accountability of individuals and organisations to ensure these rights are fulfilled. The UNCRC and child rights principles, then, collectively establish the structure and function of a child rights-based approach (“the CRBA”) to child health and well-being. The CRBA provides the ideals, strategies, and tools to radically transform child health practice into a rights, justice, and equity-based paradigm.

### 3.2 The Child’s Rights Framework

Within both the theory and practice of international human rights law, it is an accepted principle that the interdependence and equal importance of children’s rights across all categories (civil, political, economic, social and cultural) is that which enables all children and young people to develop their mental and physical abilities, personalities, talents, and agency, to the fullest extent possible.<sup>115</sup> It is therefore critical that *all children’s rights* are collectively recognised, protected, and promoted across public services to actively support, protect, and promote the mental health of all infants, children, and young people.

Article 24 of the UNCRC affirms every child has the right to the highest attainable standard of health, including accessing and using appropriate support and treatment within the mental health. This “highest attainable” standard clearly recognises and affirms that good health is an *indispensable precondition* for the realisation of the child’s enjoyment of life and full development, and the enjoyment of all other rights. Health is central to human well-being, dignity, and agency and its protection is recognised as being central to human rights law.<sup>116</sup> Article 24 has evolved since the UNCRC’s ratification, with recent General Comments and Concluding Observations of the UN Committee having emphasised its significance not only in the context of physical health, but also for “new morbidities” related to mental health and emotional well-being. In addition, the UN Committee has endorsed the respect, protect, and fulfil typology that the right to health imposes - obligations to ensure that States do not violate the child’s right to health, take measures to fulfil health rights through provision of services as well as preventing third parties violating the right to health.<sup>117</sup>

Article 24 cannot be understood only within the framing of narrow bio-medical terminology, or limited to physical delivery of health services.<sup>118</sup> It instead actively recognises and understands the wider social and economic factors that influence and impact on the child’s state of health,

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<sup>115</sup> UN Committee on the Rights of the Child. (2013). General comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), at para 7.

<sup>116</sup> See Chapman, A. (1998). ‘Conceptualising the Right to Health: A Violation Approach’ 65 *Tennessee Law Review* 389, 393.

<sup>117</sup> UN Committee on the Rights of the Child. (2013). General comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health (art. 24) at para 71.

<sup>118</sup> See Whalen, C. (2022). “Article 24: The Right to Health.” in Vaghri, Z., Zermatten, J., Lansdown, G., Ruggiero, R. (eds) *Monitoring State Compliance with the UN Convention on the Rights of the Child. Children’s Well-Being: Indicators and Research*, vol 25. (Springer, Cham).

and the importance of incorporating this understanding into public policy, planning, design and delivery of mental health services.<sup>119</sup>

The right to health is an *inclusive right* which extends to the child’s right to grow and develop to their full potential and live in conditions that enable them to attain the highest standard of health.<sup>120</sup> This is particularly critical for young people undergoing adolescence, experiencing rapid physical, cognitive and social changes, and new challenges to health and development, as identified by the UN Committee.<sup>121</sup> The importance of the creation of a safe and supportive environment which is both underpinned by, and an advocate of, children’s rights across public services is recognised as a State obligation.

The child’s right to health can therefore be considered a prime example of the interrelatedness of child rights, as it is contingent upon and informed by the realisation of many other children’s rights and general principles as outlined within relevant Articles of the UNCRC. The effects of reading these general principles in conjunction with Article 24 are outlined below.

Article	Principle	Applying Article 24
2	<i>Non-discrimination</i>	Recognises the child’s right to health: <ul style="list-style-type: none"> <li>• Can often be comprised or restricted if they have a minority status, and/or through experiencing direct or indirect discrimination in healthcare services;</li> <li>• The obligation to ensure equal access to, and use of, healthcare services requires that specific measures are taken to reach and support children in vulnerable sectors, such as infants, children with disabilities, children in remote or rural areas, living in poverty, or in institutionalised care, as well as children with minority gender identities or sexual orientations; and</li> <li>• Providing healthcare services in multilingual and multi-ethnic states also requires accommodations to ensure that healthcare services, including proper instructions to consent to care and for post-discharge care, can be properly administered. International standards further highlight the harm of gender-based discrimination.</li> </ul>
3	<i>Best interests of the child</i>	<ul style="list-style-type: none"> <li>• A requirement for an inclusive and holistic rights-based approach that goes beyond a purely medical framework;<sup>122</sup></li> <li>• The determination of a child’s best interests needs to be based upon, “their physical, emotional, social and educational needs, age, sex, relationship with parents</li> </ul>

<sup>119</sup> See Tobin, J. (2019). “Article 24: The Right to health” in Tobin J. (ed.), *The UN convention on the rights of the child: A commentary* (Oxford University Press, Oxford) at pages 902–969.

<sup>120</sup> UN Committee on the Rights of the Child. (2013). General comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), at para 2.

<sup>121</sup> UN Committee on the Rights of the Child. (2003). General comment No. 4 on Adolescent Health and Development in the Context of the Convention on the Rights of the Child.

<sup>122</sup> Kilkelly, U. (2015). “Health and children’s rights” in Vandenhoe, W., Desmet, E., Reynaert, D., Lembrechts, S. (eds) *Routledge international handbook of children’s rights studies* (Routledge, London) at pages 216–233.

		<p>and caregivers, and their family and social background, and after having heard their views according to Article 12”;<sup>123</sup> and</p> <ul style="list-style-type: none"> <li>• A child’s best interests must guide decision-making in policy matters, as well as in individual case plans; it should be a primary consideration and supersede economic considerations.</li> </ul>
6	<i>Right to survival and development to the maximum extent possible</i>	<ul style="list-style-type: none"> <li>• That children are entitled to a standard of health that is commensurate with their healthy development;</li> <li>• A requirement to commit to child rights, in conjunction with a public health and social determinants approach, which includes “individual factors such as age, sex, educational attainment, socio-economic status and domicile; determinants at work in the immediate environment of families, peers, teachers and service providers, notably the violence that threatens the life and survival of children as part of their immediate environment; and structural determinants, including policies, administrative structures and systems, social and cultural values and norms”;<sup>124</sup> and</li> <li>• Supporting health policy in relation to all matters addressing infant mortality, including maternal health in the perinatal period and parental health behaviours.<sup>125</sup></li> </ul>
12	<i>Right to express their views and to have them considered</i>	<ul style="list-style-type: none"> <li>• Recognises the importance of child participation in informing health service provision in individual cases, but equally important in informing the development of health policy;</li> <li>• The need to consider the views and experiences of children and young people on the broadest range of health policy matters, and that this should include “what services are needed, how and where they are best provided, barriers to accessing or using services, the quality of the services and the attitudes of health professionals, how to strengthen children’s capacities to take increasing levels of responsibility for their own health and development, and how to involve them more effectively in the provision of services, as peer educators”;<sup>126</sup></li> <li>• The age of consent to medical treatment is not determinative of the duty upon health care providers to consult young patients, in respect of information or understanding about their treatment; and</li> <li>• Children’s evolving capacities have a bearing on their independent decision-making on their health issues, but</li> </ul>

<sup>123</sup> UN Committee on the Rights of the Child. (2013). General comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), at para 12.

<sup>124</sup> At para 17.

<sup>125</sup> See above, at para 18.

<sup>126</sup> UN Committee on the Rights of the Child. (2013). General comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), at para 19.

		equally some children may be provided fewer opportunities to exercise autonomy in various health care decisions. <sup>127</sup>
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When these relevant principles are taken collectively, a rights-based approach to health therefore perceives health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.<sup>128</sup> The highest attainable standard of health for any child shall consider the child’s own biological, social, cultural, and economic preconditions, as well as the State’s available resources, supplemented by all available sources.<sup>129</sup> The UN Committee has stated that this must be achieved by programmes that address the underlying determinants of health, thus promoting a preventive model of healthcare.<sup>130</sup>

Healthcare services should therefore include prevention, promotion, treatment, rehabilitation, and palliative care services. These should be available to every child at the primary care level, while secondary and tertiary care services should be available to the extent possible, consistent with progressive realisation. Substantial investment in the development of healthcare staff to support services at all levels of care is essential. Moreover, recourse to challenge any denial of access, or delay in access, to such services, alongside educational and administrative efforts to ensure access to remedies, must be available. Ensuring the right to access to healthcare requires working with parents, carers, and communities to create an environment and knowledge base around how to seek appropriate care.<sup>131</sup> It also requires the provision of adequate consent-based management systems for parents, carers, and competent children, and the removal of any and all financial, cultural, and institutional barriers to care.<sup>132</sup>

### 3.3 Monitoring of rights

As demonstrated within General Comment No. 4, State Parties must take all appropriate legislative, administrative and other measures for the realisation and monitoring of the rights of young people to health and development, including safeguarding their mental health.<sup>133</sup> As highlighted in the previous chapter, these actions should include the systematic collection, collation, and analysis of desegregated data so that thorough monitoring of the health and development of adolescents can be undertaken, including future review and design of relevant policy frameworks on an evidence-based approach. It is an accepted international standard that States should adopt data-collection mechanisms that allow desegregation by sex, age,

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<sup>127</sup> At para 21.

<sup>128</sup> Noted with the Preamble to the Constitution of the World Health Organization, and quoted within in UN Committee on the Rights of the Child (2013) General comment No. 15 at para 4.

<sup>129</sup> UN Committee on the Rights of the Child. (2003). General comment No. 4 on Adolescent Health and Development in the Context of the Convention on the Rights of the Child, at para 23.

<sup>130</sup> At para 2.

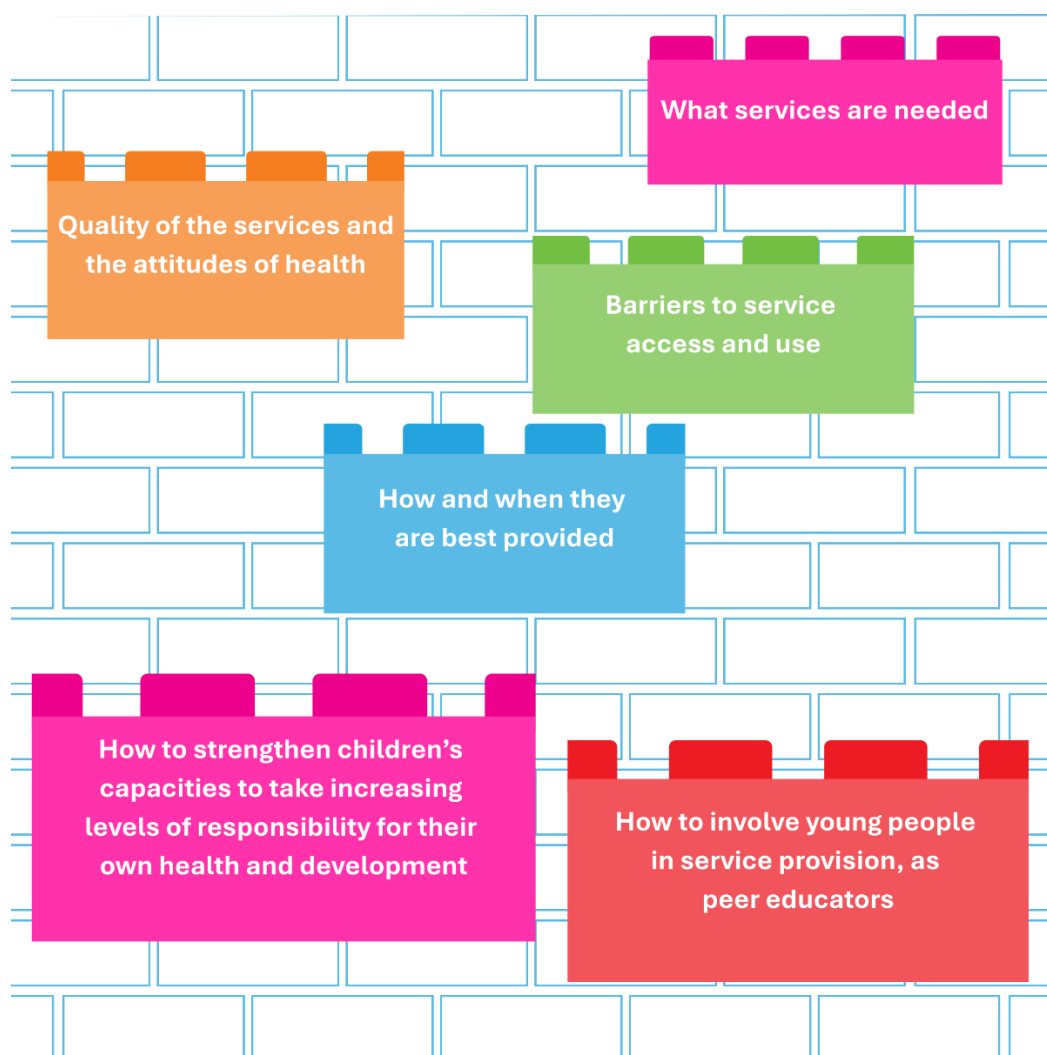
<sup>131</sup> See Whalen, C. (2022). “Article 24: The Right to Health.” in Vaghri, Z., Zermatten, J., Lansdown, G., Ruggiero, R. (eds) *Monitoring State Compliance with the UN Convention on the Rights of the Child. Children’s Well-Being: Indicators and Research*, vol 25. (Springer, Cham).

<sup>132</sup> UN Committee on the Rights of the Child. (2003). General comment No. 4 on Adolescent Health and Development in the Context of the Convention on the Rights of the Child, at para 23-31.

<sup>133</sup> See above at para 35.

origin and socio-economic status, as well as collection of data relevant to specific groups such as ethnic and/or indigenous minorities, migrant or refugee adolescents, adolescents with disabilities, and working adolescents.<sup>134</sup>

Availability, Accessibility, Acceptability, and Quality are the international norms for the provision of healthcare for children and young people.<sup>135</sup> The characteristics of participation and accountability are also present, which are critical within the context of the design and delivery of services and supports for children and young people.<sup>136</sup> In the context of mental health services in NI, participation means the active, consistent seeking of the views and experiences of children and young people on all aspects of emotional health, wellbeing, and mental health provisions in an effective, meaningful, and sustained manner. International standards have outlined that this should include:



<sup>134</sup> UN Committee on the Rights of the Child. (2003). General comment No. 4 (2003) on Adolescent Health and Development in the Context of the Convention on the Rights of the Child, at para 9.

<sup>135</sup> See above at para 37.

<sup>136</sup> See Hall, P. (2008). "The right to health and accountability" *The Lancet*, Volume 372, Issue 9644, 1150; see also Stålberg, A., Söderbäck, M., Kerstis, B., Harder, M., Widarsson, M., *et al.* (2024). "Children's Right to Health through the Principles of Protection, Promotion, and Participation, from the Perspectives for Children, Parents, and Professionals: A Systematic Review". *Child Care in Practice*, 30(4), 537–572.

The UN Committee has also drawn particular attention to the challenges faced by young people in accessing healthcare services, which are rarely designed to accommodate their needs.<sup>137</sup> As such, when undertaking monitoring of the rights of young people to health and development, it is important for government and statutory authorities to recognise that the very healthcare structures and systems may pose the clearest significant barrier to the full exercise and enjoyment of the right to health. States Parties therefore have been urged to invest in a collaborative approach to analysis of young people’s specific needs to inform health policies, strategies, and services.

### 3.4 Childs Rights-Based Approach

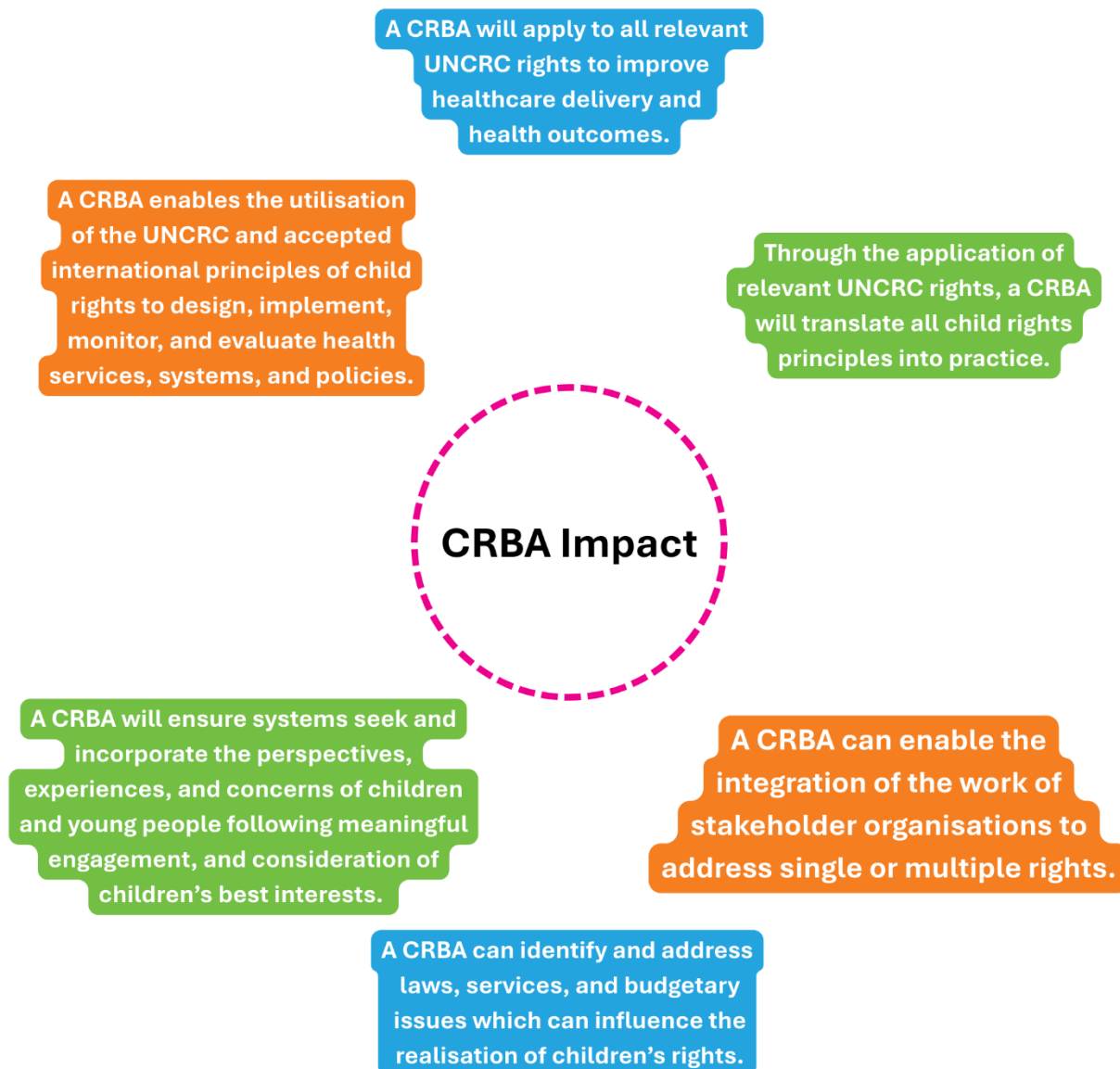
A CRBA to health and well-being is grounded on active realisation and promotion of children’s civil-political, social, economic and cultural rights by fulfilling their right to healthcare. This approach translates the UNCRC into practice in clinical services and public health programmes, systems development and policy formulation.<sup>138</sup> In this process, children are identified as “rights-holders” with corresponding entitlements. Those responsible to fulfil these entitlements are deemed as “duty-bearers” with obligations for which they are accountable. When applied to the design and delivery of services, systems, and policy, this approach enables a clear and direct shift in the perception of children as passive subjects of adult protection towards being active subjects of rights, with corresponding entitlements to having their needs met, and their best interests protected.<sup>139</sup> The significant impact of a CRIA within policy planning is outlined below:

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<sup>137</sup> UN Committee on the Rights of the Child. (2016). General Comment No. 20 on the implementation of the rights of the child during adolescence, at para 56-57.

<sup>138</sup> Goldhagen J, Clarke A, Dixon P, *et al.* (2020). “Thirtieth anniversary of the UN Convention on the Rights of the Child: advancing a child rights-based approach to child health and well-being.” *BMJ Paediatr Open*. 12;4(1).

<sup>139</sup> For contemporary examples, see: Save the Children. (2009). *Child Survival Campaign Legislative Frameworks for child survival*. (Freshfields Bruckhaus Deringer, London); World Health Organization. (2017). “Children’s rights in hospital: Rapid-assessment checklists. Copenhagen, Denmark: World Health Organization”; (2015). “Children’s rights in primary health care series. Copenhagen, Denmark: World Health Organization.”; (2014). *Reproductive, maternal, newborn and child health and human rights: a toolbox for examining laws, regulations and policies*. (World Health Organization, Geneva, Switzerland); Human Early Learning Partnership. (2012). *Early childhood rights indicators. A guide for monitoring the convention on the rights of the child*.



The CRBA can enable the design of informative recommendations grounded in the relevant standards of UNCRC. In September 2025, the European Network of Ombudspersons for Children (“ENOC”) published its Policy Position statement on “Protecting and Promoting Children's Right to Physical Health” which outlines recommendations to State governments and relevant authorities.<sup>140</sup> These recommendations made reference to the linkage between mental health and broader health obligations, and confirmed the importance of a CRBA in the context of the implementation of Article 24.

The practice of a CBRA recognises the child’s voice and agency to state their opinions and preferences, including a right to be consulted and, when sufficiently mature, to participate in the decisions that impact their health and wellbeing. This shift requires health providers and

<sup>140</sup> ENOC. (2025). *ENOC Policy Position statement on "Protecting and Promoting Children's Right to Physical Health"*.

parents to identify effective means of engaging with children and young people according to their specific developmental stages.<sup>141</sup>

Despite active participation being a fundamental right for children, it has been found that they are not always involved in decision-making processes during their healthcare - a child can express needs and opinions, yet decisions about their treatment are usually made either by healthcare professionals and/or and parents only.<sup>142</sup> A CBRA ensures the recognition of the child as a subject with rights, and capable of participation within decision-making.

### 3.5 Child Public Health Action

The concept of child health has evolved over recent decades, transitioning from a definition of health as the absence of disease and disability to a more encompassing, sophisticated understanding of how a combination of many factors leads to a healthy childhood, and to producing the support systems for enabling a healthy lifetime.<sup>143</sup> It has also evolved to recognise the importance of intervention and prevention, including through ensuring adequate care and support pathways are operational and accessible. This is relevant within the mental health sphere, particularly if we understand mental health as a complex and dynamic process within children and young people's development.

Children's health is impacted by a variety of continuously evolving factors, including new health problems and changing priorities. This includes pandemics, but also wider social factors such as poverty, and the prolonged financial and economic stress for example, the pressures experienced during and post- the COVID-19 pandemic.<sup>144</sup> Our understanding of "health" and "public health" has shifted, with many definitions of what constitutes "public health" lacking contemporary relevance.<sup>145</sup> This has been revisited following the COVID-19 pandemic, and increasing awareness of the impact of climate and environmental change, raising questions as to reactive responses and policymaking. Whilst this encourages shifting attitudes towards public health definitions, this equally should prompt changes in policymaking and planning within public health policy.<sup>146</sup>

Further, this should entail consideration of child public health, and more specifically child public health action ("CPHA"). This requires consideration of determinants of health and wellbeing, underlying factors of health crises, and impact upon children and their physical,

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<sup>141</sup> See Schalkers, I., Parsons C., Bunders J., and Dedding, C. (2016). "Health professionals' perspectives on children's and young people's participation in health care: a qualitative multihospital study". 25:7-8 *Journal of Clinical Nursing*.

<sup>142</sup> Quaye, A., Coyne, I., Söderbäck, M., and Kristensson Hallström, I. (2019). "Children's active participation in decision-making processes during hospitalisation: An observational study". 28:23-24 *Journal of Clinical Nursing*.; Bessell, S. (2011). "Participation in decision-making in out-of-home care in Australia: What do young people say?" 33(4) *Children and Youth Services Review* 496–501.

<sup>143</sup> Stein, R.E.K.(2024). "Defining child health in the 21st century." 96 *Pediatr Res* 1438–1444.

<sup>144</sup> UN Committee on the Rights of the Child. (2013). General comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)', at para 5.

<sup>145</sup> Mold A, Clark P, Millward G, Payling D. (2019). "The public and public health" in *Placing the public in public health in post-war Britain, 1948–2012*. (Springer International Publishing, Cham); Azari R, Borisch B. (2023). "What is public health? a scoping review". *Arch Public Health*.

<sup>146</sup> See Pan-American Health Organisation (2002). *Public health in the Americas: conceptual renewal, performance assessment, and bases for action*. (Washington, DC).

behavioural, and emotional development, with evidence-based action undertaken by relevant departments and agencies to protect and promote child health. This can be defined as:<sup>147</sup>



### 3.6 Staffing and workforce capacity

Article 24 and its requirement for the provision of and access to facilities, also recognises the importance of staffing and workforce capacity. The UN Committee acknowledges that to ensure the protection and promotion of the right to health for children and young people, States Parties should ensure an appropriately trained workforce of sufficient size.<sup>148</sup> This extends beyond operational health services and structures into provision within schools, requiring workforce capacity is sufficient within educational settings. Strategic implementation plans are required across all levels of government, to ensure that evidence-based practice is sustainable in the longer term. Enhancing the capacity of the workforce is a critical component of these endeavours to close the research – practice implementation gap, and address current challenges including inequalities and the social determinants of mental health.<sup>149</sup>

Moreover, how healthcare professionals *understand* and *adhere* to children’s rights within their practice is a vital pillar in the daily recognition, protection, and promotion of children’s rights, particularly the right to health. Treating children with dignity and respect, appreciating their

<sup>147</sup> Cresswell, T. (2004). “What is child public health?” *Current Paediatrics* Volume 14, Issue 7, 612 – 618.

<sup>148</sup> UN Committee on the Rights of the Child. (2013). General comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), at para 27; see also para 36 which explains, “in all cases effective health systems will be required, including: a robust financing mechanism; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; well-maintained facilities and logistics systems to deliver quality medicines and technologies; and strong leadership and governance.”

<sup>149</sup> Reupert, A. (2018). “Enhancing workforce capacity in mental health promotion, prevention and early intervention”. *Advances in Mental Health* 16(1), 1–4.

competence, and supporting their choices are critical in contemporary healthcare; the participation of children in the healthcare context however is rarely enabled in practice.<sup>150</sup>

There are significant barriers to the implementation of children's rights within healthcare which may arise due to limited understanding of how to implement and uphold children's rights in practice.<sup>151</sup> As healthcare professionals hold the responsibility of advocating for children's rights, ensuring their active involvement in decision-making processes, and providing guidance within the healthcare system, a better understanding of children's rights is needed to ensure the implementation of these rights into practice. Obtaining and incorporating of children's perspectives and preferences within healthcare settings is essential, however children will often not be able to participate in their healthcare decisions as much as they desire, despite having the legal right to express their views freely.

Despite recognising the value of engaging with children, healthcare professionals may not always seek or acknowledge children's perspectives because of:

- doubts about children's understanding;
- time constraints;
- parental dominance in consultations;
- lack of training;
- institutional barriers; and
- fears of disrupting the consultation process.

There is a demonstrable need for the development of a mechanism able to monitor changes in the perception and understanding of children's rights in healthcare environments to gauge implementation of children's rights, as efforts to increase awareness become more widely recognised. This is particularly acute in the context of mental health crisis. There is evidence to demonstrate that Emergency Department landscapes in NI currently do not ensure a child rights-based approach for children and young people experiencing mental health crisis. The Regulation and Quality Improvement Authority ("the RQIA") in its 2022 inspection report of the Royal Belfast Hospital for Sick Children identified a number of pressing issues regarding the treatment of children and young people with self-harm, suicidal ideation etc.<sup>152</sup> This included:

- the Emergency Department lacking sufficient space to treat children and young people presenting with self-harm or who have suicidal ideation;

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<sup>150</sup> Coyne L, Harder M. (2011). "Children's participation in decision-making: balancing protection with shared decision-making using a situational perspective". *J Child Health Care*.15(4):312–9; Virkki, M. Tolonen TH, Koskimaa, T., and Paavilainen, E. (2014). "Children as decision-makers in health care - an integrative review". *Clinical Nursing Studies*.

<sup>151</sup> Alshammari, S.M., Linden, M.A., Kerr, H. *et al.* (2025). "Healthcare professionals' understanding of children's rights: a systematic review of the empirical evidence-base". *Syst Rev* 14, 9; Lundberg, V., Eriksson, C., Lind, T., *et al.* (2021). "How children with juvenile idiopathic arthritis view participation and communication in healthcare encounters: a qualitative study." *Pediatric Rheumatology*; Coyne I. (2008). "Children's participation in consultations and decision-making at health service level: a review of the literature." *Int J Nurs Stud*. 45(11):1682-9; Paul, M. (2004). "Decision-making about children's mental health care: ethical challenges." *Advances in Psychiatric Treatment*. 10(4):301-311; Yigitbas C, Top Fu. (2020). "The implementation of child rights in healthcare services." *Nurs Ethics*. 27(7):1517–28.

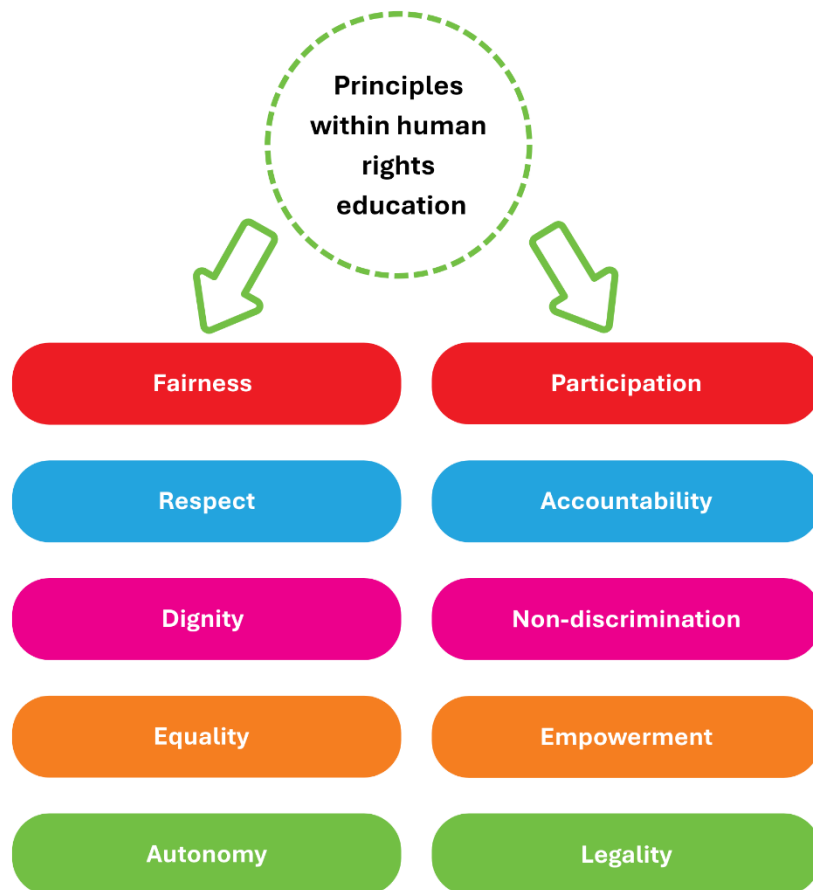
<sup>152</sup> RQIA. (August 2022). "Inspection Report 18 August 2022. Belfast Health & Social Care Trust."

- the lack of an available ligature free room to assess children and young people presenting with acute mental health disturbance;
- patients presenting with complex/ special and sensory needs having no suitable space (quiet and uncrowded area) to wait and instead being made to wait in busy and/or loud areas that might exacerbate their conditions/ behaviours; and
- conditions which can cause anxiety for children and young people, and their families.

The workplace environment as an extension of workforce capacity is therefore vital to be designed and implemented in a manner which practices and promotes children’s rights.

### 3.7 Human Rights Education

Human rights education is twofold: in patient care practice, it refers to “human rights in patient care” or human rights as applied for the benefit of patients.<sup>153</sup> When incorporated into healthcare approaches, it entails the practice and realisation of key principles, outlined below:



Increasing awareness of human rights and its application within healthcare has enabled the recognition of the important role of human rights-based approaches (“HRBAs”) for children’s health. This is important in understanding barriers to accessing help, as research

<sup>153</sup> Cohen J, Ezer T. (2013). “Human rights in patient care: a theoretical and practical framework.” *Health Hum Rights* 15(2): 7–19.

demonstrates mental health disorders in children and young people are highly prevalent, yet undertreated.<sup>154</sup> There is also a complex variety of internal and external factors that determine whether they will seek and access help for mental health.<sup>155</sup> Equally apparent is the need for educational awareness for children and young people, including evidence-based interventions to reduce perceived public stigma; improve young people's knowledge of mental health problems and available support, including what to expect from professionals and services; and improving knowledge and awareness of children's rights, both among healthcare professionals and children and young people themselves.

In Scotland, a children's HRBA was utilised to examine the impact of the legislative and policy measures that were implemented in response to the COVID-19 pandemic on children's rights related to their mental health.<sup>156</sup> Three key concerns were identified around children's rights to access mental health services and information, participation in decision-making and non-discrimination of vulnerable groups:

1. Given reports of increased worries about mental health among young people, there is strong potential for increased demand for children's mental health services as they face challenges related to staffing, funding, and social distancing. This raises concern as to the accessibility of mental health services, and thus, the protection and promotion of the child's right to health in the context of mental health support.
2. As there are some groups of young people who are particularly at risk of not having their mental health-related rights met, and that this inequality of risk is likely to continue into the future, it is necessary to identify, communicate with and support young people who have been particularly affected by the crisis. This raises concerns as to ensuring levels of awareness of children's rights among healthcare professionals, as well as children and young people themselves, understanding that they should be engaged and participate within their mental health care.
3. There must be ongoing engagement with young people around decisions that will affect their lives and their mental health.

Participation in decision-making, then, is not only an intrinsic right to be met but also a key protective factor for young people's mental health and development. It is vital to involve young people in decisions about their mental health to ensure that their rights are met, and because future measures and services are likely to be more effective if they are more suited to young people's expressed needs; it is equally important young people are informed as to their right to be involved and to be heard, and to understand they should be empowered to exercise this

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<sup>154</sup> Radez, J., Reardon, T., Creswell, C. *et al.* (2021). "Why do children and adolescents (not) seek and access professional help for their mental health problems? A systematic review of quantitative and qualitative studies." *Eur Child Adolesc Psychiatry* 30, 183–211.

<sup>155</sup> A majority of studies undertaken within a research project discovered there were barriers related to young people's individual factors, such as limited mental health knowledge and broader perceptions of help-seeking; social factors such as perceived social stigma and embarrassment; and young people's perceptions of the therapeutic relationship with professionals; see Radez, J., Reardon, T., Creswell, C. *et al.* (2021). "Why do children and adolescents (not) seek and access professional help for their mental health problems? A systematic review of quantitative and qualitative studies." *Eur Child Adolesc Psychiatry* 30, 183–211.

<sup>156</sup> See McMellon, C., and MacLachlan, A. (2021). "Young People's Rights and Mental Health During a Pandemic: An Analysis of the Impact of Emergency Legislation in Scotland." *YOUNG*, 29(4\_suppl), S11-S34.

right within mental healthcare contexts.<sup>157</sup> Evidence demonstrates the importance of ensuring children and young people are aware of their rights within the healthcare system, and particularly in the context of seeking access and/or use of mental health healthcare.<sup>158</sup> Enhancing patients' rights and enabling effective communication arguably enables the promoting of people-centred care; improving patients' satisfaction of care outcomes, increasing utilisation of care services, and empowering individuals and families to self-advocate for their health.<sup>159</sup>

### 3.8 Financial resourcing

To fully recognise, protect, and promote Article 24, it is important to provide adequate financial resourcing and investment in strategies, public health initiatives, and services. This is vital for the effective delivery of strategic frameworks given their scope across various state authorities and agencies, and the requirement for collaboration across same.

The conceptualisation of the right to health generally clearly outlines that it is expected that State Parties will make every possible effort, within available resources, to realise the right to health and advance it without delay. States cannot justify a failure to respect and uphold their obligations under international law because of a lack of resources but rather must guarantee the right to health to the maximum of their available resources, even if these are under strain.<sup>160</sup>

The investment in public health within a rights-based framework can also enable positive changes to economic performance. Healthcare expenditure can result in better provision of health opportunities, which in turn can strengthen human capital and improve productivity, thereby contributing to economic performance.<sup>161</sup> Careful investment in various healthcare aspects can boost income, GDP, and productivity, and alleviate poverty.

In this context, the application of a CRBA within strategic decision-making including budgetary allocations is critical. This can be realised through the undertaking of Child Rights Impact Assessments ("CRIAs"), which ensure children's rights are fully considered in government decision-making. In recent years, NICCY has been concerned about the impact of budget cuts on vital children's services in NI. In 2023, the UNCRC Committee urged the UK State Party to:

*'Withdraw the 2023/24 budget for Northern Ireland and fully consider the Equality and human rights implications of a new budget, taking all possible Steps to mitigate any adverse impact on children's rights before issuing a Revised budget.'*<sup>162</sup>

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<sup>157</sup> Beresford P. (2019). "Public participation in health and social care: Exploring the co-production of knowledge." *Frontiers in Sociology*, 3(41).

<sup>158</sup> See Paul, M. (2004). "Decision-making about children's mental health care: ethical challenges." *Advances in Psychiatric Treatment*. 10(4):301-311.

<sup>159</sup> Kwame, A., Petrucka, P.M. (2022). "Universal healthcare coverage, patients' rights, and nurse-patient communication: a critical review of the evidence." *BMC Nurs* 21, 54.

<sup>160</sup> See for example as outlined in Office of the United Nations High Commissioner for Human Rights and the World Health Organisation, "The Right to Health Factsheet No 31".

<sup>161</sup> See Raghupathi, V. and Raghupathi, W. (2020). "Healthcare Expenditure and Economic Performance: Insights From the United States Data" *Frontiers in Public Health*.

<sup>162</sup> UN Committee on the Rights of the Child. (2023). "Concluding observations on the combined sixth and seventh periodic reports of the United Kingdom of Great Britain and Northern Ireland".

Given the continued budgetary constraints experienced across all NI Executive Departments, notably the Department of Health, it is essential that all departments and agencies undertake CRIAs to ensure that they have given due consideration as to how they will affect children and young people.

### **3.9 Conclusion**

Human rights provide a clear, standardised universal framework for the safeguarding and advancing of health within a social justice and equality approach. Adopting this framework within policy design in NI would enable a radical transformation from the current approach. Instead of viewing human rights as a burden creating further pressures, they should instead be acknowledged as crucial to public health policy interventions which utilise rationality, proportionality and accountability; construct public trust through transparency, education, and participation; and prioritise the safety and protection of vulnerable and marginalised populations, especially infants, children, and young people.

#### **NICCY recommends:**

- 6. The Department incorporates clear and direct reference to Article 24 of the UNCRC within future strategic documents governing the design and operation of children and young people’s mental health services. This should include clearly outlining how these Strategic documents provide for establishment and implementation of a rights-based approach to the design and delivery of children and young people’s mental health services.**
- 7. The Department should include child public health as a specific, individual category within its strategic policymaking, and should incorporate a Child Public Health Approach model which upholds children’s rights in public health awareness and prevention measures.**
- 8. The Department utilises the Childs’ Rights-Based Approach framework within the design and delivery of future strategic documents governing the design and operation of children and young people’s mental health services. This should include consideration of workforce capacity, resources, recruitment, retention, and safe working environments.**
- 9. The NI Executive incorporates a Childs’ Rights-Based Approach into its Departmental budgeting processes. This should include the undertaking of Child Rights Impact Assessments by all Departments and corresponding agencies in addition to EQIAs, to ensure that all due consideration as to how budgetary decisions will affect children and young people. This is especially critical in the context of continued budgetary pressures.**

## 4. Revisiting Still Waiting

### 4.1 Introduction

NICCY's 2018 Still Waiting Review aimed to assess the adequacy of mental health services and support for children and young people, utilising a children's rights framework. Central to this was enabling children and young people (and their parents and carers) to share their direct experiences of accessing, or trying to access, mental health services or support; identify barriers preventing children and young people accessing adequate support; highlight good practice and make recommendations for improving services. By examining the operation and process of CAMHS, with comparative analysis utilising rights-based standards, the report provided a detailed overview of its status and produced recommendations for service improvement.

The Still Waiting report was framed on the premise that data collection, including the use of targets and indicators, and the monitoring of same, is an important pillar for the protection and promotion of the health of infants, children and young people.<sup>163</sup> Still Waiting therefore sought to serve as a mechanism for the collection and collation of data relating to children and young people's mental health in NI, and further, to utilise such data for the purposes of future monitoring and assessment of service delivery.

Participation of children and young people and recording their lived experiences of healthcare services was important in identifying barriers and challenges faced by children and young people. It demonstrated that incorporating participation mechanisms can enable the recording of experiences as data and therefore develop measurable indicators which can inform decision-making in the design and delivery of services, to allow for future monitoring.

### 4.2 Role of Rights Based Statements and connection to participation

The Still Waiting report, recommendations, and subsequently, the SWAP utilised the incorporation of human rights-based indicators ("HRBI") to develop a comprehensive understanding of the status of mental health service provision, including within the context of intervention and prevention for children and young people.

Given that States bear an obligation to report periodically to human rights treaty bodies on their efforts to ensure compliance with international human rights law, indicators are seen to *give meaning* to human rights treaty monitoring: framing state reports in accordance with universal standards, supporting external scrutiny through 'shadow reports', and structuring state assessment.

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<sup>163</sup> The development of standard data and data collection processes can enable thorough comparisons and progress assessments over time, support the design and implementation of vital interventions and associated indicators for monitoring emerging priority areas such as child development, chronic conditions, disabilities, and injuries, and enable the implementation of key strategies to increase the uptake of data on child health to improve evidence-based planning, programming, and advocacy efforts. See Requejo, J., Strong, K., Agweyu, A., *et al.* (2022). "Measuring and monitoring child health and wellbeing: recommendations for tracking progress with a core set of indicators in the Sustainable Development Goals era." *Lancet Child Adolesc Health*. 6(5):345-352.

As outlined previously, the UN Committee has recommended the regular collection of comprehensive, disaggregated data on child mental health and develop strategies with clear time frames, targets, measureable indicators, monitoring mechanisms, and sufficient resources in the UK.<sup>164</sup> Adopting this, NICCY designed and implemented HRBIs to understand the practical, lived experiences of users of children and adolescent mental health services, identify particular issues of concern and inform the outcomes and recommendations of the report. This included HRBI incorporation into the Children and Young People’s survey as part of the investigation.

### 4.3 Findings

The Still Waiting report found that young people experienced issues within accessing and using mental health services:

When seeking early intervention and support, due to difficulties in accessing services; not feeling heard or taken seriously.

Not feeling involved in decision-making relating to their care and treatment.

Feeling they were referred and/or signposted across different services and supports without understanding why.

Feeling that their mental health needed to deteriorate before they would be seen and taken seriously.

It revealed a mental health system under significant pressure, finding it difficult to respond to both the scale of need and the complexity of issues children and young people are presenting with. Gaps were found in the collation of disaggregated, basic operational data required to efficiently plan, commission and deliver CAMHS. Services suffered from budgetary instability; the Review found that the core budget for children and young people’s mental health services has not changed significantly enough to meet its ambitions for system reform.

The Still Waiting report identified significant issues of chronic under-investment in mental health services; historical patterns of funding allocations which are not based on known mental health needs; and a very mixed experience from young people on the availability, accessibility and quality of services provided. Levels of mental health awareness and literacy across young people revealed a lack of awareness particularly among young people with a learning disability. Limited support was found to exist for young people (and their parents/carers) to develop awareness and literacy around emotional well-being and mental health, and age appropriate and effective ways to address stigma and fear around talking about

<sup>164</sup> CRC/C/GBR/CO/5. (12 July 2016). UN Committee on the Rights of the Child Concluding Observations on the Fifth Periodic Report of the UK of Great Britain and NI at para 60 (a) and (b).

emotional health and mental health distresses. The adoption of a consistent regional approach to educating children, and normalising conversations about mental health and emotional well-being were recommended as being the vital parts of a system in which prevention and early intervention are prioritised.

Key findings from the Children and Young People’s survey included:

The statement ‘I was given useful information to help me understand my mental health needs’ had an average rating of 49% and ‘I was given a choice of treatment/ support’ had an average rating of 40%.

The CVS scored much higher against the statements under the ‘information and access’ cluster than any of the other services: 80% of young people agreed the CVS gave useful information to help them understand their mental health needs and 67% agreed they were given a choice of treatment/support.

A&E and GP services scored lowest on the statement ‘I was given useful information to help me to understand my mental health needs’: 31% of young people agreed A&E had given them useful information, and only 35% agreed information from their GP was useful.

Generally, services rated higher on the statements ‘I felt listened to and respected’ (average score 57%) and ‘I was spoken to in a way that I could understand’ (73%), and considerably lower on the statements ‘I felt involved in the decisions that were being made about my care or treatment’ (42%) and ‘The support I received was helpful’ (49%).

It was, and remains, NICCY’s opinion that Still Waiting and its subsequent follow-up reports demonstrate the importance of understanding children and young people’s experiences of mental health services, and to incorporate HRBIs to both ensure the participation of young people, and that children’s rights are realised and upheld across the system and processes of CAHMS and support.

#### 4.4 Monitoring

50 recommendations across eight thematic areas were presented in the Still Waiting report. These required a system-wide response, with all relevant agencies and sectors needing to engage.

In October 2019, the Department on behalf of the Inter-Departmental Group (“the IDG”)<sup>165</sup> published the SWAP action plan for delivering on the recommendations. The IDG’s response outlined a classification approach, accepting 35 full and sub recommendations, accepting 18 full and sub recommendations “in principle”, and 11 classified as “still under consideration”, as outlined below.<sup>166</sup>

<sup>165</sup> The IDG consisted of representatives of the Department of Education, Justice and Communities, and the CVS.

<sup>166</sup> To access the SWAP as a downloadable document, please see NICCY. “Mental Health Review – Still Waiting”.

**35 full and sub recommendations were accepted.** These included:

- Designated mental health practitioners, trained to work with young people, to be attached to every GP surgery;
- Using fund mapping and needs analyses to map increases in spending on services over time;
- An online booking system for mental health appointments to give young people and their carers more control over the appointment time;
- Ensuring the availability of community based after care supports for young people after they are discharged from Community CAMHS or inpatient care;
- Crisis intervention support for children and young people being available 24 hours a day, all year round, in all Trusts; and
- A comprehensive and urgent review of community based emotional, mental and behavioural support services for young people with a learning disability.

**18 full and sub recommendations were accepted in principle.** This meant they were accepted subject to additional resources being found for their implementation. These included:

- A mandatory programme for mental health training for all professionals working with children and young people;
- The development of a long term, sustainable children and young people’s Mental Health Transformation Fund taking account of the investment required across all services and sectors in the Stepped Care Model;
- Statutory mental health professionals available to every primary and post primary school in NI; and
- Services which are currently not available in NI established, to ensure that children and young people receive mental health treatment close to their family, and not through Extra Contractual Referrals i.e. outside NI.

**11 recommendations were described as “still under consideration”.**

This included the recommendation for the full implementation of the CAMHS Dataset across each HSC region.

NICCY subsequently committed to monitoring the progression of Still Waiting and the SWAP, and between 2020 and 2023, published four monitoring reports which are summarised below.

#### *First monitoring report*

NICCY published its first monitoring report in February 2021. Commenting on the position of the IDG on the recommendations accepted in principle, NICCY recognised additional resources were required to fully implement some of these recommendations but asserted that in “most cases progress can still be made by changes to existing practice without the need for further resources”.<sup>167</sup>

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<sup>167</sup> NICCY. (February 2020). “Still Waiting Monitoring Report - Feb 2020”.

NICCY outlined an expectation that the relevant Departments/Agencies would bid for the additional resources needed to deliver on the recommendations. NICCY advised that it was critical that decisive action was taken to ensure that a sufficient and suitably qualified workforce was in place. Whilst recognising that the devolved institutions had recently been re-established, NICCY assessed the progress made on the SWAP actions, and expressed its view that there was a lack of detail, planning, and clarity in respect of delivery.<sup>168</sup> The lack of concrete timelines provided by the IDG made it difficult to assess what progress was being made. The report consensus, however, was that progress must be made in light of the findings of the Still Waiting report.

It was noted that the IDG and NICCY had previously agreed the focus areas were areas of: data and funding; referral pathways to include the role of the voluntary and community sector; improving the quality of care provided by A&E; and treatment of young people with mental health and drug or alcohol related problems. However, none of these areas had featured in the IDG's Progress Update Report. The monitoring report reiterated that data and funding were key priorities and expressed concern as to the uncertain funding status of relevant departments/agencies and the consequences for achieving full implementation of all recommendations. Particular concern was expressed about the ongoing lack of progress on the CAMHS dataset, including the lack of consistency in the data and the time lag before the data was available for publication.<sup>169</sup>

### *Second monitoring report*

The second monitoring report was published in February 2021. It was noted the COVID-19 pandemic was being prioritised by Government and consequently had impacted on the ability of the IDG to meet and progress actions within the SWAP.<sup>170</sup> The report advised the pandemic must be recognised in terms of its impact on mental health. The increased attention directed towards mental and emotional health across Departments between the first and second monitoring report was welcomed, but NICCY expressed concern as to the limitations for funding provision to mental health services, and the detrimental impact arising for progression of SWAP actions. It was argued that increased prominence given to mental health services needed to be accompanied by corresponding significant funding allocation.

Between the first and the second monitoring reports, there had been several key policy developments, including: the introduction of the Mental Health Action Plan featuring a plan on dealing with the response to COVID-1; the consultation on the then-proposed Mental Health Strategy; the planning towards the design of an Emotional Health and Wellbeing in Education Framework; and work undertaken towards advancing a Substance Misuse Strategy. NICCY recognised there were areas of overlap and commonality across the identified policy developments in respect to intentions and actions but noted it was important that these separate but related plans formed one integrated and coherent set of actions. NICCY was also

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<sup>168</sup> "Some of the proposed actions are vague and inadequate and many are subject to the relevant government department or agency securing funding to take them forward or to Ministerial sign-off. With regard to some of the actions, it is not yet clear whether Ministerial sign-off is required or not"; see NICCY. (February 2020). "Still Waiting Monitoring Report - Feb 2020".

<sup>169</sup> "We understand the data relating to the period to March 2019 will not be available for publication before January 2020 and this is clearly unacceptable." At page 12.

<sup>170</sup> NICCY. (February 2021). "Still Waiting- Implementation NICCY Progress Update Monitoring Report - Feb 2021".

concerned about the Department's focus on progressing the Still Waiting recommendations and the SWAP actions. The second monitoring report acknowledged reassurances had been provided by both the Department and the Minister of Health that both the Still Waiting report and the SWAP remained a priority.

Similar issues and concerns regarding the progression of SWAP actions around mental health data were outlined. NICCY welcomed the publication of the first prevalence survey on children and young people's mental health in October 2020, recognising it would address evidence base gaps for developing strategies. The commitment by the Department to utilise the survey's data to help inform the Mental Health Strategy was also welcomed. The report also acknowledged the work being undertaken to develop a standardised mental health database, but it did express concern about continued significant gaps between what was collected and what was publicly available.

Issues relating to progression of SWAP actions were acknowledged, such as the continued pressure on GP system to take the bulk of referrals; the non-progression of a system to track the movement of young people between services within the Stepped Care Model for CAMHS; no improvement in rates of non-attendance at appointments; continued use of A&E attendance for young people in mental health crisis; limited crisis support; troubling rates of anti-depressant prescribing; the percentage of young people discharged from CAMHS without having had their goals met; and the status of all actions relating to young people with additional needs.<sup>171</sup> As such, the assessment of progression of SWAP actions ultimately presented a mixed picture, mostly finding delayed progress.

### *Third monitoring report*

The third monitoring report was published in February 2022.<sup>172</sup> The ongoing impact of the COVID-19 pandemic, particularly upon public services, was recognised. However, when comparing actions undertaken between the second and third monitoring report, it was evident that limited progress had been achieved. The pandemic's impact on mental health was a significant public health issue and there was clear evidence that children and young people had been disproportionately affected.

Recognising that limited statistics on service activity were available, what was accessible painted a concerning picture. For example, it was reported there was a significant fall in waiting time figures for Step 3 CAMHS between March 2020 and March 2021: whilst in "normal times" this could indicate positive progress, in the context of the pandemic, there was a concern this was likely to be due to children with mental health needs not coming forward for support or having problems accessing support. Statistics illustrated an increase in referrals to CAMHS from Emergency Departments for mental health crisis presentation, and figures showed an upward trajectory in waiting times between March and November 2021. The report suggested the mental health system may be unable to meet the needs of children and young people and

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<sup>171</sup> Data found that referrals to CAMHS from A&E increased significantly between 2018/19 and 2019/20, from 27% to 42% and showed that approximately 40% of CYP discharged from CAMHS do so without their goals being achieved.

<sup>172</sup> NICCY. (February 2022). "Still Waiting- Implementation NICCY Progress Update Monitoring Report Feb 2022".

reaffirmed the importance of systemic reform and additional investment in services, particularly given increasing mental health need arising from the pandemic.

Concern was expressed about the lack of evidence indicating improved outcomes for children and young people, particularly children with additional needs. NICCY welcomed the planning work in the form of strategies and frameworks to improve much-needed pathways and support, but further found no clear evidence that support and outcomes for children had improved. NICCY also expressed its concern as regards the rates of anti-depressant prescribing.

In respect of the SWAP actions pertaining to mental health data collection, access, and use, the relevant Still Waiting report recommendation was considered “outstanding”. NICCY did acknowledge work being undertaken to integrate the CAMHS dataset into Encompass, and welcomed the commitment made by the Department to scope out options for sharing information captured by the CAMHS dataset shared publicly.

Ultimately, the report concluded that the human, technical and financial resource allocation needed to implement the SWAP fully remained unclear, and there was a requirement for a detailed fund mapping exercise to fully understand the gap between current investment and what is needed to ensure that children and young people have access to a comprehensive range of mental health services.

#### *Fourth monitoring report*

The fourth, and final, monitoring report was published in 2023.<sup>173</sup> It acknowledged that at the beginning of the final monitoring process, it became apparent progress was slow in some areas, and that many of the recommendations would not be complete by February 2023. As such, NICCY had focused on providing advice in respect of processes and/or structures to support long-term work required to reform the mental health system. The IDG and NICCY agreed that all incomplete actions from the SWAP not already linked to longer term strategic work “would find a home”.<sup>174</sup>

The fourth report drew on the previous report, namely reaffirming the necessity of seeing outcomes from strategic policy interventions as it was vital that plans and reviews were translated into services and supports which would have a positive impact on children and young people. However, it noted that:

*“...the pandemic, cost of living crisis and lack of functioning Government are just some of the key external factors that has made it extremely challenging to progress the plans set out in the SWAP and which have also exacerbated poor mental health and wellbeing of children and young people. We are not seeing the positive change we had hoped in the trajectory of the key service activity indicators...”*

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<sup>173</sup> NICCY. (February 2023). “Still Waiting- Implementation NICCY Progress Update Monitoring Report 4 February 2023”.

<sup>174</sup> This will be examined further in Chapter Seven, “7. Implementation Assessment: the “Still Waiting Action Plan””.

In relation to service activity, CAMHS data indicated a transition back to pre-pandemic levels for some measures and for others, “the situation is worse than at any other timepoint”.<sup>175</sup> NICCY was concerned that despite it being the fourth year of monitoring, the need for improvements in the accessibility and quality of mental health data still remained. The report acknowledged the formation of a Task and Finish Group, established to determine the appropriate level of data to be published. It was anticipated that a limited range of data, (initially relating to waiting times only) would be published on the Departmental website in early 2023; NICCY however reiterated it was essential that the full CAMHS dataset was published without further delay.

NICCY was acutely aware of the financial pressures affecting mental health services, and the Department more broadly. This was exacerbated by the absence of a functioning government. The public sector funding crisis and its impact on services was also acknowledged, particularly for those relating to children and young people, alongside the limited funding allocated to the delivery of the Mental Health Strategy. NICCY urged that funding was ringfenced for key mental health interventions and initiatives, including to meet the commitments to increase CAMHS funding to 10% of the adult mental health funding. The report further reiterated the importance of undertaking, and publishing, a detailed fund mapping exercise.

NICCY recognised, and appreciated, work that had been undertaken to progress the SWAP actions, but the continued delay of many actions was a notable source of frustration, with many actions remaining as works-in-progress.

#### **4.5 Conclusion**

The Still Waiting report was a seminal investigation which produced a comprehensive assessment of the operation, process, and status of mental health services, and an equally comprehensive overview of children and young people’s experiences and pathways to accessing those services including the importance of utilising tailored HRBIs as accountability mechanisms.

It also demonstrated the importance of understanding children and young people’s experiences of mental health services, especially by ensuring the involvement of children and young people in their care. Meaningful youth involvement is essential for addressing the key social, economic and environmental challenges affecting young people and their mental health.<sup>176</sup>

Healthcare planning and design must be underpinned by evidence relating to the factors affecting the lives and mental health of children and young people. This is particularly important in contexts such as NI, as a post-conflict society with high levels of deprivation, mental health challenges, and transgenerational trauma which have been previously highlighted. Given that the recommendations arising from the Still Waiting report were shaped and influenced by the participatory mechanisms undertaken within the review, it was always

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<sup>175</sup> NICCY. (February 2023). “Still Waiting- Implementation NICCY Progress Update Monitoring Report 4 February 2023”.

<sup>176</sup> United Nations (April 2023). *Our Common Agenda Policy Brief 3; Meaningful Youth Engagement in Policy and Decision-making Processes*.

crucial that they would be implemented and included in the design and delivery of key strategic policy frameworks undertaken by the Department in the years following its publication.

The monitoring process of the Still Waiting report, and the SWAP actions, demonstrates that this can be a prolonged, complex process, and one made more difficult by political, financial, and wider global challenges. The role of disaggregated, basic operational data required to efficiently plan, commission, and deliver CAMHS has been reaffirmed, especially as regards the efficient design and delivery of key strategic interventions within mental health services. The relevance of the Still Waiting report's recommendations, and the SWAP actions remain apparent – as does the documented pressures within children and young people's mental health services, not least issues of investment.

**NICCY recommends:**

- 10. The establishment of an information-exchange system which will enable communication between the Department and NICCY on the status of the Still Waiting recommendations and SWAP actions. This should include the provision of bi-annual updates from the Department on the progression of all outstanding SWAP Actions to enable comprehensive engagement and accountability, and NICCY's engagement within the implementation process.**
- 11. The establishment of a dialogue / monitoring mechanism, involving representatives of the CVS, which will enable the continued monitoring of progress and impact arising from the continued implementation of the SWAP actions. This should include the provision of engagement from the Department, the SPPG, and the HSCTs.**

## 5. Methodology

### 5.1 Introduction

This Review comprised of a mixed methods approach, which included the design and submission of information requests to the Department, the SPPG, and the HSCTs to understand the operation of CAMHS, the status of the Still Waiting report recommendations and the SWAP actions, and the delivery of the Mental Health Strategy. It also included the undertaking literature review of relevant investigative reports and research to produce an evidence-based and informed analysis.

### 5.2 Information requests

#### *Still Waiting report*

To enable the monitoring of the Still Waiting recommendations and the SWAP actions, separate information requests were made to relevant authorities. These were designed separately to gather information relating to progress in delivery and identified actions for 2025/2026. They are outlined at Appendix 1. Updates were sought for the 32 SWAP Actions identified as “under review” following the publication of NICCY’s final monitoring report in 2023.<sup>177</sup> Requests made to the Department and the SPPG therefore enquired only for those 32 Actions meaning some SWAP Actions are not included within the report’s analysis. Information was returned relating to the SWAP actions, however there was no information provided to the request seeking progress updates on the Still Waiting recommendations.

#### *CAMHS*

Information requests sought information on the operation of mental health services available to children and young people and corresponding activity data. Information collection took place between December 2024 and March 2025. The information requests are outlined at Appendix 2. The information requested was returned by the Department and SPPG, with the HSCTs having engaged with the SPPG to collate their respective data. NICCY cannot ascertain whether there is standardisation in the collection and monitoring of data pertaining to children and young people’s mental health services across the HSCT regions, as had been identified within the Still Waiting report, or whether issues relating to standardisation remain. Information is collected from the HSCTs by the SPPG on a monthly basis. This is validated by the HSCTs prior to submission to the SPPG, but this information undergoes a further validation process by the latter. NICCY was advised that information/data provided in response to the information requests is management information, used internally by the Department and the SPPG for performance monitoring and service development, and are not classified as official statistics. Moreover, figures below six were suppressed for non-disclosure purposes. NICCY was further advised in respect of the CAMHS data information requests that the rollout of the Encompass system required that for any data collected by HSCTs during this time to undergo extensive

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<sup>177</sup> See NICCY (February 2023). “Still Waiting- Implementation NICCY Progress Update Monitoring Report 4 February 2023”. The detailed assessment can be downloaded as an Excel spreadsheet; see NICCY. Mental Health Review - Still Waiting [online] available at: <https://www.niccy.org/mental-health-review-still-waiting/>.

validation. It was advised that until this process is complete, there may be gaps in the data they are able to submit for reporting purposes.

*Mental Health Strategy*

Information requests in respect of the status of delivery of Actions 10-13 of the Mental Health Strategy were made to the Department. These are available at Appendix 3. These sought updates regarding progress made in their delivery, proposed actions for future delivery, and Departmental funding including the allocation for the 2024/2025 financial year.

For both the SWAP and Mental Health Strategy assessments, information returns were reviewed and collated into tabular formats, and analysed by NICCY accordingly. This incorporated a grading process, following a “traffic light” grading system. This interpreted the provided information subject to the following categories:

	Clear evidence of demonstrable progress made and/or underway
	Some evidence of demonstrable progress; where present this is limited and/or delayed
	No evidence of demonstrable progress; there is evidence indicating significant delay and/or stalling

## 6. Implementation Assessment: the “Still Waiting Action Plan”

### 6.1 Introduction

During the four rounds of monitoring of progression of the Still Waiting recommendations and the SWAP actions undertaken between 2020-2023, several recurring trends were identified, including:

The lack of availability, and consistency, of resources, including the uncertainty as regards funding status of relevant departments, namely the Department, and agencies, including the HSCTs.

Mental health data access and collation, particularly what data is collected and available within in the public domain, as well as improvements in quality and accessibility.

Understanding whether key strategic policy interventions were sufficiently joined up into one integrated and coherent set of actions.

Understanding whether support and outcomes for children and young people have improved, including through the design and delivery of key strategic policy interventions.

This Chapter presents an implementation assessment of the SWAP actions, outlined in two parts. The first part collates and reviews the information returned relating to the status of the SWAP actions to date and the second presents NICCY’s analysis of the outstanding actions which is available in Appendix 1, “Review of the Still Waiting Action Plan (“SWAP”) February 2023 – February 2025”.

### 6.2 Status of the SWAP: updates provided in 2025

NICCY had specifically sought information relating to means of delivery, progress made in delivery, and any identified actions for 2025/2026 within its information requests. The review included comparative analysis against the updates provided during the final monitoring exercise undertaken in 2022-2023. The full review is available in Appendix 1, “Review of the Still Waiting Action Plan (“SWAP”) February 2023 – February 2025”.

NICCY’s review has found that whilst progress has clearly been made in some areas of the SWAP, this has been fragmented, and there are areas, such as improving transitions from CAMHS to adult services which appear to have stalled. It is concerning that those areas which the Department has identified as being taken forward through the delivery of the Mental Health Strategy, such as achieving sustainable funding in CAMHS, are considered as items in progress - but their continued progression may not be secure due to budgetary pressures and funding constraints. The limited progress made in the rollout of crisis services is concerning. This is particularly in the context of the findings of the Getting It Right First Time (“GIRFT”) 2025 report

examining the operation of Emergency Departments across NI.<sup>178</sup> The report is based on the observations and discussions from visits to all type 1 (major) Emergency Departments in June 2023. This included a visit to the Royal Belfast Hospital for Sick Children, during which time issues in critical care for children and young people, including delays in CAMHS assessments and inpatient admission were noted. This followed from issues identified by the RQIA in its 2022 inspection report regarding the treatment of children and young people with self-harm, suicidal ideation etc.<sup>179</sup> Further, whilst progress has been made in areas requiring monitoring, assessment, and evaluation of CAMHS, such as Actions 1.8 and 1.11, their full implementation will not be achieved until the stabilisation and optimisation process for the Encompass system concludes, which is due to last for two years. This runs the risk of continued delay in the realisation of a robust and comprehensive data system which underpins system design and delivery.

In summary:

- Of the 32 SWAP Actions which were subject to information returns, 19 have been identified as remaining in the same categorised status / progress since 2023.
- 22 actions remain categorised as “in progress”. This has included items which sought to ensure the implementation of improved services and/or system change.
- 10 were marked as completed; however these were actions which had previously been confirmed as having been completed in 2023 and thus indicate no further/additional progress has been made.
- Of the 10 actions marked as completed, there are discrepancies arising between the updates provided in 2023 and the updates provided in 2025 for three of the actions, namely in that they had been categorised in 2023, but in 2025 NICCY was informed that they had been completed prior to 2023. Actions which require further investment, improved data or the monitoring, assessment, and evaluation of CAMHS services continue to be marked as actions in progress. NICCY is concerned at the status of progression of these actions, given their importance to ensuring a robust operational system which is underpinned by strong data collection and review to ensure the identification and addressing of relevant trends and issues.
- Actions which seek to ensure provision of a regional mental health crisis service for children and young people appear to have made some limited progress, but the exact nature of this is uncertain, with the Department providing an update from June 2024, advising that meetings of the Strategic Implementation Group to the Regional Mental Health Crisis Service took place in January and May 2024.
- Actions which sought to address longstanding issues within the CAMHS system in the context of ensuring provision of life-long care, such as transitions to AMHS or support for children and young people with a learning disability have fragmented progress. Future progress requires the development and review of implementation plans and the Department has advised that progress relating to ensuring support for children with a learning disability has been stalled, “largely due to other competing priorities”.

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<sup>178</sup> Department of Health. (2025). “Getting It Right First Time Review (GIRFT) of Emergency Medicine in Northern Ireland”.

<sup>179</sup> RQIA. (August 2022). “Inspection Report 18 August 2022. Belfast Health & Social Care Trust.”

- Actions which sought to address the gap in service provision relating to dual diagnosis, namely provision of support for young people with mental ill-health and co-occurring drug/alcohol use are awaiting the outcome of work undertaken by Task and Finish Groups.

Further, several issues were identified which align with the recurring trends found during the previous monitoring process:

- Recognising the lack of availability, and consistency, of resources and the corresponding prioritisation adopted by the Department.
- Identifying the uncertainty as regards funding status of relevant departments, namely the Department, and agencies and the corresponding impact on progression.
- Understanding whether key strategic policy interventions were sufficiently joined up into one integrated and coherent set of actions.
- Understanding the status and use of mental health data access and collation, particularly given the identified requirement for stabilisation and optimisation phases following the rollout of Encompass.
- Understanding whether support and outcomes for children and young people have improved, including through the design and delivery of key strategic policy interventions.
- Recognising general limited or stalled progress on key areas, including transitions.

### **6.3 The SWAP and incorporation within strategic frameworks**

During the final monitoring exercise of the SWAP, the IDG and NICCY had agreed that all incomplete actions from the SWAP not already linked to longer term strategic work “would find a home”.<sup>180</sup> Since this time, NICCY has been informed that SWAP was incorporated into the Mental Health Strategy, and that any outstanding items would be addressed by the delivery of it.<sup>181</sup> In June 2025, NICCY was advised that the Department continues to “ensure that the intent of Still Waiting is still met through the Mental Health Strategy governance and accountability arrangements.”<sup>182</sup> This communication did not specifically give mention or engage with the SWAP, including the actions categorised as being “in progress”, further suggesting a broader approach to the delivery of any identified outstanding work/actions.

In NICCY’s opinion, the terminology of the intent is different to the previous commentary suggesting direct incorporation of remaining tasks and actions from the SWAP. This is particularly important given that the Department did not provide any information to NICCY’s specific request in respect of the progression of the Still Waiting report recommendations. It still remains unclear as to the specific actions and programmes of work which are being utilised to advance the recommendations of the Still Waiting report and the SWAP, and how the Mental Health Strategy has served as a vehicle to ensure progression since its commencement

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<sup>180</sup> NICCY. (February 2023). “Still Waiting- Implementation NICCY Progress Update Monitoring Report 4 February 2023”.

<sup>181</sup> This has been communicated through formal private correspondence to NICCY, namely as updates from the Department in the context of Children’s Champion reporting / monitoring, since 2023.

<sup>182</sup> This was communicated via the Department’s June 2025 updates in the context of Children’s Champion reporting.

in 2021.<sup>183</sup> Information was requested as part of this Review but was not provided, with NICCY being informed by the Department that outstanding items were being addressed/would be addressed by the delivery of the Mental Health Strategy.<sup>184</sup>

NICCY sought to map the SWAP actions with corresponding actions of the Mental Health Strategy based on information provided in 2023 and 2025. This analysis is available in Appendix 1, “Review of the Still Waiting Action Plan (“SWAP”) February 2023 – February 2025”.

This demonstrates incomplete understanding as to the full incorporation of the SWAP actions within the delivery of the Mental Health Strategy. This is also complicated by the approach of the Department, outlined in June 2025, as to the realisation of the “intent” of the Still Waiting report.

Given the scale of actions which remain categorised as in progress, alongside the budgetary landscape and the identified issues facing the progress of the delivery of the Mental Health Strategy, it is critical that a current, thorough mapping exercise as to the positioning of the SWAP actions recognised as being “in progress” within the design and delivery of the Mental Health Strategy is undertaken.

#### **6.4 Status of the SWAP: analysis by NICCY in 2025**

NICCY produced a final status evaluation of the SWAP, which is coded depending on the status of progression and our understanding of prospects for future progression based on broader policy and financial landscape, available in Appendix 1, “Review of the Still Waiting Action Plan (“SWAP”) February 2023 – February 2025”.

In summary:

- Of the 32 SWAP Actions which were subject to information returns, six actions were coded as red. NICCY is concerned as to the status of progression of these actions and considers these as actions requiring urgent attention.

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<sup>183</sup> This was communicated to key relevant authorities by correspondence from the Commissioner enquiring as to the implementation of the Mental Health Strategy in respect of infants, children, and young people in December 2024.

<sup>184</sup> This was communicated to NICCY during online meetings between January – February 2025.

Action	NICCY's Progress Coding
1.4 Increase funding for CAMHS.	
1.11 CAMHS referral pathways will be kept under review.	
3.3 Establishment and launch of additional specialist mental health support available for schools, delivered through the Emotional Health and Wellbeing in Education Framework:  -Text a Nurse (Post primary) -Expanded rise provision (Primary) -CAMHS school service (Primary and Post Primary). -Extension of Abbey School Nursing pilot.	
4.1 Provide greater opportunities for mental health support community and voluntary sector organisations to apply for funding from the Department of Health's core grant funding scheme, through introducing an open call for applications to the scheme.	
4.10 Create a regional crisis service for children and young people.	
5.1 Develop proposals for transitions between CAMHS and adult mental health services, engaging widely with all relevant stakeholders.	

Action 3.3, which calls for the establishment and launch of additional specialist mental health support available for schools, delivered through the Emotional Health and Wellbeing in Education Framework, was coded red. NICCY recognises the Department of Education is also experiencing budgetary pressures, and as such, is concerned for the future progression of this Action.

Action 4.1, which calls for the provision of greater opportunities for mental health support CVS organisations to apply for funding from the Department's core grant funding scheme, was coded red. NICCY is aware of the financial pressures experienced by the CVS in the last four years, and the increased demand on CVS services and supports.

Considering budgetary pressures and the Department's analysis of the deliverability of the Mental Health Strategy to date, including the emphasis placed on the role of the CVS, it is important to ensure the CVS is sufficiently funded and further, has enhanced opportunities to apply for further funding from the Department's core grant funding through a clearer and more open process. NICCY is concerned as to the current operation of the CVS, and thus the corresponding impact on the realisation of this recommendation.

Action 4.10 (merged with Action 1.10) relating to the development of provision of a regional mental health crisis service for children and young people was coded red.

The exact status of this action is uncertain, with the Department having provided an update from June 2024. No direct confirmation of current progress has been provided. NICCY is concerned that the Regional Mental Health Crisis Service was announced in 2021 and yet has not been fully rolled out. The regional mental health crisis service must be rolled out as a matter of urgency.

Of the 32 SWAP Actions which were subject to information returns, only four actions were coded as green. Whilst NICCY welcomes the progress made in these areas, it is concerned that only four actions can be coded as green.

Action	NICCY's Progress Coding
2.5 Review CAMHS appointment systems in relation to recommendation 8 to consider the viability and practical implications.  Fully implement CAMHS care pathway across NI, including gap analysis and where additional resources should be deployed.	
3.1 Roll out at Trust level of short course programme on the CAMHS Care pathway to GPs and other children services.	
4.5 Evaluate and analyse the need for Psychiatric Intensive Care provisions in Northern Ireland and make decision on the future need.	
8.2 Establish a regional board with SPPG/Iveagh and 5 trusts to strengthen operating procedures within Iveagh to prevent delayed discharges as well as keep focus of plans to discharge.	

22 actions were coded as orange. These actions include the full development and rollout of critical support services and systems. NICCY advises that these actions are kept under review and updates as to the precise nature of available supports are provided.

Action	NICCY's Progress Coding
1.3 Create a fund map of spending in children and adolescent mental health and emotional wellbeing services.	
1.5 Full implementation of CAMHS dataset.	
1.6 Development of Encompass across the HSCT to provide a system of recording and reporting on patient data and trends.	
1.8 On an annual basis trusts, along with SPPG will reflect back on referral trends to identify changes in referrals patterns and undertake specific awareness rising activities as required.	
1.9 Establishment of a fully implemented and operational Managed Care Network (MCN).	
1.10 Develop MH Liaison Service (for 16+), CAIT and acute care pathways for children and young people. REPLACED with 1.10 Create a regional mental health crisis service that will meet the needs of children and young people.	

2.1 Scope what supports are currently on offer for children and young people awaiting appointments or in between appointments. Analyse any resource and practical implications for implementing this.	
2.2 Consider creation of a Mental Health Passport Scheme, through existing portals.	
2.3 Review Integrated Elective Access Protocol (IEAP) to ensure fit for purpose for children and young people.	
2.4 Develop an APP that will assist young people requiring help and support with health and social wellbeing or who may have difficulty in engaging with CAMHS.	
3.2 Implement primary care Multi Disciplinary Teams (MDTs) with a mental health practitioner attached to all GPs across the region. The role of the MHP within the MDT is to provide mental health support across a whole life approach.	
4.2 Provide a greater range of self-help support for young people.	
4.4 Fully implement psychological therapies in CAMHS, as per the existing 2010 Psychological Therapies Strategy.	
4.7 Ensure suitable protocols exist for children who are admitted to adult wards.	
4.9 Review the Card Before You Leave (CBYL) Scheme for children and young people.	
6.1 Audit of existing complaints process across trust and review complaints made within 2 years for baseline. Consult with existing Service User groups re: appropriateness of current arrangements.	
6.2 Scope children and young people involvement in service evaluation and development. Consider development of an action plan and setting up a mental health youth forum in each trust to support this action.	
8.1 Understand current provision of ID CAMHS across all trusts through undertaking scoping exercise of existing pathways.	
8.3 Development of the Children and Young People Emotional Health and Wellbeing Framework including scoping a regional ADHD service.	
8.4 Carry out a review of community based emotional, mental and behavioural support services for children and young people.	
8.5 Establish a service that will provide support and care for young people with co-occurring drug and/or alcohol and mental health problems.	
8.6 The SPPG and the PHA will review services available for children and young people, particularly looking at the transition of young people from children to adult services, and ensure this is incorporated into the new outcomes-focused strategic plan being developed to replace the Alcohol and Drugs Services Commissioning Framework.	

Actions which require further investment into CAMHS (SWAP Action 1.4), improved CAMHS data (SWAP Actions 1.6 and 1.7) or the monitoring, assessment, and evaluation of CAMHS services (see SWAP Actions 1.8 and 1.11) have not yet been realised. NICCY expresses its

concern at the status of progression of these actions, given their importance to ensuring a robust operational system which is underpinned by strong data collection and review to ensure the identification and addressing of relevant trends and issues.

## **6.5 Conclusion**

In 2023, NICCY had stated the human, technical and financial resource needed to implement the SWAP fully remained unclear. There was a requirement for the undertaking of a detailed fund mapping exercise to fully understand the gap between current investment, and what is needed to ensure that children and young people have access to a comprehensive range of mental health services. Equally uncertain was the evidence of outcomes/improvements for children and young people within mental health services. In 2025, these questions remain just as pertinent.

As the above analysis demonstrates, progression of the SWAP actions remains fragmented and slow. The issues of funding and resourcing have resulted in the Department expressly noting that progression of actions is undertaken on a priority basis which raises questions as to when they will be taken forward. Mental health data access and collation, whilst progressing through the implementation of Encompass, will continue to be an issue in light of the Department's own acknowledgment of a two-year timeframe for optimisation and stabilisation phases to be completed, to ensure that data obtained via the digital system is accurate and validated for use.

As the above analysis also revealed, there is incomplete understanding as to the incorporation of the SWAP actions within the delivery of the Mental Health Strategy which is complicated by the Department's approach to the realisation of the "intent" of the Still Waiting report. Given the scale of actions which remain categorised as in progress, alongside the budgetary landscape and the identified issues facing the future progress of the delivery of the Mental Health Strategy, NICCY believes it is critical that a current, thorough mapping exercise which demonstrates the precise relationship of the SWAP actions recognised as being "in progress" with the Mental Health Strategy is produced.

### **NICCY recommends:**

- 12. The Department clarifies how the SWAP has been incorporated into the Mental Health Strategy, and further clarifies what is meant by its comments that the "intent" of the Still Waiting report is being "met" through the governance and accountability arrangements of the Mental Health Strategy.**
- 13. The Department undertake and publish a mapping exercise which demonstrates the precise incorporation of relevant SWAP Actions within the Mental Health Strategy. This mapping exercise should also detail the exact status of progress of the identified SWAP Actions within the development of their corresponding Mental Health Strategy Actions, and identify actions for future progression within the 2026/2027 financial year.**
- 14. The Department undertakes a robust, refreshed mapping exercise which produces a refreshed funding map for CAMHS services, as well as ascertaining the existing**

need among the CVS in the mental health support sector, recognising increasing demand on CVS support services.

15. Funding for CAMHS is increased by the Department to sit at 10% of mental health services allocations.
16. The Department, the SPPG, and the HSCTs undertake an internal review of existing referral pathways, which assesses the current design and operation of referral pathways using a CRBA, including recognition of waiting lists and waiting times for access. The review should include the design and application of relevant indicators as an assessment framework. This review should be published within one year, and subsequent review should be undertaken using the same CRBA, including Child Rights-based indicators.
17. That reviews of the pilot programmes undertaken under SWAP Action 3.3 are published, with evidence of learning and recognition of best practice and opportunities for design improvement identified. These reviews should comply with Article 12 of the UNCRC and participation of those engaged in services provided by the pilot programmes, including in the design of recommendations for future work.
18. The Departments of Health and Education, in accordance with the Children's Services Co-Operation (NI) Act 2015, produce a comprehensive action plan for the future design and delivery of specialist mental health support services within schools and educational settings. This action plan should be framed within a CRBA and identify opportunities for collaboration and cooperation across all relevant services, including between the Emotional Health and Wellbeing in Education Framework and the Emotional Health and Wellbeing Framework (when finalised).
19. The Department engage in a stakeholder consultation exercise to understand the needs of the CVS, and to work alongside the CVS to ensure sufficient funding is provided in order to realise the ambitions of the Mental Health Strategy, and the role identified for the CVS within this, as well as the (draft) Emotional Health and Wellbeing Framework.
20. The Regional Mental Health Crisis Service is rolled out as a matter of urgency.
21. The Department advises of the status of implementation of recommendations made within the 2024 GIRFT review report, "The Emergency Departments of NI" and particularly in relation to those made in respect of the Royal Belfast Hospital for Sick Children, and further, confirms what work has been undertaken within the Belfast HSCT region to progress on ensuring a safe ED environment for children and young people experiencing mental health crisis and/or requiring CAMHS assessment.
22. The development of a clear, regionally consistent, and child rights-based transitions pathway is upgraded to a priority by the Department, and undertaken as a matter of urgency.

## 7. An Analysis of the operation of CAMHS

### 7.1 Introduction

In July 2012, a preferred model for the organisation and delivery of CAMHS in NI was published, providing a proposed framework to enable the remodelling of the service. The development of a stepped care approach model was a direct response to a recommendation of the RQIA review and aligned with the overall strategic direction set out in the Bamford Review of Mental Health and Learning Disability (“Bamford Review”).<sup>185</sup> Five levels of support were introduced in the stepped care approach: prevention; early intervention; specialist intervention services; crisis intervention; and inpatient and regional specialist services. This stepped care model has, however, been criticised by practitioners and service users including for its limited resources, with children and young people essentially being passed from service to service within the model due to the individual services struggling to cope with service demand.<sup>186</sup>

The review of the Still Waiting report and the SWAP actions monitoring process in Chapter 5 identified that the matter of the operation of CAMHS was a recurrent issue and that the mental health system may be unable to meet the needs of children and young people.

In October 2023, the NI Audit Office (“NIAO”) published its report into mental health services in NI (“the NIAO report”).<sup>187</sup> This was a high-level examination exploring issues around mental health strategy, funding, activity, and data and presented a picture of mental health services feeling the strain of increasing service demand, whilst facing financial pressures and data constraints.

The report found:

Referrals data illustrated a substantial increase (by 50%) in the level of demand for mental health services over the five years to March 2020.

Referrals data showed a documented increase in the complexity of cases presenting to mental health services, particularly the co-presentation of drug and alcohol addiction alongside mental ill-health.

In the period 2015 to 2022, the number waiting longer than the maximum standard waiting time to access mental health services increased by almost 400%.

<sup>185</sup> See RQIA. (February 2011). *RQIA Independent Review of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland* and the Department of Health. “Bamford Review of Mental Health and Learning Disability”.

<sup>186</sup> See NICCY. (2018). “Still Waiting: A Rights Based Review Based Review of Mental Health Services and Support for Children and Young People in NI”.

<sup>187</sup> NI Audit Office. (2023). *Mental Health Services in Northern Ireland*.

The number of patients on mental health waiting lists has increased since 2015, with data indicating a particular jump between March 2018 and March 2019, with waiting lists increasing by around 25%.

Commissioning plans were found to have acknowledged that there were underlying gaps:

- between capacity and demand;
- a funding gap between need and provision in respect of mental health services and the level of funding available to invest in psychological therapies;
- a continuation of the trend in increased demand for services to treat substance misuse and associated health problems.

The report's findings on waiting lists were particularly concerning.

The increase in waiting lists in the latter part of 2020-21 continued into the 2021-22, with overall numbers rising to almost 16,000; this marked an 18% increase when compared to pre-pandemic levels.

At the end of March 2022, almost 16,000 patients were on mental health waiting lists.

As of May 2023, waiting lists for mental health services were above pre-pandemic levels.

Following the lifting of pandemic restrictions, with a recovery in referrals in the second half of the year, waiting lists once more began to increase.

By the end of the 2021 year, the total number of patients on mental health waiting lists had increased to approximately 14,000 - close to the level recorded at the end of March 2020.

In terms of CAMHS, the report found:

In 2019-20, just over 100 children were admitted to the acute mental health ward for children and young people.

For the period 2020-2021, CAMHS data showed inpatient figures increased by around 25% (from 111 to 141) although total numbers were relatively small.

The increase recorded in 2020-2021 appeared to have reversed in 2021-2022, with CAMHS admissions falling below previous levels (to 81) - indicating a return to the decreasing trend identified in earlier years.

The fall in numbers on waiting lists was most pronounced in the early months of 2020-2021 during the initial lockdown, when waiting lists for CAMHS fell between March 2020 and March 2021 by around 30%.

An initial reading of the CAMHS waiting list data between 2020-2021 suggests that numbers fell, and that children and young people were progressing through the system and were attending appointments. However, the decline was not due to progress in cutting waiting list numbers, but due to the numbers of accepted referrals falling due to system pauses/adaptations introduced and implemented as part of the response to the pandemic. This could mean any decrease in CAMHS waiting lists and waiting times during this timeframe was because children and young people with mental health needs were not coming forward for support or had problems accessing support.

There has been a regional failure to achieve mental health waiting time targets, including within CAMHS.

The mental health care pathway states no one should wait longer than nine weeks to access CAMHS within Trust secondary care provision. The NIAO report confirmed that a “significant number of people wait longer than intended to access mental health services”.<sup>188</sup> From 2015-2022, waiting time targets were not met regionally; during this time, the number of those waiting longer has steadily increased, particularly evident after March 2018 with the overall total number of target breaches almost doubling by the end of March 2019.

As of 31 March 2022, the longest wait in CAMHS was 549 days.

This Chapter examines the operation of children and young people’s mental health services. Data collection, collation, and review is undertaken in respect of all CAMHS services, including: Beechcroft Inpatients; the Knowing Our identity (“KOI”) Gender Identity Team; the Family Trauma Centre; and Forensic Services. The full dataset can be accessed within Appendix 2, “Review of CAMHS Data 2021 -2024”.

## 7.2 CAMHS

CAMHS promotes mental and emotional wellbeing and provides mental health services to children and young people up to the age of 18. CAMHS supports children and young people with complex mental health needs as well as their parents and/or carers. CAMHS is accessed via referrals, made by GPs, the education welfare service, school nurses, and family social workers and cannot be accessed via self-referrals. If considered necessary, children and young people can be referred for intensive care, support, and treatment in hospital.

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<sup>188</sup> NI Audit Office. (2023). *Mental Health Services in Northern Ireland*. At 4.22.

Services include: the Child and Family Clinic; a Crisis Assessment and Intervention Team; the Drug and Alcohol Mental Health Service; Eating Disorder Youth Service; the Family Trauma Centre; the Knowing Our Identity Gender Identity Service; and Primary Mental Health Team.

## Referrals

On the basis of the data obtained, there is a clear and consistent trend of decreasing referrals to CAMHS between 2021/2022 to 2023/2024.

There is also a recent trend of decreasing acceptance of referrals within the service.

As outlined in Table 3, in the 2021/2022 year, 15,279 total referrals to CAMHS were received. Of these, 10,363 were accepted, representing a 67.8% referral acceptance rate.<sup>189</sup>

13,668 referrals were received in 2022/2023, with 9,376 referrals accepted. This represented a 68.6% acceptance rate, a slight increase on the previous year.

In 2023/2024, there were 12,680 referrals received, of which 8,406 were accepted – a 66.3% acceptance rate.

*Table 3: Global Total Referrals Received, Accepted and Percentage Accepted (Step 2 / Step 3 / Eating Disorders / Addictions / Crisis).*

Year	Total Referrals Received	Total Referrals Accepted	Percentage of Referrals Received
21/22	15,279	10,363	67.8
22/23	13,668	9,376	68.6
23/24	12,680	8,406	66.3

Table 4 shows a number of trends for referrals on the basis of HSCT acceptance between 2021/2022 to 2023/2024.

There was a clear and consistent trend of decreasing referrals to CAMHS within the Belfast HSCT.

Belfast HSCT CAMHS figures include South Eastern HSCT. Belfast HSCT provides CAMHS community services for both Trusts in line with the Regional CAMHS Care Pathway.

There also appears to be a recent trend of decreasing acceptance of referrals within the service.

There was a clear and consistent trend of decreasing referrals to CAMHS within the Northern HSCT.

There also appears to be a trend of increasing acceptance of referrals within the service, with this decreasing slightly by the timeframe 2023/2024.

<sup>189</sup> Unless otherwise stated, data presented in this chapter has been collected within a fiscal year timeframe.

There was a clear and consistent trend of increasing referrals to CAMHS within the Southern HSCT.

There also appears to be a recent trend of increasing acceptance of referrals within the service, from 2022/2023.

There has been some fluctuation of referral rates to CAMHS within the Western HSCT.

After a period of decreasing referrals between the timeframe 2021/2022 to 2022/2023, there was a slight increase between 2022/2023 and 2023/2024.

There also appears to be a recent trend of decreasing acceptance of referrals within the service, from the timeframe 2022/2023.

Table 4: Global referrals received, accepted and percentage accepted by Trust area, and NI region, 2021-24, (Step 2 / Step 3 / Eating Disorders / Addictions / Crisis).

Year	Referrals	BHSCT and SEHSCT	NHSCT	SHSCT	WHSCT	NI Region
<b>21/22</b>						
	Total received	6,447	3,147	3,286	2,399	15,279
	Total accepted	4,084	2,257	2,295	1,727	10,363
	% accepted	63.3	71.7	69.8	72.0	67.8
<b>22/23</b>						
	Total received	5,385	2,874	3,239	2,170	13,668
	Total accepted	3,432	2,123	2,251	1,570	9,376
	% accepted	63.7	73.9	69.5	72.4	68.6
<b>23/24</b>						
	Total received	4,882	2,395	3,206	2,197	12,680
	Total accepted	3,009	1,768	2,281	1,348	8,406
	% accepted	61.6	73.8	71.1	61.4	66.3

There was a clear and consistent trend of decreasing referrals to CAMHS within the Belfast HSCT.

Belfast HSCT CAMHS figures include South Eastern HSCT. Belfast HSCT provides CAMHS community services for both Trusts in line with the Regional CAMHS Care Pathway.

There also appears to be a recent trend of decreasing acceptance of referrals within the service.

There was a clear and consistent trend of decreasing referrals to CAMHS within the Northern HSCT.

There also appears to be a trend of increasing acceptance of referrals within the service, with this decreasing slightly by the timeframe 2023/2024.

There was a clear and consistent trend of increasing referrals to CAMHS within the Southern HSCT.

There also appears to be a recent trend of increasing acceptance of referrals within the service, from 2022/2023.

When reviewing available data for referrals accepted for CAMHS services (Step 2/ Step 3/ Eating Disorders/ Addictions) on the basis of priority between 2021-2024, it appears there is a trend of decreasing accepted referrals, and decreasing rates of referrals across the categories of emergency, routine, and urgent. However, there are fluctuations in the trends of accepted routine and urgent referrals relative to the total accepted referrals: there has been an increase in accepted routine referrals relative to total accepted referrals, whilst there has been a decrease in urgent referrals relative to total accepted referrals. This is outlined in more detail in Table 5 below.

Table 5: Referrals Accepted by Trust and Priority for 2021-24 (Step 2 / Step 3/ Eating Disorders / Addictions)

Year	HSCTs	Emergency Accepted	Routine Accepted	Urgent Accepted	Total
<b>21/22</b>					
	BHSCT; SEHSCT		2,795	92	<b>2,888</b>
	NHSCT		1,841	7	<b>1,850</b>
	SHSCT	254	1,913	128	<b>2,295</b>
	WHSCT		1,119	251	<b>1,372</b>
	<b>Region</b>	<b>259</b>	<b>7,668</b>	<b>478</b>	<b>8,405</b>
<b>22/23</b>					
	BHSCT; SEHSCT		2,234	96	<b>2,331</b>
	NHSCT		1,743	12	<b>1,758</b>
	SHSCT	217	1,891	143	<b>2,251</b>
	WHSCT		1,072	213	<b>1,286</b>
	<b>Region</b>	<b>222</b>	<b>6,940</b>	<b>464</b>	<b>7,626</b>
<b>23/24</b>					
	BHSCT; SEHSCT		2,033	23	<b>2,056</b>
	NHSCT		1,412	7	<b>1,421</b>
	SHSCT		1,875	141	<b>2,016</b>
	WHSCT		964	115	<b>1,080</b>
	<b>Region</b>		<b>6,284</b>	<b>286</b>	<b>6,573</b>

- In 2021/2022, of the 8,405 accepted referrals, 3% were emergency referrals, 91.2% routine and 5.6% urgent.
- In 2022/2023, of 7,626 accepted referrals, 2.9% were emergency referrals, 91.0% routine and 6.0% urgent.
- In 2023/2024, of the 6,573 accepted referrals, 0.04% were emergency referrals, 95.6% routine and 4.0% urgent.

The data provided also identifies a number of trends for referrals on the basis of HSCT referral acceptance between 2021 to 2024.

There appears to be a trend of decreasing accepted referrals and a trend of declining accepted routine referrals within the Belfast HSCT.

- In 2021/2022, there were 2,888 accepted referrals. Of these, 2,795 were routine referrals (96.7% of total referrals); and 92 were urgent (3.1% of total referrals).
- In 2022/2023, there were 2,331 accepted referrals, of which 2,234 were routine referrals (95.8% of total referrals); and 96 were urgent (4.1% of total referrals).
- In 2023/2024, there were 2,056 accepted referrals, of which 2,033 (98.8% of total referrals); and 23 were urgent (1.1% of total referrals).

There appears to be a trend of decreasing accepted referrals within the Northern HSCT. The rates of accepted routine referrals have remained generally consistent during this time.

- In 2021/2022, there were 1,850 accepted referrals. Of these, 1,841 were routine referrals (99.5% of total referrals); and 7 were urgent (0.37% of total referrals).
- In 2022/2023, there were 1,758 accepted referrals, of which 1,743 were routine referrals (99.1% of total referrals); and 12 were urgent (0.68% of total referrals).
- In 2023/2024, there were 1,421 accepted referrals, of which 1,412 (99.3% of total referrals); and 7 were urgent (0.49% of total referrals).

There appears to be a trend of decreasing accepted referrals within the Southern HSCT. The rates of accepted routine referrals have decreased in this time, as have the rates of emergency referrals.

- In 2021/2022, there were 2,295 accepted referrals. Of these, 254 were emergency referrals (11.0% of total referrals); 1,913 were routine referrals (83.3% of total referrals); and 128 were urgent (5.5% of total referrals).
- In 2022/2023, there were 2,251 accepted referrals, of which 217 were emergency referrals (9.6% of total referrals); 1,891 were routine referrals (84.0% of total referrals); and 143 were urgent (6.3% of total referrals).
- In 2023/2024, there were 2,016 accepted referrals, of which 1,875 (93.0% of total referrals); and 141 were urgent (6.9% of total referrals).

There appears to be a trend of decreasing accepted referrals within the Western HSCT. The rates of accepted routine referrals have decreased in this time, as have the rates of urgent referrals.

- In 2021/2022, there were 1,372 accepted referrals. Of these, 1,119 were routine referrals (81.5% of total referrals); and 251 were urgent (18.2% of total referrals).
- In 2022/2023, there were 1,286 accepted referrals, of which 1,072 were routine referrals (83.3% of total referrals); and 213 were urgent (16.5% of total referrals).
- In 2023/2024, there were 1,080 accepted referrals, of which 964 (89.2% of total referrals); and 115 were urgent (10.6% of total referrals).

Table 6 presents data relating to the type of accepted referral (emergency, routine, urgent) to CAMHS for the specific services of Step 2; Step 3; Eating Disorder; and Addictions.

Table 6: Referrals Accepted by Trust and Priority for 2021-24 for Step 2 / Step 3 / Eating Disorders / Addictions)

Year	Step	Emergency Accepted	Routine Accepted	Urgent Accepted	Total
<b>21/22</b>					
	Step 2		3,285	83	3,368
	Step 3	256	4,055	360	4,671
	Eating Disorder		278	33	314
	Addictions		50		52
	<b>Region</b>	<b>259</b>	<b>7,668</b>	<b>478</b>	<b>8,405</b>
<b>22/23</b>					
	Step 2		2,942	14	2,956
	Step 3	219	3,780	417	4,416
	Eating Disorder		176	32	210
	Addictions		42		44
	<b>Region</b>	<b>222</b>	<b>6,940</b>	<b>464</b>	<b>7,626</b>
<b>23/24</b>					
	Step 2		2,598	31	2,629
	Step 3		3,411	231	3,643
	Eating Disorder		204	20	226
	Addictions		71		75
	<b>Region</b>		<b>6,284</b>	<b>286</b>	<b>6,573</b>

A number of trends can be identified:

- The rates of emergency accepted referrals across the period 2021/2022 to 2023/2024 were for the CAMHS Step 3 service.
- There is a documented decrease in the number of accepted routine referrals to the CAMHS Step 2 and 3 services.
- There is a documented decrease in the number of accepted routine referrals to the CAMHS Step 3 service. The number of accepted routine referrals to the CAMHS Step 3 service continues to be greater than the number of accepted routine referrals to the CAMHS Step 2 service.
- There has been a recent increase in the number of accepted urgent referrals to the CAMHS Step 2 service when previously this figure was declining.
- There has been a recent decrease in the number of accepted urgent referrals to the CAMHS Step 3 service (231 referrals in 2023/2024; down on 417 in 2022/2023) when previously this figure was increasing (360 in 2021/2022).
- There has been a recent increase in the number of accepted routine referrals to the CAMHS Addictions services.
- There has been annual decrease in the number of accepted urgent referrals to the Eating Disorder service, from 33 referrals in 2021/2022, to 32 in 2022/2023, and 20 referrals in 2023/2024.

Table 7 presents data obtained in the context of accepted referrals to CAMHS for the specific services of Step 2, Step 3, Eating Disorder, Addictions, and Crisis on the basis of the age band and gender of service users.

Table 7: Global Age and Breakdown of Accepted Referrals by Step for 2021-2024 (Step 2 / Step 3 / Eating Disorders / Addictions), by age and gender.

Year	Gender	Age Band	Step 2	Step 3	Eating Disorder	Addictions	Crisis	Region
<b>21/22</b>								
	<i>Female</i>	0 to 4						6
		5 to 11	580	239	15		53	887
		12 to 14	839	1,199	101		469	2,611
		15 to 17	634	1,472	162	10	858	3,136
		18 plus		8			10	23
		<b>Total</b>	<b>2,056</b>	<b>2,923</b>	<b>281</b>	<b>13</b>	<b>1,390</b>	<b>6,663</b>
	<i>Male</i>	0 to 4	10	6				16
		5 to 11	638	383			59	1,083
		12 to 14	378	613	17	7	149	1,164
		15 to 17	284	742	13	32	352	1,423
		18 plus						6
		<b>Total</b>	<b>1,311</b>	<b>1,746</b>	<b>33</b>	<b>39</b>	<b>563</b>	<b>3,692</b>
	<b>TOTAL</b>		<b>3,368</b>	<b>4,671</b>	<b>314</b>	<b>52</b>	<b>1,958</b>	<b>10,363</b>
<b>22/23</b>								
	<i>Female</i>	0 to 4						7
		5 to 11	508	283	7		56	854
		12 to 14	735	1,075	74		487	2,373
		15 to 17	510	1,222	89	8	679	2,508
		18 plus					20	28
		<b>Total</b>	<b>1,758</b>	<b>2,586</b>	<b>174</b>	<b>10</b>	<b>1,242</b>	<b>5,770</b>
	<i>Male</i>	0 to 4	7					8
		5 to 11	529	415	6		58	1,008
		12 to 14	360	644	16		148	1,172
		15 to 17	302	766	14	30	297	1,409
		18 plus						6
		<b>Total</b>	<b>1,198</b>	<b>1,828</b>	<b>36</b>	<b>34</b>	<b>507</b>	<b>3,603</b>
	<b>TOTAL</b>		<b>2,956</b>	<b>4,416</b>	<b>210</b>	<b>44</b>	<b>1,750</b>	<b>9,376</b>
<b>23/24</b>								
	<i>Female</i>	0 to 4						
		5 to 11	462	230	13		64	769
		12 to 14	638	859	86	8	487	2,078
		15 to 17	434	1,013	111	14	704	2,276
		18 plus					6	9

	Total	1,536	2,105	210	22	1,261	5,134
<i>Male</i>	0 to 4						6
	5 to 11	531	357			52	943
	12 to 14	353	547	8	8	174	1,090
	15 to 17	206	630		45	334	1,220
	18 plus					7	8
	<b>Total</b>	<b>1,093</b>	<b>1,537</b>	<b>16</b>	<b>53</b>	<b>568</b>	<b>3,267</b>
<b>TOTAL</b>		<b>2,629</b>	<b>3,643</b>	<b>226</b>	<b>75</b>	<b>1,833</b>	<b>8,406</b>

A number of trends can be identified for each year under examination.

#### For the timeframe 2021/2022:

- Girls were the majority of service users (64.2% of total referrals) compared to boys (35.6% of total referrals).
- Girls were the majority of service users for Step 2 (61.0%) compared to boys (38.9%).
- Girls were the majority of service users for Step 3 CAMHS (62.5%) compared to boys (37.3%). However, the only referrals made to Step 2 and Step 3 CAMHS for the age band 0-4 were for boys (10 referrals; 6 referrals respectively).
- Girls of all age bands were the dominant users of Eating Disorder services (89.4% of total referrals, compared to 10.5% of total referrals for boys).
- Girls were the dominant users of Crisis services. Boys slightly edged out girls for referrals within the 5-11 age band, but girls were the dominant users across all other age bands.
- Boys were the dominant users of Addiction Services (75% of total referrals compared to 25% for girls); this included 7 referrals for boys in the 12-14 age band and 32 referrals within the 15-17 age band.

#### For the timeframe 2022/2023:

- Girls were the majority of service users (61.5% of total referrals) compared to boys (38.4% of total referrals).
- Girls were the majority of service users for Step 2 (59.4%) compared to boys (40.5%).
- Girls were the majority of service users for Step 3 CAMHS (58.5.5%) compared to boys (41.3%). However, the only referrals made to Step 2 CAMHS for the age band 0-4 were for boys.
- Girls of all age bands were the dominant users of Eating Disorder services (82.8% of total referrals, compared to 17.1% for boys).
- Girls were the dominant users of Crisis services. Boys slightly edged out girls for referrals within the 5-11 age band, but girls were the dominant users across all other age bands including 15-17.
- Boys were the dominant users of Addiction Services (77.2% compared to 22.7% for girls); this included 30 referrals for boys referrals within the 15-17 age band.

#### **For the timeframe 2023/2024:**

- Girls were the majority of service users (61.0% of total referrals) compared to boys (38.8% of total referrals).
- Girls were the majority of service users for Step 2 (58.4%) compared to boys (41.5%).
- Girls were the majority of service users for Step 3 CAMHS (57.7%) compared to boys (42.1%).
- Girls of all age bands were the dominant users of Eating Disorder services (92.9% of total referrals, compared to 7.0% for boys).
- Girls were the dominant users of Crisis services across all age bands, including the 12-14 range (487 referrals compared to 174 of boys), and 15-17 (705 referrals compared to 334 for boys).
- Boys were the dominant users of Addiction Services (70.6% of total referrals compared to 29% for girls); this included 45 referrals for boys referrals within the 15-17 age band.

As such, for the period 2021/2022 – 2023/2024, the following key patterns were identified:

- There has been a slight decrease in the percentage by which girls comprise the majority of referrals, and a slight increase in the percentage by which boys comprise referrals, however girls have consistently been the majority of overall service users compared to boys, overall and in terms of service users of Step 2 CAMHS;
- There has been a decrease in the percentage by which girls comprise the majority of referrals, and an increase in the percentage by which boys comprise referrals, however girls have consistently been the majority of overall service users of Step 3 CAMHS compared to boys;
- Girls of all age bands are the dominant users of Eating Disorder services (comprising 89.4% of total referrals in 2021/2022, 82.8% in 2022/2023, and 92.9% in 2023/2024) with boys now forming the lowest levels of referrals in the period under assessment (10.5% of total referrals in 2021/2022, 17.1% in 2022/2023, and 7.0% in 2023/2024);
- Overall, girls were the dominant figures of referrals to Crisis services – boys had slightly edged out girls for referrals within the 5-11 age band in 2021/2022 and 2022/2023, but by 2023/2024, girls were the dominant figures across all age bands; and
- Boys were the dominant figures of Addiction Services (comprising 75% of total referrals in 2021/2022, 77.2% in 2022/2023, and 70.6% in 2023/2024), but the composition of girls relative to the total referrals to the system has increased, now forming the highest levels of referrals in the period under assessment (25% of total referrals in 2021/2022, 22.7% in 2022/2023, and 29% in 2023/2024).

Table 8 presents data relating to accepted referrals by Source to Step 2/ Step 3/ Eating Disorders/ Addictions CAMHS.

Table 8: Referrals Accepted by Source by Year for 2021-24 (Step 2 / Step 3 / Eating Disorders / Addictions)

Source	21/22	22/23	23/24
General Practitioner (GP)	6,451	5,852	5,210
Paediatrics/Child Health/ Inpatient Service	1,057	868	579
AMH	329	290	263
Education	171	157	155
Social Services - CP/FS/Disability	136	135	110
VCS	31	113	104
AHP	76	72	57
ASD Services /Professional	81	63	29
Health Visiting / School Nurse	57	56	52
Social Services - LAC	13	10	-
Youth Justice	-	10	10
<b>Region</b>	<b>8,405</b>	<b>7,626</b>	<b>6,573</b>

A number of trends can be identified:

- Referrals made by GPs remain the dominant source of accepted referrals.
- Referrals made by GPs have increased relative to total accepted referrals (comprising 76.7% of total accepted referrals in 2021/2022; 76.7% in 2022/2023; and 79.2% in 2023/2024);
- Accepted referrals from Paediatrics / Child Health / Inpatient Service have decreased within this time and relative to total accepted referrals (12.5% of total accepted referrals in 2021/2022; 11.3% in 2022/2023; and 8.8% in 2023/2024);
- There has been an increase in accepted referrals made by the CVS, which have also increased relative to total number of accepted referrals (0.36% of total accepted referrals in 2021/2022; 1.48% in 2022/2023; and 1.58% in 2023/2024);
- There has been a slight decrease in accepted referrals made within Education, which have also increased relative to total accepted referrals (2.03% of total accepted referrals in 2021/2022; 2.05% in 2022/2023; and 2.35% in 2023/2024);
- There has been a slight decrease in accepted referrals made by Social Services CP/FS/Disability;
- Accepted referrals made by Social Services CP/FS/Disability relative to total accepted referrals has remained consistent (1.6% of total accepted referrals in 2021/2022; 1.7% in 2022/2023; 1.6% in 2023/2024); and
- There has been a decrease in accepted referrals made by ASD Services/Professionals, and accepted referrals made by ASD Services / Professionals have decreased relative to total accepted referrals (0.9% of total accepted referrals in 2021/2022; 0.8% in 2022/2023; and 0.4% in 2023/2024).

Table 9 shows accepted referrals by source to Crisis Service.

Table 9: Referrals Accepted by Source by Year for Crisis Service for 2021-24.

Source	21/22	22/23	23/24
Emergency Department	981	535	776
General Hospital	292	688	537
GP	361	307	312
VCS	<b>33</b>	<b>64</b>	<b>94</b>
AMH	50	61	41
Social Services	84	26	32
Card Before You Leave (CBYL)	47	20	19
Community and Voluntary Service	22	23	9
AHP	33		
GP Out of Hours	23		
Child Health	11	16	
Education	16		
Youth Justice			
Addictions Service			
Social Services Out Of Hours			
<b>Region</b>	<b>1,958</b>	<b>1,750</b>	<b>1,833</b>

A number of trends can be identified:

- Referrals made by EDs were the dominant source of total accepted referrals in 2021/2022 (50.1%) and 2023/2024 (42.3%), and the second source in 2022/2023 (30.5%).
- General Hospital was the primary source of accepted referrals in 2022/2023 (39.3%), having been the third source in 2021/2022 (14.9%). It was the second source in 2023/2024 (29.2%).
- Accepted referrals made by GPs have decreased across the period under assessment and decreased relative to total accepted referrals (18.4% of total accepted referrals in 2021/2022; 17.5% in 2022/2023; and 17.0% in 2023/2024);
- Accepted referrals from the CVS have increased across the period under assessment (from 1.6% in 2021/2022, 3.6% in 2022/2023, and 5.1% in 2023/2024);
- Accepted referrals from Social Services sharply decreased between 2021/2022 – 2022/2023 (from 4.2% to 1.4%). There has been a slight increase in 2023/2024 (1.7%).

## Discharges

There have been fluctuations in the rates of discharges within the period under assessment.

Discharges decreased between 2021/2022 to 2022/2023 (from 9,226 to 9,060) but sharply increased to the period 2023/2024 (9,771).

Table 10 shows discharges recorded within each HSCT and for Step 2, Step 3, Eating Disorders, Addictions, and Crisis between 2021-24.

Table 10: Discharges recorded by HSCT and Step, 2021-24.

Year	Trusts	Step 2	Step 3	Eating Disorder	Addictions	Crisis	Total
21/22							
	BHSCT; SEHSCT	935	1,335	99	45	1,150	3,564
	NHSCT	980	666	94	30	418	2,188
	SHSCT	943	1,372	55			2,370
	WHSCT	168	567	49	36	284	1,104
<b>Region</b>		<b>3,026</b>	<b>3,940</b>	<b>297</b>	<b>111</b>	<b>1,852</b>	<b>9,226</b>
22/23							
	BHSCT; SEHSCT	850	1,318	120	36	1,055	3,379
	NHSCT	1,123	707	84	33	367	2,314
	SHSCT	869	1,336	76			2,281
	WHSCT	162	587	60	22	255	1,086
<b>Region</b>		<b>3,004</b>	<b>3,948</b>	<b>340</b>	<b>91</b>	<b>1,677</b>	<b>9,060</b>
22/24							
	BHSCT; SEHSCT	984	1,695	107	38	953	3,777
	NHSCT	1,167	632	53	34	334	2,220
	SHSCT	863	1,490	102		349	2,804
	WHSCT	126	561	53	24	206	970
<b>Region</b>		<b>3,140</b>	<b>4,378</b>	<b>315</b>	<b>96</b>	<b>1,842</b>	<b>9,771</b>

A review of available discharge data found the following:

- Discharges from Step 2 had slightly decreased between 2021/2022 – 2022/2023 but increased between 2022/2023 – 2023/2024;
- Discharges from Step 3 have increased, with a significant increase between 2022/2023-2023/2024);
- Discharges from Eating Disorder services have fluctuated, initially increasing between 2021/2022 – 2022/2023 before slightly decreasing between 2022/2023 – 2023/2024;
- Discharges from Addictions services have slightly fluctuated, initially decreasing between 2021/2022 – 2022/2023 before slightly increasing between 2022/2023 – 2023/2024; and
- Discharges from Crisis services had decreased between 2021/2022 – 2022/2023 but increased between 2022/2023 – 2023/2024.

Key findings for each HSCT are outlined below.

### **Belfast HSCT**

- Discharges for Step 2 have fluctuated: from 26.2% of total discharges in 2021/2022, to 25.1% in 2022/2023 and 26.0% in 2023/2024.
- Discharges for Step 3 have fluctuated: from 37.4% of total discharges in 2021/2022 to 39.0% in 2022/2023 and 44.8% in 2023/2024.
- Discharges for Eating Disorders services have fluctuated: from 2.7% of total discharges in 2021/2022 to 3.5% in 2022/2023 and 2.8% in 2023/2024.
- Discharges for Addictions services decreased: 1.2% of total discharges in 2021/2022 to 1.0% in 2022/2023 to 1.0% in 2023/2024; and
- Discharges for Crisis services steadily decreased: 32.2% of total discharges in 2021/2022 to 31.2% in 2022/2023 to 25.2% in 2023/2024.

### **Northern HSCT**

- Discharges for Step 2 have increased: from 44.7% of total discharges in 2021/2022 to 48.5% in 2022/2023 and 52.5% in 2023/2024.
- Discharges for Step 3 have fluctuated, recently decreasing: from 30.4% of total discharges in 2021/2022 to 30.5% in 2022/2023 and 28.4% in 2023/2024.
- Discharges for Eating Disorders services have decreased: from 4.2% of total discharges in 2021/2022 to 3.6% in 2022/2023 and 2.3% in 2023/2024.
- Discharges for Addictions services increased: 1.3% of total discharges in 2021/2022 to 1.4% in 2022/2023 and 1.5% in 2023/2024.
- Discharges for Crisis services decreased: from 19.1% of total discharges in 2021/2022 to 15.8% in 2022/2023 and 15.0% in 2023/2024.

### **Southern HSCT**

- Discharges for Step 2 have decreased: from 39.7% of total discharges in 2021/2022 to 38.0% in 2022/2023 and 30.7% in 2023/2024.
- Discharges for Step 3 have fluctuated, recently increasing: from 57.8% of total discharges in 2021/2022 to 58.5% in 2022/2023 and 53.1% in 2023/2024.
- Discharges for Eating Disorders services have increased: from 2.3% of total discharges in 2021/2022 to 3.3% in 2022/2023 and 3.6% in 2023/2024.
- No discharges for Addictions services were recorded; and
- The only data available for Crisis services was from 2023/2024, when there were 349 discharges recorded.

## Western HSCT

- Discharges for Step 2 have decreased: from 15.2% of total discharges in 2021/2022 to 14.9% in 2022/2023 and 12.9% in 2023/2024.
- Discharges for Step 3 have fluctuated, recently increasing: from 51.3% of total discharges in 2021/2022 to 54.0% in 2022/2023 and 57.8% in 2023/2024.
- Discharges for Eating Disorders services have fluctuated: from 4.4% of total discharges in 2021/2022 to 5.5% in 2022/2023 and 5.4% in 2023/2024.
- Discharges for Addictions services have also fluctuated: 3.2% of total discharges in 2021/2022 and 2.0% in 2022/2023 and 2.4% in 2023/2024 and
- Discharges for Crisis services decreased: 25.7% of total discharges in 2021/2022 to 23.4% in 2022/2023 and 21.2% 2023/2024.

Table 11 shows the reasons for the discharges for Step 2, Step 3, Eating Disorders, and Addictions between 2021-24.

Table 11: Discharges recorded by Reason and Step, 2021-24.

Year	Step	Step 2	Step 3	Eating Disorder	Addictions	Total
21/22						
	Goal Achieved	1,767	2,591	212	42	4,612
	Goal Achieved	1,767	2,591	212	42	4,612
	Client Disengaged	803	891	52	35	1,781
	Goal Partially Achieved	352	349	29	24	754
	Goal not Achieved (no change)	104	109		10	227
	<b>Total</b>	<b>3,026</b>	<b>3,940</b>	<b>297</b>	<b>111</b>	<b>7,374</b>
22/23						
	Goal Achieved	1,650	2,477	232	52	4,411
	Client Disengaged	825	815	54	20	1,714
	Goal Partially Achieved	403	537	47	17	1,004
	Goal not Achieved (no change)	126	119	7		254
23/24						
	Goal Achieved	1,614	2,644	251	47	4,556
	Client Disengaged	857	1,111	38	29	2,035
	Goal Partially Achieved	507	489	21	20	1,037
	Goal not Achieved (no change)	162	134			301
	<b>Total</b>	<b>3,140</b>	<b>4,378</b>	<b>315</b>	<b>96</b>	<b>7,929</b>

The reasons recorded for discharges during the period under assessment were subsequently analysed as follows:

**For the period 2021/2022:**

- Discharges made on the basis of the identified Goal having been Achieved equated to: 58.3% from Step 2, 65.7% from Step 3, 71.3% from Eating Disorder services, and 37.8% from Addictions services.
- Discharges made on the basis of the identified Goal having been Partially Achieved equated to: 11.6% from Step 2, 8.8% from Step 3, 9.7% from Eating Disorder services, 21.6% from Addictions services.
- Discharges made on the basis of client disengagement equated to: 26.5% from Step 2, 22.6% from Step 3, 17.5% from Eating Disorder services, and 31.5% from Addictions services.
- Discharges made on the basis of the identified Goal having Not Been Achieved equated to: 3.4% from Step 2, 2.7% from Step 3, and 9.0% from Addictions services.

**For the period 2022/2023:**

- Discharges made on the basis of the identified Goal having been Achieved equated to: 54.9% from Step 2, 62.7% from Step 3, 68.2% from Eating Disorder services and 57.1% from Addictions services.
- Discharges made on the basis of the identified Goal having been Partially Achieved equated to: 13.4% from Step 2, 13.6% from Step 3, 13.8% from Eating Disorder services, 18.6% from Addictions services.
- Discharges made on the basis of client disengagement equated to: 27.4% from Step 2, 20.6% from Step 3, 15.8% from Eating Disorder services, and 21.9% from Addictions services.
- Discharges made on the basis of the identified Goal having Not Been Achieved equated to: 4.1% from Step 2, 3.0% from Step 3, and 2.0% from Eating Disorder services.

**For the period 2023/2024:**

- Discharges made on the basis of the identified Goal having been Achieved equated to: 51.4% from Step 2, 60.3% from Step 3, 79.6% from Eating Disorder services, and 48.9% from Addictions services.
- Discharges made on the basis of the identified Goal having been Partially Achieved equated to: 16.1% from Step 2, 11.1% from Step 3, 6.6% from Eating Disorder services and 20.8% from Addictions services.
- Discharges made on the basis of client disengagement equated to: 27.2% from Step 2, 25.3% from Step 3, 12.0% from Eating Disorder services and 30.2% from Addictions services.
- Discharges made on the basis of the identified Goal having Not Been Achieved equated to: 5.1% from Step 2 and 3.0% from Step 3.

Analysing the above data, the following key patterns were identified:

- The percentage of discharges within Step 2 and Step 3 made on the basis of the identified Goal having been Achieved has decreased each year, and the rates for

2023/2024 are the lowest within the period under assessment (at 51.4% and 60.3% respectively);<sup>190</sup>

- The percentage of discharges within Eating Disorder services made on the basis of the identified Goal having been Achieved has increased each year, and the rate for 2023/2024 is the highest within the period under assessment (at 79.6%);
- The percentage of discharges within Addictions services made on the basis of the identified Goal having been Achieved has fluctuated, initially increasing (from 37.8% in 2021/2022 to 57.1% in 2022/2023) before decreasing (to 48.9% in 2023/2024).
- The percentage of discharges within Step 2 and Step 3 made on the basis of the identified Goal having Not been Achieved has increased each year, and the rates for 2023/2024 are the highest within the period under assessment (at 5.1% and 3.0% respectively);
- The percentage of discharges within Step 2 made on the basis of the identified Goal having been Partially Achieved has increased each year, and the rate for 2023/2024 is the highest within the period under assessment (at 16.1%);
- The percentage of discharges within Step 3 made on the basis of the identified Goal having been Partially Achieved has fluctuated, initially increasing (from 8.8% in 2021/2022 to 13.6% in 2022/2023) before decreasing (at 11.1% in 2023/2024);
- The percentage of discharges within Eating Disorder services made on the basis of the identified Goal having been Partially Achieved has fluctuated, initially increasing (from 9.7% in 2021/2022 to 13.8% in 2022/2023) before decreasing sharply (at 6.6% in 2023/2024);
- The percentage of discharges within Addictions service made on the basis of the identified Goal having been Partially Achieved has fluctuated, initially decreasing (from 21.6% in 2021/2022 to 18.6% in 2022/2023) before increasing sharply (at 20.8% in 2023/2024);
- The percentage of discharges within Step 2 made on the basis of client disengagement has slightly increased each year from 2021/2022 to 2022/2023 (from 26.5% to 27.4%), slightly decreasing by 2023/2024 (at 27.2%);
- The percentage of discharges within Step 3 made on the basis of client disengagement has fluctuated, initially decreasing (from 22.6% in 2021/2022 to 20.6% in 2022/2023) before increasing (at 25.3% in 2023/2024);
- The percentage of discharges within Eating Disorder services made on the basis of client disengagement has decreased each year, and the rate for 2023/2024 is the lowest within the period under assessment (at 12.0%); and
- The percentage of discharges within Addictions services made on the basis of client disengagement has fluctuated, initially decreasing (from 31.5% in 2021/2022 to 21.9% in 2022/2023) before increasing (at 30.2% in 2023/2024).

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<sup>190</sup> CAMHS operates on the Goal Based Outcomes model. This means that the individual goals are identified, discussed, and agreed for inclusion in the service user's care plan. Progress on these goals are periodically reviewed and rated with the service user. Based on this progress, there is discussion and decision-making re: discharge from CAMHS. "Goal having been Achieved" means that there is shared agreement that the identified goals have been realised and the service user is now suitable for discharge from CAMHS.

Table 12 shows the reasons for the discharges from Crisis services between 2021-24.

Table 12: Discharges recorded by Reason for Crisis, 2021-24.

Metric Description	21/22	22/23	23/24
Crisis Resolved and No Further Action	1,174	1,093	1,248
Crisis Resolved and requires continuing psychological care (Step 2 or Step 3)	299	261	269
Uncategorised	284	255	206
Declined on-going care	47	63	113
Admitted to in patient care	25		
On-going intensive intervention	23		
<b>Total</b>	<b>1,852</b>	<b>1,677</b>	<b>1,842</b>

The above demonstrates that:

- There has been an increase in discharges made on the basis of resolution, from 63.3% in 2021/22 to 65.1% in 2022/23, and 67.7% by 2023/24.
- There has been a decrease in discharges made on the basis of resolution and requiring ongoing care, from 16.1% in 2021/22 to 15.5% in 2022/23, and 14.6% by 2023/24.
- Whilst the figures are low, there is a trend of increasing rates of discharges made on the basis of the young person declining on-going care, from 0.02% in 2021/22, to 0.03% to 2022/23, and 0.06% by 2023/24.

### Active Clients

There has been a steady decline in the number of regional active clients recorded within CAMHS (Step 2, Step 3, Eating Disorders services, Addictions services, and Crisis) during the period under assessment.

Table 13 shows active clients in CAMHS as of 31<sup>st</sup> March for the timeframe under assessment.

Table 13: Active Clients in CAMHS Services by Trust and Service, as at 31<sup>st</sup> March 2022; 2023; 2024.

Year	Trust	Step 2	Step 3	Eating Disorder	Addictions	Crisis	Total
31 <sup>st</sup> March 2022							
	BHSCT; SEHSCT	937	1,787	104	40	101	2,969
	NHSCT	434	788	63	17	41	1,343
	SHSCT	410	924	111			1,445
	WHSCT	55	618	35	15		728
	<b>Total</b>	<b>1,836</b>	<b>4,117</b>	<b>313</b>	<b>72</b>	<b>147</b>	<b>6,485</b>
31 <sup>st</sup> March 2023							
	BHSCT; SEHSCT	635	1,804	95	38	43	2,615
	NHSCT	393	761	54	10	54	1,272
	SHSCT	419	912	92			1,423
	WHSCT	102	738				858
	<b>Total</b>	<b>1,549</b>	<b>4,215</b>	<b>246</b>	<b>60</b>	<b>98</b>	<b>6,168</b>
31 <sup>st</sup> March 2024							
	BHSCT; SEHSCT	470	1,896	99	38	28	2,531
	NHSCT	318	704	49	25	35	1,131
	SHSCT	423	763	71		34	1,291
	WHSCT	74	653	30	23	16	796
	<b>Total</b>	<b>1,285</b>	<b>4,016</b>	<b>249</b>	<b>86</b>	<b>113</b>	<b>5,749</b>

This data shows that:

- The number of active clients within Step 2 as of year end has decreased each year;
- The number of active clients within Step 3 as of year end had increased between 31<sup>st</sup> March 2022 and 31<sup>st</sup> March 2023 but has since decreased as of 31<sup>st</sup> March 2024;
- The number of active clients within Eating Disorder services as of year end had decreased between 31<sup>st</sup> March 2022 and 31<sup>st</sup> March 2023 but has since increased as of 31<sup>st</sup> March 2024;
- The number of active clients within Addictions services as of year end had decreased between 31<sup>st</sup> March 2022 and 31<sup>st</sup> March 2023 but has since increased sharply as of 31<sup>st</sup> March 2024; and
- The number of active clients within Crisis services as of year end had decreased between 31<sup>st</sup> March 2022 and 31<sup>st</sup> March 2023 but has since increased as of 31<sup>st</sup> March 2024.

## Waiting Lists

As of March 2024, there were 1,990 total CAMHS waiters.

The amount of children and young people waiting who had been waiting longer than nine weeks has increased to 51.5% (1,026 waiters).

In March 2022, it was reported that there were 2,106 total CAMHS waiters. Of this, 929 (44.1%) had been waiting for a time longer than nine weeks. By March 2023, the waiting list had increased to 2,302 total CAMHS waiters. The amount of those waiting who had been waiting longer than nine weeks had also increased to 1,033 (44.8%). As of March 2024, there were 1,990 total CAMHS waiters. Whilst this represented a decrease on March 2023 figures, those waiting for a time longer than nine weeks had increased to 51.5% (1,026 waiters). This can be seen from Table 14 below:

Table 14: Total CAMHS Waiting List at year End Position across All Trusts and All Services as of March 2022; 2023;2024

Numbers waiting	Mar-22	Mar-23	Mar-24
Total Waiting	2,106	2,302	1,990
Total > Nine Week Waits	929	1,033	1,026

Data in respect of waiting lists per HSCT region was requested, and key findings are outlined below. The full data is available within Appendix 2: Review of CAMHS Data, 2021 -2024 at 6. Total Waiting Lists.

### Belfast HSCT

Between March 2022 to March 2024, the number of young people waiting fewer than nine weeks has decreased. More young people are waiting longer than nine weeks.

In March 2022:

- 58.4% waited fewer than nine weeks.
- 41.5% waited longer than nine weeks.

In March 2023:

- 50.4% waited fewer than nine weeks.
- 47.9% waited longer than nine weeks.

As of March 2024:

- 50.4% waited fewer than nine weeks.
- 49.5% waited longer than nine weeks.

## **Northern HSCT**

Between March 2022 to March 2024, the number of young people waiting fewer than nine weeks has decreased, and there has been significant increase in the number of young people waiting longer than nine weeks.

In March 2022:

- 53.9% waited fewer than nine weeks.
- 46.0% waited longer than nine weeks.

In March 2023:

- 100% waited fewer than nine weeks.

As of March 2024:

- 27.0% waited fewer than nine weeks.
- 72.8% waited longer than nine weeks.

## **Southern HSCT**

Between March 2022 to March 2024 the number of young people waiting fewer than nine weeks has increased, and there has been significant decrease in the number of young people waiting longer than nine weeks.

In March 2022:

- 99.2% waited fewer than nine weeks.

In March 2023:

- 43.7% waited fewer than nine weeks.
- 68.6% waited longer than nine weeks.

As of March 2024:

- 88.2% waited fewer than nine weeks.
- 11.7% waited longer than nine weeks.

## Western HSCT

Between March 2022 to March 2024, the number of young people waiting fewer than nine weeks has decreased, and there an increase in the number of young people waiting longer than nine weeks.

In March 2022:

- 30.6% waited fewer than nine weeks.
- 346 (69.3%) waited longer than nine weeks.

In March 2023:

- 43.7% waited fewer than nine weeks.
- 56.2% waited longer than nine weeks.

As of March 2024:

- 36.4% waited fewer than nine weeks.
- 63.5% waited longer than nine weeks.

Trends were identified regarding waiting lists for each CAMHS service area.

## By the year end 31<sup>st</sup> March 2022:

- For Step 2, the Northern HSCT had the highest number of waiters across the HSCT regions (53.8% of total Step 2 waiting lists across the HSCT regions), with this waiting list comprising 69.2% of its total service waiting list;
- The Western HSCT had second highest number of waiters for Step 2 services across the HSCT regions (21.2% of total Step 2 waiting lists), with this waiting list comprising 36.8% of its total service waiting list;
- For Step 3, the Belfast HSCT had the highest number of waiters across the HSCT regions (42.4% of total Step 3 waiting lists across the HSCT regions), with this waiting list comprising 75.0% of its total service waiting list;
- The Western HSCT had second highest number of waiters for Step 3 services across the HSCT regions (26.3% of total Step 3 waiting lists), with this waiting list comprising 60.7% of its total service waiting list;
- For Eating Disorder services, the Belfast HSCT had the highest number of waiters across the HSCT regions (39.5% of total Eating Disorder service waiting lists across the HSCT regions), with this waiting list comprising 2.6% of its total service waiting list; and
- The Western HSCT had second highest number of waiters for Eating Disorder service across the HSCT regions (23.2% of total Eating Disorder service waiting lists), with this waiting list comprising 2.0% of its total service waiting list.

**By the year end 31<sup>st</sup> March 2023:**

- For Step 2, the Northern HSCT had the highest number of waiters across the HSCT regions (66.7% of total Step 2 waiting lists across the HSCT regions), with this waiting list comprising 75.2% of its total service waiting list;
- The Southern HSCT had second highest number of waiters for Step 2 services across the HSCT regions (22.5% of total Step 2 waiting lists), with this waiting list comprising 46.6% of its total service waiting list;
- For Step 3, the Belfast HSCT had the highest number of waiters across the HSCT regions (48.1% of total Step 3 waiting lists across the HSCT regions), with this waiting list comprising 82.2% of its total service waiting list; and
- The Western HSCT had second highest number of waiters for Step 3 services across the HSCT regions (20.4% of total Step 3 waiting lists), with this waiting list comprising 86.2% of its total service waiting list.

**By the year end 31<sup>st</sup> March 2024:**

- For Step 2, the Northern HSCT had the highest number of waiters across the HSCT regions (60.3% of total Step 2 waiting lists across the HSCT regions), with this waiting list comprising 91.9% of its total service waiting list;
- The Southern HSCT had second highest number of waiters for Step 2 services across the HSCT regions (25.2% of total Step 2 waiting lists), with this waiting list comprising 54.1% of its total service waiting list;
- For Step 3, the Belfast HSCT had the highest number of waiters across the HSCT regions (42.5% of total Step 3 waiting lists across the HSCT regions), with this waiting list comprising 81.2% of its total service waiting list; and
- The Western HSCT had second highest number of waiters for Step 3 services across the HSCT regions (33.0% of total Step 3 waiting lists), with this waiting list comprising 74.1% of its total service waiting list.

### **7.3 Beechcroft Inpatients**

The Beechcroft Child and Adolescent Inpatient Unit (“Beechcroft”), located within the Belfast HSCT, provides assessment and treatment for children and young people under 18 with complex mental illness, acute risk, diagnostic complexity that cannot be assessed or safely treated in the community. This service accepts acute and elective referrals from relevant authorities only.

Community and crisis teams can also suggest a young person may need the help of the Beechcroft service for a short period of time.

Admissions to Beechcroft have declined between 2021/2022 - 2023/2024, with the decline being particularly evident between 2022/23 and 2023/2024.

Data indicates that 81 young people were admitted to Beechcroft in 2021/2022; 79 were admitted in 2022/2023; and 52 were admitted in 2023/2024.

Out of Hours Admissions have also witnessed a decline between 2021/2022 - 2023/2024, with the decrease Out of Hours Admissions most apparent between 2022/23 and 2023/2024. Data indicates that in 2021/2022, 62 young people were admitted in an Out of Hours context; 59 were admitted in this manner in 2022/2023; and just 39 were admitted via Out of Hours in 2023/2024.

Discharges from Beechcroft have also witnessed a decrease between 2021/2022 - 2023/2024. The decrease however is most apparent between 2021/2022 and 2022/2023.

Data shows that 85 young people were discharged in 2021/2022; 72 young people were discharged in 2022/2023; and 60 young people were discharged in 2023/2024.

Data provided in respect of current inpatients shows that as of March 2024, there were 16 young people receiving support at Beechcroft, representing a decrease on the previous two years. By the year end of March 2022, there were 20 young people at Beechcroft, and this had increased to 24 by the end of March 2023.

Most young people at Beechcroft received support as an inpatient for a period of at least over a week to three months. Data shows that as of March 2024, six young people stayed for a period of 91-365 days. This is a decrease on previous years: as of March 2023, 11 young people stayed for that period of time, and 10 young people stayed for the same time in March 2022. In March 2023, 11 young people had stayed for a period of 8-90 days, an increase from March 2022, when 9 young people had stayed for that timeframe. On the basis of the data obtained, it appears that fewer inpatients are attending Beechcroft, but we are unable to ascertain whether they are staying for shorter periods.

NICCY had requested information in respect of Admissions, including Out of Hours Admissions, and Discharges for Beechcroft patients in respect of their Trust of Residence. This information is presented below at Table 15 and key findings outlined below. The full data is available within Appendix 2: Review of CAMHS Data, 2021 -2024 at 20. Beechcroft Inpatients.

Table 15: Beechcroft Admissions, Out of Hours Admissions and Discharges by Trust of Residence for Each Patient – 2021-24

HSCT region	21/22	22/23	23/24
<b>Belfast</b>			
Total Admissions	17	19	20
Out of Hours Admissions	14	9	15
Total Discharges	20	15	20
<b>Northern</b>			
Total Admissions	15	13	
Out of Hours Admissions	11	11	
Total Discharges	17	10	6
<b>South Eastern</b>			
Total Admissions	29	27	15
Out of Hours Admissions	22	23	12
Total Discharges	26	27	15
<b>Southern</b>			
Total Admissions	8	7	
Out of Hours Admissions			
Total Discharges	8	8	7
<b>Western</b>			
Total Admissions	12	13	10
Out of Hours Admissions	10	11	6
Total Discharges	14	12	12
<b>Total Admissions</b>	<b>81</b>	<b>79</b>	<b>52</b>
<b>Out of Hours Admissions</b>	<b>62</b>	<b>59</b>	<b>39</b>
<b>Total Discharges</b>	<b>85</b>	<b>72</b>	<b>60</b>

#### Belfast HSCT

- There is a pattern of increased Admissions of patients residing in the Belfast HSCT region to Beechcroft between 2021/2022 - 2023/2024.
- For 2021/2022 and 2023/2024, the majority of Admissions were Out of Hours Admissions. This reflected a decline in Out of Hours Admissions from 2021/2022 to 2022/2023 but an increase between 2022/2023 to 2023/2024.

### **Northern HSCT**

- There appears to be a pattern of decreased Admissions of patients residing in the Northern HSCT region to Beechcroft between 2021/2022 - 2023/2024.
- For 2021/2022 and 2022/2023, the majority of Admissions were Out of Hours Admissions.

### **South Eastern HSCT**

- There is a pattern of decreased Admissions of patients residing in the South Eastern HSCT region to Beechcroft between 2021/2022 - 2023/2024.
- For 2021/2022 - 2023/2024, the majority of Admissions were Out of Hours Admissions. This reflected a decline in Out of Hours Admissions from 2022/2023 to 2023/2024 but a slight increase between 2021/2022 to 2022/2023.

### **Southern HSCT**

- There appears to be a pattern of decreased Admissions of patients residing in the Southern HSCT region to Beechcroft between 2021/2022 - 2023/2024.
- There appeared to be no Out of Hours Admissions for 2021/2022 - 2022/2023.

### **Western HSCT**

- There is a new pattern of decreased Admissions of patients residing in the Western HSCT region to Beechcroft between 2021/2022 - 2023/2024.
- For 2021/2022 - 2023/2024, the majority of Admissions were Out of Hours Admissions. This reflected a decline in Out of Hours Admissions from 2022/2023 to 2023/2024 but a slight increase between 2021/2022 to 2022/2023.

Overall, it can be determined:

- For 2021/2022, the majority of Admissions, both total and Out of Hours specifically, to Beechcroft were patients from the South Eastern HSCT region. The Belfast HSCT region was second for both total and Out of Hours Admissions.
- For 2022/2023, the majority of Admissions, both total and Out of Hours specifically, to Beechcroft were patients from the South Eastern HSCT region. The Belfast HSCT region was second for total admissions but the Northern HSCT region was second for Out of Hours Admissions.
- For 2022/2023, the majority of Admissions, both total and Out of Hours specifically, to Beechcroft were patients from the Belfast HSCT region
- The South Eastern HSCT region was second for both total and Out of Hours Admissions.

## 7.4 The Knowing our Identity Gender Identity Team

The KOI service is comprised of an expert team located in the Belfast HSCT region. The team provides support to children, young people, and their families on gender related issues. The service operates for children and young people up to the age of 18. Access to KOI is by referral only, which is usually through CAMHS, or a learning disability service.

Accepted referrals to the KOI service in 2021/2022 - 2023/2024 have come through CAMHS, and specifically, CAMHS Step 3. Internal accepted referrals made via CAMHS Step 3 comprised 100% of accepted referrals in 2021/2022, 97% in 2022/2023, and 100% in 2023/2024.

Data on internal referrals accepted to the KOI service on the basis of the HSCT region of residence for the service user was requested. The data obtained is limited, due to preventing identification of service users. Of the data obtained and outlined at Table 16, it can be determined that service users come from all HSCT regions, and that there are fluctuations in the number of internal referrals made from CAMHS in HSCT regions.

Table 16: Internal Referrals Accepted into KOI by Trust of Residence, 2021-2024

Trust of Residence	21/22	22/23	23/24
BHSCT	11	9	
NHSCT		7	6
SEHSCT		9	8
SHSCT	7	8	
WHSCT	9	6	
<b>Total</b>	<b>35</b>	<b>39</b>	<b>26</b>

In examining data relating to Review Activity within the KOI service, as outlined at Table 17, it became clear that there have been fluctuations in the categories of activity between the years 2021/2022 – 2023/2024.

Table 17: Review Activity by Category and Year for KOI, 2021-2024

Category	21/22	22/23	23/24
Review Seen	178	105	181
Review DNA	21		10
Review CNA	20	6	7
Review CND	6	7	14
Review Cancellation			
<b>Total</b>	<b>227</b>	<b>125</b>	<b>215</b>

This pattern of fluctuation can be seen in the review of “seen” cases.

For review Did Not Attend (“DNA”), there appears to be a trend of decreasing activity.<sup>191</sup>

In the context of review “Could Not Attend” (“CNA”),<sup>192</sup> there also appears to be a trend of decreasing activity. 20 cases were reviewed in this category in 2021/2022.

Conversely, there is a pattern of increasing activity in the context of review “Could Not Attend on the Day” (“CND”).<sup>193</sup>

Discharges from the KOI service appear to have decreased between 2021/2022 – 2023/2024, as outlined at Table 18.

Table 18: Discharges by Reason for KOI By Year, 2021-2024

Metric	21/22	22/23	23/24
Resolved in Discharge	20	11	8
Referred for Continuing Intervention	15		
Refused Ongoing Care	6		9
Already Known to Community CAMHS			
Referred to Community CAMHS			
<b>Total</b>	<b>45</b>	<b>18</b>	<b>22</b>

Whilst the data provided was not complete, there appears to be a new trend of decreasing numbers of discharges undertaken on the basis of issues resolved in discharge. There may also be a pattern of increasing rates of refusing ongoing care. 13% of total discharges were made on this basis in 2021/2022; this increased to 40.9% of total discharges were made in 2023/2024.

Data also indicates there have been decreasing numbers of active clients at the end of each fiscal year between 2021/2022-2023/2024. As of March 2024, there were 16 active clients within KOI. This is a decrease on both of the preceding years: 19 active clients were recorded in March 2023, with 25 recorded in March 2022. The full data is available within Appendix 2: Review of CAMHS Data, 2021 -2024 at 22. KOI Gender Identity Team.

## 7.5 Family Trauma Centre

The Family Trauma Centre supports children, young people, and their families who are experiencing difficulties in coping with a traumatic and frightening experience. The service operates for children and young people aged 18 and under. There are multiple routes to

<sup>191</sup> A service user may be categorised as Did Not Attend (“DNA”) when the service is not notified in advance of the service user’s unavailability to attend on the offered admission date, or for any appointment.

<sup>192</sup> A service user may be categorised as Could Not Attend (“CNA”) when the service is notified in advance of the service user’s unavailability to attend on the offered admission date, or for any appointment.

<sup>193</sup> A service user may be categorised as Could Not Attend on the Day (“CND”) when the service is notified in advance on the day of the scheduled appointment of the service user’s unavailability to attend on the offered admission date, or for any appointment.

accessing the Family Trauma Centre. Referrals may be made by GPs, health visitors, children’s services, hospital services, community nurses, educational welfare officers, school nurses, social workers, psychologists, the CVS and charity organisations. Access can also be by self-referral.

Referrals to the Family Trauma Centre service have fluctuated between 2021/2022 - 2023/2024, with a period of decline and increase.

164 young people were referred in 2021/2022; 155 in 2022/2023, with 187 being referred in 2023/2024.

There has been a trend of fluctuation in accepted referrals to the Family Trauma Centre service between 2021/2022 - 2023/2024, outlined at Table 19 below: 86% of referrals were accepted in 2021/2022, 84.5% in 2022/2023, and 88.2% in 2023/2024.

Table 19: Referrals received, accepted, and percentage accepted for Family Trauma Centre, 2021-2024

Year	Total Referrals Received	Total Referrals Accepted	Percentage of Referrals Accepted
21/22	164	141	86.0
22/23	155	131	84.5
23/24	187	165	88.2

Data on internal referrals accepted to the Family Trauma Centre service on the basis of the HSCT region of residence for the service user is presented at Table 20.

Table 20: Referrals Accepted by Trust of Residence of Patient and Year for Family Trauma Centre, 2021-24

Trust of Residence	21/22	22/23	23/24
BHSCT	80	57	76
NHSCT	15	10	22
SEHSCT	28	39	45
SHSCT	8	21	13
WHSCT	10		9
<b>Total</b>	<b>141</b>	<b>131</b>	<b>165</b>

Data on internal referrals accepted to the Family Trauma Centre service on the basis of source of the referral was requested, and is presented at Table 21.

Table 21: Referrals Accepted by Source by Year for Family Trauma Centre, 2021-2024

Source	21/22	22/23	23/24
General Practitioner	66	63	77
Social Services - Child Protection / Family Services / Disability	22	33	54
Paediatrics / Child Health / Inpatient Service		29	12
Education	7		16
AHP	15		
Social Services - Looked After Children	14		
3rd Sector			
Family / Self	7		
ASD Services / Professional			
<b>Region</b>	<b>141</b>	<b>131</b>	<b>165</b>

This data demonstrates that the number of referrals made by both GPs and Social Services (Child Protection / Family Services / Disability) have been increasing each year across the years 2021/2022-2023/2024.

- 46% of total accepted referrals were made by a GP in 2021/2022. This increased in 2022/2023 to 48%. This was a slight decrease in 2023/2024 to 46.6%.
- 15.6% of total accepted referrals were made by Social Services (Child Protection / Family Services / Disability) in 2021/2022. This increased to 25.1% in 2022/2023, and again to 32.7% in 2023/2024.

In examining data relating to new referrals, known as “New Activity”, within the Family Trauma Centre service, it became clear that there have been fluctuations in the categories of activity between 2021/2022 – 2023/2024.

This pattern of fluctuation can be seen in the number of new Seen cases. 93 new seen cases were reviewed in 2021/2022 (60.7% of total new activity). 53 seen cases were reviewed in 2022/2023 (58.8% of total new activity), representing a decrease in both the number of new Seen cases as well as relative to total new activity between years. This pattern reversed in the subsequent year with 81 Seen cases reviewed in 2023/2024. However, this represented a decrease in the number of new Seen cases relative to total new activity (45.7% for 2023/2024).

For new DNA, there appears to be a trend of fluctuation in activity; this is also suggestive of new CNA. Conversely, there is a pattern of increasing activity in the context of new CND. The full data is available within Appendix 2: Review of CAMHS Data, 2021 -2024 at 21.Family Trauma Centre.

In examining data relating to Review Activity within the Family Trauma Centre service, it became clear that there have been fluctuations in the categories of activity between years 2021/2022 – 2023/2024. This pattern of fluctuation can also be seen in the number of the review of Seen cases.

For review DNA, there appears to be decrease in activity. In the context of review CNA, there also appears to be a trend of fluctuation in activity. There is also a pattern of fluctuating activity in the context of review CND. Conversely there is a pattern of increasing activity in the context of review Cancellation

The full data is available within Appendix 2: Review of CAMHS Data, 2021 -2024 at 21.Family Trauma Centre.

When reviewing data relevant to service discharge, data suggests that whilst overall numbers of discharges have decreased, the reasons for discharges have shifted in the years 2021/2022 – 2023/2024, as outlined at Table 22.

Table 22: Discharges by Reason and Year for Family Trauma Centre, 2021-2024

Metric Description	21/22	22/23	23/24
Goal Achieved	123	57	54
Drop out of Care	78	55	70
Goal Partially Achieved	34	17	12
Assessment Only			
Goal Not Achieved (no change)			
<b>Total</b>	<b>235</b>	<b>133</b>	<b>137</b>

There has been a significant decrease in the number of discharges made on the basis of goal achievement within the Family Trauma Centre service, suggesting that goals are now increasingly not being met within the service.

In 2021/2022, 52.3% of discharges were made on the basis of goal achievement. This however sharply decreased to 42.8% in 2022/2023 and decreased again in 2023/2024 to 39.4%.

There has also been a significant decrease in the number of discharges made on the basis of partial goal achievement, further suggesting that goals are now increasingly not being met, whether fully or partially.

In 2021/2022, 14.4% discharges were made on the basis of partial goal achievement. This decreased to 12.7% in 2022/2023 and decreased again to 8% in 2023/2024.

There has been a fluctuation in the number of discharges made on the basis of users dropping out of the service. However, as of 2023/2024, the majority of recorded discharges (51%) were on the basis of users dropping out of the service.

33% cases were recorded on this basis in 2021/2022. This decreased to 41.3% in 2022/2023, and increased to 51% in 2023/2024.

The number of active clients in the Family Trauma Centre service as of the end year point has increased between 2021- 2024. As of March 2024, there were 159 active clients in the service, an increase on March 2023 (110) and March 2022 (112).

## 7.6 Forensic Services

The Forensic Mental Health Service comprises of a multi-disciplinary team, which works to support the safe discharge of patients from medium and low secure units. These patients may be subject to restriction orders or require intensive monitoring or supervision. The team is comprised of specialists to support the mental health, psychological, behavioural, and social care needs of patients under 18. They work in conjunction with other health and social care agencies, in a way which is mutually compatible with a public protection role. The Forensic Mental Health Team will have established links with Courts, Prisons, Police Service, and Probation Service. The service is accessed via Mental Health Services/Medium Secure Settings and Criminal Justice Agencies.

There is strong evidence suggesting children and young people within the criminal justice system have considerably higher levels of mental health needs compared to their peers. Recognising children involved with the Youth Justice Agency (“YJA”) historically had struggled to engage with formal mental health services, CAMHS and the YJA established and co-funded an assertive outreach pilot service in the Southern HSCT region in 2019. As part of the pilot, YJA practice staff screened children and a co-located senior mental health practitioner delivered direct services to children, connected children to other CAMHS-related services, and provided consultation and support to YJA staff to help them to develop their knowledge, skills and confidence in dealing with lower-level mental health needs. Following this, the service was extended to all five HSCTs since February 2025.<sup>194</sup>

Referrals to Forensic Services have fluctuated between 2021/2022 - 2023/2024, with a period of decline and increase during this period.

Data indicates that 90 young people were referred to Forensic Services in 2021/2022. 65 were referred in 2022/2023, representing a decrease in referrals to the service between 2021/2022 and 2022/2023. 86 were referred in 2023/2024, demonstrating a sharp increase in referrals between 2022/2023 and 2023/2024.

There has been a decrease in accepted referrals to Forensic Services between 2021/2022 - 2023/2024. 88 referrals were accepted in 2021/2022, representing 98% of referrals. 64 referrals were accepted in 2022/2023, representing 98% of referrals. In 2023/2024, 66 referrals were accepted, representing 77% of referrals.

Forensic Services operate as Tertiary and In-Reach Services, with referrals being made specifically to each service.

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<sup>194</sup> See Department of Justice. (2025). Youth Justice Agency PERFORMANCE IMPACT REPORT 2024 – 2025.

### Tertiary Forensic Services

Referrals to Tertiary Forensic Services have sharply fluctuated between 2021/2022 - 2023/2024, with a period of decline and increase during this period.

Data indicates that 23 young people were referred to Tertiary Forensic Services in 2021/2022. 8 were referred in 2022/2023, representing a significant decrease in referrals to the service between 2021/2022 and 2022/2023. 24 were referred in 2023/2024, demonstrating a significant increase in referrals between 2022/2023 and 2023/2024.

There is a trend of decreasing acceptance rates of referrals between 2021/2022 - 2023/2024.

21 referrals to Tertiary Forensic Services were accepted in 2021/2022, representing an acceptance rate of 91%. 7 referrals were accepted in 2022/2023, an acceptance rate of 88%. Data indicates that just 17% of made referrals to Tertiary Forensic Services were accepted in 2023/2024, a significant decrease in acceptance rates.

### In-Reach Forensic Services

Referrals to In-reach Forensic Services have been generally consistent between 2021/2022 - 2023/2024.

Data indicates that 67 young people were referred to Tertiary Forensic Services in 2021/2022. 57 were referred in 2022/2023, representing a slight decrease in referrals to the service between 2021/2022 and 2022/2023. 62 were referred in 2023/2024, demonstrating a slight increase in referrals between 2022/2023 and 2023/2024.

There is a trend of complete acceptance rates of referrals to In-Reach Forensic Services between 2021/2022 - 2023/2024. All referrals made in 2021/2022, 2022/2023, and 2023/2024 were accepted, representing a 100% acceptance rates across all timeframes.

As presented in Table 23, there is a trend of decreasing discharge figures for both Tertiary and In-Reach Forensic Services between 2021/2022 - 2023/2024.

Table 23: Discharges by Forensic Services, 2021-2024

	21/22	22/23	23/24
Forensic Inreach Total Discharges	64	60	59
Forensic Tertiary Total Discharges	18	10	8

There appears to be a trend of consistent active clients in In-Reach Forensic Services between 2021/2022 - 2023/2024 with six active clients recorded in both years. In contrast, there is a trend of decreasing active clients in Tertiary Forensic Services: 10 active clients recorded in 2021/2022, eight in 2022/2023, and six were recorded in 2023/2024. These figures are outlined at Table 24 below.

Table 24: Active Clients by Forensic Services, 2021-2024

	21/22	22/23	23/24
Forensic Inreach Active Cases	6		6
Forensic Tertiary Active Cases	10	8	6

## 7.7 Conclusion

The above data review and analysis present a CAMHS system which has been in demand and now showing signs of strain. There are a number of findings which are particularly disconcerting, including in the context of age and gender of service users.

A trend of decreasing referrals to CAMHS between 2021/2022 to 2023/2024 was identified. There is also a recent trend of decreasing acceptance of referrals within the service. By 2023/2024, the acceptance rate was 66.3%, the lowest acceptance rate for the period under assessment.

When reviewing referrals accepted for CAMHS services (Step 2/ Step 3/ Eating Disorders/ Addictions) on the basis of priority between 2021-2024, it appears there are trends of decreasing accepted referrals and decreasing rates of referrals across the categories of emergency, routine, and urgent. However, there are fluctuations in the trends of accepted routine and urgent referrals relative to total accepted referrals. By 2023/2024, there were 6,573 accepted referrals, and figures recorded for the categories of emergency and urgent were the lowest recorded figures for their respective categories.

The analysis of referrals to CAMHS services on the basis of gender revealed some troubling trends. Girls have consistently been the majority of overall referrals for CAMHS service use compared to boys, including Step 2 and Step 3. Girls of all ages are the dominant users of Eating Disorder services, and boys are the dominant users of Addiction Services - but the composition of girls relative to the total referrals to the system has increased, forming the highest level of referrals in the period examined in this report. Overall, girls comprised the majority of referrals to Crisis services – boys had slightly edged out girls for referrals within the 5-11 age band in 2021-2023, but by 2023/2024, girls were the dominant figures across all ages.

Whilst there has been some fluctuation in waiting lists during the examined period, waiting beyond the targeted nine weeks has increased. As of March 2024, children and young people beyond than nine weeks had increased to 51.5% (1,026 waiters) – the highest figure for this category within the period under assessment.

NICCY had expressed its concern regarding the status of operations of CAMHS within its monitoring of the SWAP. These concerns were especially acute in the context of waiting lists and services under pressure to meet demand. The data presented above indicates these issues remain, and NICCY continues to hold concerns about the status of CAMHS, and the implications for children and young people entitled to timely access to robust services.

## 8. An Analysis of the Mental Health Strategy

### 8.1 Introduction

The publication of the Mental Health Strategy in 2021 was a seminal moment in the mental health policy landscape in NI.<sup>195</sup> Prior to its introduction, NI was the only region in the UK without an overarching strategy, and the delivery of mental health treatments and care was described as “fragmented and not properly resourced”.<sup>196</sup> This situation was despite the strong evidence that NI has very high levels of mental ill-health and mental health needs. As explored in Chapter 3, the mental health needs of children and young people in NI are complex, persistent, and require urgent focus.

In 2018, at a time when the NI devolved institutions were not operating, a coalition of CVS organisations had published a call for action to the UK Government to intervene, describing the political vacuum as having “worsened NI’s mental health crisis”.<sup>197</sup> One of the coalition’s recommendations was for the delivery of a 10-year Mental Health Strategy; this call was followed by the NI Affairs Select Committee urging the Department to begin work on a mental health strategy.<sup>198</sup>

In October 2002, the then-Department of Health, Social Services and Public Safety (“the DHSSPS”) commenced a significant independent review of the law, policy and provision affecting people with mental health needs or a learning disability in NI. The 2008 Bamford Review published a series of 11 interlinked reports.<sup>199</sup> Collectively, they envisioned mental health services being able to provide a meaningful difference to service users, and outlined recommendations focused on developing and improving services. This included recommendations focusing on promoting positive mental health; using a person-centred approach; developing specialist services for children and young people, older people, those with addictions problems and those in the criminal justice system; and operating a trained workforce. It was envisaged that the full implementation of the Bamford Review’s recommendations would require a 10–15-year timeframe, dependent on the availability of additional resources. The reports’ recommendations formed the Bamford Action Plan 2012–2015 (“the Bamford Action Plan”).<sup>200</sup>

A key recommendation within the Bamford Action Plan was for the DHSSPS to publish and implement a revised cross-sectoral promoting Mental Health Strategy, but the progression of this was limited, and focused on a suicide prevention and positive mental health promotion

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<sup>195</sup> Department of Health. (2021). *Mental Health Strategy 2021–2031*.

<sup>196</sup> O’Neill, S., Heenan, D. and Betts, J. (June 2019). “Review of Mental Health Policies in Northern Ireland: Making Parity a Reality”. *Ulster University*.

<sup>197</sup> See Together for You, Mental Health Foundation, Action Mental Health, Nexus, Cause. (2018). “Mental Health in Northern Ireland”.

<sup>198</sup> NI Affairs Select Committee. (2019). *Health Funding in Northern Ireland*. (House of Commons, UK Parliament London). At para 135.

<sup>199</sup> See Department of Health. “Bamford Review of Mental Health and Learning Disability”.

<sup>200</sup> DHSSPS. (2012). “Delivering the Bamford Vision The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan 2012–2015.”

strategy, a final version of which was expected in 2014.<sup>201</sup> In 2016, the Department commenced an evaluation of the Bamford Action Plan with the aim to assess the performance of the NI Departments against the identified targets, and was to include the views of service users and carers. At the time of writing, the final evaluation report does not appear to be publicly available.<sup>202</sup> By 2020, however, mental health service reform, including CAMHS, continued to be grounded by the Bamford Review. As such, despite “a plethora of evidence-based research” being cited in strategies for healthcare in NI, and the need for radical, collaborative action across stakeholders, there was still no overarching mental health strategy by 2020.<sup>203</sup>

## 8.2 Introduction of the Mental Health Strategy

The restoration of the NI devolved institutions in January 2020 brought a renewed focus on mental health, with two notable strategic developments. The Department launched a Mental Health Action Plan in 2020, followed by the introduction of the Mental Health Strategy in 2021. These marked the fulfilment of commitments set out in the 2020 New Decade, New Approach agreement.

The Mental Health Action Plan was designed to be a short-term measure, aiming to deliver a degree of immediate improvement in services, and to facilitate the development of a further long-term approach.<sup>204</sup> The first action was to develop a 10-year mental health strategy, co-produced with key stakeholders, and appoint a Mental Health Champion. It also outlined other actions to review services to inform the new strategy, including those for eating disorder, personality disorder, mental health crisis, and rehabilitation services.

When launching the Mental Health Strategy in 2021, the Minister for Health acknowledged that mental health services were under “significant pressure” and inpatient services facing “extreme demand”.<sup>205</sup> The Strategy consists of 35 actions across three themes:

Theme 1: Promoting mental wellbeing resilience and good mental health across society - focused on promotion, resilience and additional support across various parts of a person’s life, and actions around additional therapy hubs support and support for carers in mental health settings;

Theme 2: Providing the right support at the right time – focused on the delivery of services, to ensure people who need support receive the support they need, when they need it; and

Theme 3: New ways of working - focused on the systems around mental health services, such as the creation of a single mental health service, digital mental health, workforce, data and outcomes and innovation and research.

<sup>201</sup> DHSSPS. (2014). “Delivering the Bamford Vision The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan 2012-2015. Monitoring Report November 2014. At page 5.

<sup>202</sup> See Department of Health. “Bamford published reports”.

<sup>203</sup> O’Neill, S., Heenan, D. and Betts, J. (June 2019). “Review of Mental Health Policies in Northern Ireland: Making Parity a Reality”. Ulster University. At page 28.

<sup>204</sup> Improvements for mental health services included developing new perinatal services; expanding talking therapies and other community-based support through mental health hubs in primary care; implementing a regional trauma network; and developing a managed care network for CAMHS.

<sup>205</sup> Department of Health. (29 June 2021). ORAL STATEMENT TO THE ASSEMBLY BY HEALTH MINISTER ROBIN SWANN – TUESDAY 29 JUNE 2021 – PUBLICATION OF MENTAL HEALTH STRATEGY 2021 – 2031.

Five actions are deemed particularly critical to address the recurring issues known within mental health services:

Creating an action plan for promoting mental health through early intervention and prevention, covering a whole life approach from infancy to old age and seeks to reduce stigma associated with mental ill-health services (**Action 2**);

Increasing the share of funding for CAMHS to 10% of that provided to adult mental health services, improving delivery to ensure the needs of young people, their families and their support networks are met (**Action 10**);

Changing the structure of service delivery, refocusing and reorganising more towards community-based services, centred around GPs and primary care teams (**Action 15**); and

Developing a regional mental health service, across the five HSCTs, to ensure consistency in service delivery and development (**Action 31**).

In addition to Action 10, there are dedicated actions for child and adolescent mental health (outlined within Theme 2: Providing the right support at the right time).

**Action 11:** Ensure that the needs of infants are met in mental health services, and meet the needs of vulnerable children and young people when developing and improving CAMHS, putting in place a ‘no wrong door’ approach;

**Action 12:** Create clear and regionally consistent urgent, emergency and crisis services for children and young people that will work together with crisis services for adult mental health; and

**Action 13:** Develop proposals for transitions between CAMHS and adult mental health services, engaging widely with all relevant stakeholders.

The Strategy was published with a Mental Health Funding Plan, (“Funding Plan”) which was designed to identify the costs associated with developing, establishing, and maintaining the services outlined in the Strategy’s actions.<sup>206</sup> It identified an estimated investment need of approximately £112mn to £158mn revenue funding on a year-on-year basis, as well as an approximate £285mn one-off capital investment. The total cost associated with the implementation of the Strategy over its 10-year lifespan was estimated at approximately £1.2bn which includes funding for the construction of three new inpatient facilities and revenue costs associated with new and improved services.

The Funding Plan identified funding requirements for Actions 10-13 as follows:

- Actions 10 and 11 (in conjunction with Action 7): a recurrent revenue cost of between £7.5mn and £21.1mn;

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<sup>206</sup> Department of Health. (2021). “Mental Health Strategy 2021-2031 Funding Plan”.

- Action 12 (in conjunction with Action 27): a recurrent revenue cost of between £2.93mn and £8.02mn; and
- Action 13: a recurrent revenue cost of approximately £4.2mn.

Upon the launch of the Strategy, it was acknowledged that the level of funding outlined with the Funding Plan would not be available from within existing departmental resources without having severe implications for existing activities. A collective effort across all Executive Departments to prioritise mental health funding in future budgetary processes would therefore be required.

The Strategy does not contain any specific measure or detail as regards its implementation and the Funding Plan also makes clear that it was not possible to commence all actions at once. Annual Delivery plans, produced since 2022, outline the Department’s facilitation and implementation of the Strategy.

A review of these plans finds fragmented progress across Actions 10-13. Whilst there is evidence of organisational planning, strategic development, implementation of initiatives, and review/evaluation of pilots, understanding how these work streams connect to progress each specific action is not always clear. Progress has clearly been stalled in relation to Action 14, due to other competing priorities. The review of Departmental progress can be read in full within Appendix 3, “Review of the Mental Health Strategy March 2025”.

### **8.3 Status of the Mental Health Strategy: 2025 updates**

Within its information requests, NICCY specifically sought information relating to means of delivery, progress made in delivery and identified actions for 2025/2026. The analysis can be read in full within Appendix 3, “Review of the Mental Health Strategy March 2025”.

What is notable is the recognition of delayed progression of the actions most relevant to children and young people’s mental health services. This is compounded by the recognition of the financial landscape and corresponding budgetary pressures. Actions 10, 11, and 13 were all described by the Department as being delayed, and the financial situation was identified as barriers to future progress, particularly in the 2025/2026 year. Based on the information provided, specific commentary on Actions 10, 11, 12, and 13 are provided below.

#### *Action 10*

The Department advised that CAMHS funding sits at 8% of mental health funding, with this framed as a positive development, especially given the Department’s financial situation. However, this represents just a 0.5% increase in funding since the 2019/2020 year, when the Department estimated that of the then-£300mn budget, just over £20mn related to CAMHS (about 7.5% of the overall mental health budget).<sup>207</sup> The 2023 NIAO report found that whilst the proportion of the NI mental health budget attributable to CAMHS services increased between 2010/2011 and 2019/2020 (from 7.2% to 7.5% respectively), there had been a decrease in

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<sup>207</sup> NICCY recognises there are other services, under children’s services and the PHA, which work to address and support the emotional and mental health of children and young people; it is not possible to disaggregate this funding.

funding from the “peak levels” between 2012/2013 and 2013/2014 (8.1% of the overall mental health budget).<sup>208</sup> Funding still falls short of the 10% of the then-HSCB calculated should be invested in CAMHS.<sup>209</sup>

### *Action 11*

The Department had advised that the PHA was planning a “refresh” of the Infant Mental Health Framework, which was due to be launched in 2025. At the time of writing, no such launch has taken place by the PHA, and consequently the 2016 Infant Mental Health Framework remains as the operational framework.<sup>210</sup> The monitoring of its implementation also appears to be limited: the Department for example only provides updates relating to 2017/2018 on the dedicated webpage for the Infant Mental Health Framework.<sup>211</sup> Whilst the PHA published a report in 2024 which sought to provide insight into measures promoting infant mental health in NI, this was not a significant strategic development.<sup>212</sup>

Post-pandemic, it is clearly a critical time to take stock of the new and exacerbated needs of infants and their families, and to ensure that strategic developments and emerging services recognise and address these needs.<sup>213</sup> Priorities have been identified by relevant stakeholders, including the need to review the relevant impact data being collected or reported on across aligned strategies, identifying formal opportunities for data sharing mechanisms to inform practice, and considering where additional data is still needed to address gaps in knowledge.

### *Action 12*

Whilst the Department did provide updates, these did not provide clarity as to specific items of work, targets, relevant timeframes and/or deadlines. It is therefore not possible to have a clear understanding of its progress which is a cause for concern.

In 2021, the Minister for Health announced a new regional Mental Health Crisis Service for NI, which to date, has not been fully implemented.<sup>214</sup> This should, however, be progressed as a matter of urgency as it is vital that a unified and consistent regional mental health crisis service across all age groups is secured.

### *Action 13*

The Department advised that proposals for future transitions arrangements will be considered, but this is dependent on budget and wider resourcing considerations. Whilst there was evidence of service improvement following on from the 2011 RQIA report, the general

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<sup>208</sup> NI Audit Office. (2023). *Mental Health Services in Northern Ireland*. At 3.7 and 3.8.

<sup>209</sup> See NICCY. (April 2017). “Child and Adolescent Mental Health in NI A Scoping Paper which includes the human rights basis of mental health, a review of evidence regarding prevalence and need, an overview of the CAMHS system, and an outline of key policy implications.” At page 24.

<sup>210</sup> PHA. (April 2016). ‘*Supporting the best start in life*’ *Infant Mental Health Framework for Northern Ireland*.

<sup>211</sup> See Department of Health. “Infant Mental Health Framework”.

<sup>212</sup> PHA. (June 2024). *Insights in infant mental health in Northern Ireland*.

<sup>213</sup> See National Children’s Bureau and PHA. (February 2022). “Infant Mental Health: an update on relevant policy developments”.

<sup>214</sup> See Department of Health. (24 August 2021). “New regional mental health crisis service”.

consensus within research is that there is considerable variability between service providers in how they meet the transition needs of young people, and there is no consistent or singular approach to dealing with CAMHS-AMHS transition within HSCT regions.<sup>215</sup> Research published in 2019 found major gaps in the quality of the transition process, with those CAMHS-AMHS transition cases under examination having been found to not meet the key criteria of an optimum process.<sup>216</sup>

#### **8.4 Status of the Mental Health Strategy: 2025 analysis**

NICCY has produced a final status evaluation of Actions 10-13 of the Strategy, which is coded depending on the status of progression and NICCY's understanding of prospects for future progression based on broader policy and financial landscape; this is available within Appendix 3, "Review of the Mental Health Strategy March 2025".

In summary:

- Of the four Actions which were subject to information returns, three actions were coded as red. NICCY is concerned as to the status of progression of these actions and considers these as actions requiring urgent attention.

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<sup>215</sup> See Paul, M. *et al.* (2013). "Young people's transfers and transitions between child and adolescent and adult mental health services: the TRACK study." *Br J Psychiatry* 202(S54) 36–s40; and Leavey, G. *et al.* (2018). *Improving mental health pathways and care for adolescents in transition to adult services in Northern Ireland (IMPACT)*. PHA (Belfast).

<sup>216</sup> Leavey, G., McGrellis, S., Forbes, T., Thampi, A. *et al.* (2019). "Improving mental health pathways and care for adolescents in transition to adult services (IMPACT): a retrospective case note review of social and clinical determinants of transition." 54(8) *Social Psychiatry and Psychiatric Epidemiology* 955-963.

Action	NICCY's Progress Coding
10. Increase the funding for CAMHS to 10% of adult mental health funding and improve the delivery of the stepped care model to ensure it meets the needs of young people, their families and their support networks.	Red
11. Ensure that the needs of infants are met in mental health services, and meet the needs of vulnerable children and young people when developing and improving CAMHS, putting in place a 'no wrong door' approach.	Yellow
12. Create clear and regionally consistent urgent, emergency and crisis services for children and young people that will work together with crisis services for adult mental health.	Red
13. Develop proposals for transitions between CAMHS and adult mental health services, engaging widely with all relevant stakeholders.	Red

- The updates provided for Actions 10, 12, and 13 were limited, lacking information including clear timeframes and targets for full realisation. This is particularly concerning in the context of Actions 12 and 13, given their importance to CAMHS system reform and response to immediate need.
- The updates provided for Actions 10, 12, and 13 advised generally that they “should be” completed. NICCY is mindful of the financial constraints experienced by the Department, and the uncertainty this generates for future planning and delivery. Notwithstanding this, it is disconcerting that general and vague comments are provided in relation to future progression of critical actions which are needed to ensure much-needed systematic and operational reform of CAMHS. This is particularly in the context of addressing the prolonged issue of transitions from CAMHS to AMHS, which has been well-documented in NI and which has repercussions for safeguarding the future mental health of young people.
- NICCY is concerned by the limited progress made in relation to Action 11, and by the wider fragmented focus made in respect of protection and promotion of infant mental health. This is particularly given its importance to early intervention and prevention, and for ensuring the best possible start in life for children.

## 8.5 Conclusion

The publication of the Mental Health Strategy in 2021 was a seminal milestone in the mental health policy landscape in NI. The Strategy represented a radical intervention in the protection and promotion of mental health. It has particular significance for the realisation of the recognition and realisation of mental health for infants, children, and young people, and

offers a framework to enable system transformation within CAMHS. The realisation of the Strategy's ambition has, however, been limited to date and particularly constrained by financial and political instability. The issue of underinvestment in the Strategy's delivery in accordance with its own Funding Plan is becoming more pressing with each year, most noticeably in the context of CAMHS service funding and the prolonged delay in addressing the longstanding issues affecting transitions.

As the above analysis demonstrates, progression of critical actions relating to children and young people remains fragmented, and slow. The issues of funding and resourcing have resulted in the Department expressly noting that progression of actions is undertaken on a priority basis which raises questions as to corresponding impact on progression. It further raises concerns as to the potential for prolonged delay of advancing the practical changes promised by Actions 10-13, including those needed to meet demand and ensure timely and sufficient service access. This is especially evident in the context of ensuring adequate funding of CAMHS, delivering on a regional mental health crisis service, as well as ensuring an effective and supportive transitions process.

NICCY acknowledges that the Department recently conducted the Deliverability Review of the Strategy, which did provide some insight into actions undertaken to date, as well as current and projected future funding allocations (or lack thereof). It is notable that this Review was undertaken due to a recommendation from the PAC within its 2024 report. This Review could serve as a baseline for future monitoring of the delivery of the Strategy to enable understanding as to its direction of travel, and any barriers to its progression.

As the above analysis also revealed, the information available with regards to the status and progression of Actions 10-13 is limited and confined to general statements relating to potential completion. The financial constraints experienced by the Department, and the corresponding uncertainty as regards future planning and delivery, is acknowledged. It is however critical that comprehensive and clear information, including the availability of clear targets, timeframes, and deadlines, is made available in order to better understand the status and progression of critical actions which are needed to ensure much-needed systematic and operational reform of CAMHS. This is particularly in the context of addressing the prolonged issue of transitions from CAMHS to AMHS which has repercussions for safeguarding the future mental health of young people, as well as enabling system change to ensure the recognition and advancement of infant mental health.

**NICCY recommends:**

- 23. The Department undertakes a robust, refreshed mapping exercise which produces a refreshed funding map for CAMHS services, as well as ascertaining the existing need among the CVS in the mental health support sector, recognising increasing demand on CVS support services.**
- 24. Funding for CAMHS is increased to sit at the identified 10% of mental health services.**
- 25. The Regional Mental Health Crisis Service is rolled out as a matter of urgency.**

- 26. The development of a clear, regionally consistent, and Child Rights-based transitions pathway is upgraded to a priority by the Department, and undertaken as a matter of urgency.**
- 27. The refreshed Infant Mental Health Framework is published by the Public Health Agency without further delay.**
- 28. The Department to consider producing updates to its 2025 Deliverability Review within each financial year.**

## 9. The Transformation Agenda and Children’s Mental Health: An Analysis

### 9.1 Introduction

There have been seven fundamental reviews of the health and social care system in NI in the last 20 years, each which have advocated for major changes of direction. They have reached the same conclusion: NI needs to reduce its reliance on hospitals, centralise some services for a critical mass at a smaller number of sites, and focus more on prevention, intervention, and maintaining good population health.

In 2011, the Minister for the then-DHSSPS launched “Transforming Your Care: A review of health and social care in Northern Ireland” (“the Compton Report”) in which strategic assessment of the system was undertaken, bringing forward recommendations and plans for the future shape of services. It concluded that inaction was not an option and identified a clash between the needs of the population for proactive, integrated and preventive care for chronic conditions, and a health care system where the majority of resources are targeted at specialised, episodic care for acute conditions. The Compton report set out a vision for the future of health and social care which ensured safe, sustainable, effective services for all, and outlined integrated care and working together as being one of the key principles.

These successive reviews culminated in the wide-ranging review led by Professor Rafael Bengoa, which produced the 2016 “Bengoa review”.<sup>217</sup> This was established to report on the best configuration of health and social care services for NI, and concluded that:

*“The stark options facing the HSC system are either to resist change and see services deteriorate to the point of collapse over time, or to embrace transformation and work to create a modern, sustainable service.”*

The Bengoa review emphasised the need for a shift in the design and delivery of healthcare services and healthcare structures, calling for a transformation in the health and social care system, given the increasing budgetary costs of delivering health and social care (then 46% of the total NI Executive budget in 2016), changes in population needs, persistence of the existence of health inequalities and recognition that trends in healthcare were pointing towards the mainstreaming of a more personalised, preventative, participative, and predictive model of care, which would not be able to be implemented in NI due to the fragmented and reactive model of care.

The Bengoa review’s specific recommendations subsequently formed the basis of the Department’s 10-year transformation plan published in 2016, *Delivering Together*, an ambitious and detailed programme of change.<sup>218</sup> It drew on the then-draft PfG outcome for everyone to lead long, healthy, and active lives. When publishing *Delivering Together*, the Health Minister stated:

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<sup>217</sup> Department of Health. (2016). *Systems not Structures – Changing Health and Social Care*.

<sup>218</sup> See Department of Health. (2016). *Delivering Together*.

*“Radical transformation is needed across the health and social care system if we are to meet the needs of current and future generations. We must move beyond simply managing illness and instead prioritise prevention and early intervention to support people to live longer, healthier lives and help to reduce demand on our already over stretched services.”*

Combined, the Bengoa Review and *Delivering Together* promised to advance a radical shift in healthcare approaches, including a transformational shift in the design and delivery of vital services. However, the progression of their respective visions and key objectives has been fragmented – and the positioning of children and young people within what has been delivered upon has been limited. This is particularly critical in light of the position established by the Health Minister in 2024: that transformation of the structure, operation, and delivery of healthcare services is required, and that transformation is being spearheaded through the design and delivery of individual strategies focusing on specific services, including the Mental Health Strategy.

This Chapter presents an evaluation of the delivery of the Transformation Agenda in the context of mental health services, through an assessment of the design and delivery of key objectives of the Transformation Agenda’s driving framework, *Delivering Together* and contemporary strategic interventions, including the 2025 Reset Agenda. This assessment illustrates the marginalisation of children and young people’s healthcare to date, suggesting this has repercussions for the progression of the Mental Health Strategy generally and for the reform of CAMHS specifically. In so doing, it advocates for the future progression of the Transformation Agenda to be undertaken within a CRBA, and outlines the need for the mainstreaming of children’s rights within future design and delivery.

## **9.2 The Bengoa Review**

The Bengoa Review confirmed that to address the issues within the health and social care system, a whole system transformation which would entail significant cultural and operational reform, was required. Some specialist services would need to be rationalised to free up resources to enable more effective investment in new delivery models. It was further noted the most necessary change would entail moving to a more patient-centered, population health model, delivered at a sustainable cost.

Fifteen recommendations were produced in the review. These were expressed as general principles and framing guidance, rather than as precise recommendations for reconfiguration of services or governance or structures.

### **Recommendation One**

The guiding framework for the proposed transformation programme delivery is the “Triple Aim”. It is characterised by a focus on three objectives: Improving the patient experience of care (including quality and satisfaction); Improving the health of populations; and Achieving better value by reducing the per capita cost of health care.

The panel further recommended including a fourth strand / aim, based on improving the work life of those who deliver care. Lastly, the panel proposed the development of Accountable Care Systems to integrate the provider sector to take collective responsibility. Accountable Care Systems would also provide a structure for better patient engagement, empowering people to become active participants in their own care.

### **Recommendation Two**

The HSC should move to formally investing, empowering and building capacity in networks of existing health and social care providers (such as Integrated Care Partnerships and the developing GP Federations) to move towards a model based on Accountable Care Systems for defined population based planning and service delivery; and to adopt regionalised planning for specialist services.

### **Recommendations Four, Five, Six**

The Health Minister should create, communicate and lead a clear, powerful, long-term vision for the Health and Social Care system as a first step in the implementation process. The panel supplemented this recommendation by outlining three separate components for practical implementation: Driving the system towards Accountable Care Systems; Aggressively scale up good practice; and Rationalisation and stabilisation. The panel subsequently called for the preparation of plans, costs and timescales within the next 12 months, with the implementation of these actions to be led by health and care professionals and managers.

The Minister was advised that they should further establish a ring-fenced transformation fund to ensure this process is appropriately resourced.

### **Recommendation Seven**

A Transformation Board should be created and linked to the Executive’s Health and Wellbeing Strategy.

It was suggested this would assist in transforming organisational structures and management processes by promoting local decision making, local innovation and scaling up of best practices among the local systems of care.

The uptake of the Bengoa report would always have required time and consideration. The collapse of the NI Executive in March 2017, however, proved problematic for its realisation.

Research examining the implementation of the report published in 2019 found that the political vacuum in NI, caused by the collapse of the Executive in 2017, was exacerbating chronic problems in taking difficult decisions.<sup>219</sup> Further, whilst it was acknowledged that officials were working to provide structure and delivery in challenging circumstances, without the legal powers and legitimacy of serving Ministers and the wider Executive, several very important processes of change “face the end of the road”.<sup>220</sup> The work and commitment of healthcare professionals within the health and social care system has been evident, however, the political instability and limited political leadership decision-making was at the crux of the challenges of progression.

Of note is that whilst the Bengoa Review highlighted increasing waiting lists across services, and proposed that the Minister should take steps to address elective care performance, it was emphasised that addressing waiting lists in the immediate context should not be allowed to overshadow the need for long term transformation. Notwithstanding this, the political framing of the report and its next steps appeared grounded in addressing waiting lists, effectively instituting a narrative of equating transformation of healthcare services with waiting list reduction.

### 9.3 Delivering Together

Prior to the launch of the Bengoa Report, the Department had formerly introduced a strategic vision for transforming public health approaches which included a consideration of mental health as a public health action. The driving factors behind the transformative approach outlined by *Delivering Together* were grounded within *Making Life Better 2013-2023*, which provided a whole system strategic framework for public health.<sup>221</sup>

This framework recognises that health and wellbeing, and health inequalities, are influenced by factors such as age, family, community, workplace, economics, physical and social environments, and beliefs / traditions. It recognised that mental health is a major public health concern in NI, and as such, it was necessary for a strong strategic drive within government and statutory agencies to prevent mental illness where possible, as well as promote positive mental health and wellbeing in the general population. Within Theme 3, “Empowering Healthy Living”, *Making Life Better* identified as a key, long-term outcome that there would be improved mental health and wellbeing, and reduction in self-harm and suicide. It was envisioned that this strategic drive would be taken forward through the development of a new cross-departmental strategy to promote positive mental health in the NI population. An identified commitment specifically sought to increase resilience and improve mental wellbeing in children and young people through implementation of initiatives with a particular focus on children and young people from families at risk.

Only one progress report in respect of the delivery of *Making Life Better* was published.<sup>222</sup> This report sought to provide a clear overview of work progressed since the launch of the strategic framework, identifying progress as well as challenges and opportunities per theme. However,

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<sup>219</sup> Dayan, M., and Heenan, D. (July 2019). “Research report Change or collapse Lessons from the drive to reform health and social care in Northern Ireland”. Nuffield Trust.

<sup>220</sup> As above.

<sup>221</sup> See Department of Health. “Making Life Better - Strategic Framework for Public Health”.

<sup>222</sup> See Department of Health. (2015). “Making Life Better 1ST PROGRESS REPORT 2014/15”.

there were no progress updates outlined for the mental health commitments, including the action relating to children and young people’s mental health.

### *The Framework and its monitoring*

The Bengoa review’s specific recommendations subsequently formed the basis of *Delivering Together*, published in 2016. It drew on the then-draft PfG outcome for everyone to lead long, healthy, and active lives. When publishing *Delivering Together*, the Health Minister stated:

*“Radical transformation is needed across the health and social care system if we are to meet the needs of current and future generations. We must move beyond simply managing illness and instead prioritise prevention and early intervention to support people to live longer, healthier lives and help to reduce demand on our already over stretched services.”<sup>223</sup>*

*Delivering Together* outlined a commitment to advancing a new model of person-centred care, with a specific focus on prioritising early intervention and prevention, and to transform the health and social care system to ensure:

- People are supported to make informed choices and take control of their own health and wellbeing;
- Access to safe, high quality care is present when needed and service users are treated with dignity, respect and compassion;
- Staff are empowered and supported, with their expertise and experience rightly recognised; and
- Services are efficient and sustainable for the future.

To advance these aims entailed the implementation of several core changes, which are relevant in the reform of mental health services, especially in the context of focusing on prevention and early intervention for mental health challenges . These included:

- building capacity in communities, particularly in the context of prevention;
- increasing support within primary care to enable more preventive and proactive care;
- ensuring earlier detection and treatment;
- reforming community and hospital services to provide care when and where it is needed.

18 Actions are identified within the document under three core themes of stabilisation, reconfiguration and service change, and transformation. Of particular relevance for this report is Action 2, providing more support in primary care including to enable more preventive and proactive care, and earlier detection and treatment of physical and mental health problems.

The document, in identifying the mental health trends and patterns in NI and the consequences for public health, does contain a vision for addressing mental health challenges within the population, including in the expansion of services, particularly specialist services.

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<sup>223</sup> NI Executive (25 October 2016). “Executive determined to see a transformation in health and social care services”.

The grounding principle is to achieve a parity of esteem between mental and physical health. However, whilst this approach is welcome, as well as the inclusion of system change to reflect the demand for mental health services in NI, it lacks specific actions. There is no inclusion of any comprehensive indicators, targets, and timeframes for progression of items pertaining to mental health services. This is particularly apparent in the context of children and young people's mental health services.

As noted previously, what was striking within the publication was that prominence which had been allocated to actions not included within the Bengoa report, including placing a social worker in each GP practice and the suggestions for the future of elective care centres. Whilst additional actions denoting political realisation of pressing issues was welcome, the rise of "mission-creep" insofar as focusing on topical issues and challenges which now dominates discourse on the Transformation Agenda commenced with these new areas.

Conversely, within *Delivering Together*, there was evidence of limited engagement with or understanding of Bengoa's ideas and proposals as regards shared staff development - *Delivering Together* makes reference only to those proposals for GP and nurse training -- which meant a key component of radical system change in the context of supporting the development and shared expertise of experienced staff was diluted. Arguably, this has had ramifications for workforce development and capacity building more broadly, and may be a factor for the increasing reliance on the CVS for the delivery of key support services within the mental health landscape. Four broad objectives can therefore be identified from both the Bengoa Review and *Delivering Together*:

- Shifting care from a hospital-centred approach, so that greater use is made of community-centred services;
- Increasing focus on prevention rather than curative services, and within the focus of population health;
- Increasing public trust in the system by reducing waiting times to an acceptable level; and
- Enabling the centralisation of hospital services where this improves quality or safety by concentrating key staff.

#### **9.4 The Transformation Agenda post-Delivering Together**

Monitoring the implementation of *Delivering Together* can be difficult, as a result of the periods of political instability, as well as the emergence of the COVID-19 pandemic. Another key factor has been the impact of continued financial pressures within the Department, and the prolonged absence of a multi-year budget.

The Department has undertaken periodic monitoring of *Delivering Together*, with progress reports published in 2017, 2019, 2021 and 2024. The reports are not standardised, which each providing different levels of information and updates, making comprehensive comparative analysis difficult. The review of Departmental progress can be read in full within Appendix 4, "Review of the Delivering Together Strategy, 2025".

What is apparent from the NICCY's analysis is the impact of political instability and funding uncertainty for the implementation of *Delivering Together's* ambition for mental health service reform. The progress reports of 2017 and 2019 for example demonstrate efforts at commencing workstreams, with the recognition of budgetary pressures becoming apparent by 2019, yet the full realisation of this was clear with the reports of 2021 and 2024.

Fragmentation in progress is also evident, as well as the stalling of key actions/ projects. For example, in 2017, work for establishing a Regional Mental Trauma Service was "noted" and the full and complete rollout of regional crisis services is still being discussed as of 2026.

As outlined in the 2024 report, there is a recent trend in the dissemination of commentary which reiterates the broader aims of *Delivering Together* and transformation more widely, but is limited in clear and specific updates, including future actions and timeframes. Whilst this does effectively revisit the principles and actions of *Delivering Together*, it poses a challenge for the evaluation of progression of its actions, which is especially evident in the context of CAMHS. It is acknowledged that there are other vehicles for the publication and circulation of updates related to progression of workstreams for mental health service reform, such as the Annual Delivery Plans for the Mental Health Strategy, however consistency with information sharing is necessary to enable a clear understanding of the joined-up approach to the design and delivery of various related strategic frameworks within the mental health policy landscape – particularly when information relating to CAMHS is limited within other progress publications.

What is clear is that whilst work has been undertaken to advance the vision and ambition of *Delivering Together's* broader items on mental health, this contrasts with the generally limited progression of reform of children and young people's mental health services. For example, the 2021 report contains extensive commentary relating to various mental health workstreams, but no clear and specific information was provided in relation to CAMHS. The 2024 report, whilst not as extensive or detailed in its information, does provide updates in respect of broader work, but omits any reference to CAMHS.

Whilst there is growing evidence of the Department working to develop an intersectional approach within its strategic policy-making, particularly with regard to its awareness of incorporating neurodiverse approaches, there remain gaps in its operational recognition and incorporation of intersectionality more broadly. It is vital that the implementation of *Delivering Together* works to identify and address specific barriers and challenges faced by children and young people who are LGBTQIA+, disabled, neurodiverse, from ethnic minority and/or religious minority communities, residing in rural communities, carers within their families etc.

Lastly, it seems that the implementation of *Delivering Together* has resulted in the document growing extensively, becoming a network of overlapping workstreams and actions, including in the context of mental health services. The concern is that, in the midst of this overlapping policy landscape, children and young people's mental health services have been marginalised, and CAMHS reform is now lacking a clear, structured, and dedicated workstream. This has been apparent within the subsequent "reset" publications which have sought to further advance the Transformation Agenda since the restoration of devolved government in 2024. Moreover, these publications have continued the trend of omitting clear, specific actions

and/or commitments for the reform of CAMHS.<sup>224</sup> It is critical that strategic policy-making makes clear and express reference to specific targets and indicators for the transformation of children and young people’s mental health services. Further, it is also paramount that future strategic policy frameworks utilise an inclusive, holistic, child rights-based approach within its adopted terminology. It is disappointing that the 2025 reset plan used terminology that suggested mental health and mental health disorders are “problems”.<sup>225</sup> There are two further components of system change driven by the Transformation Agenda, as outlined below.

### *Integrated Care System*

The Department has been implementing a new Model of Future Planning and Care via the Integrated Care System (“ICS”). This model is underpinned by the identification of the needs of individuals and communities, and will seek to ensure, as far as possible, that services are provided in the most appropriate place, at the right time, and in a co-ordinated manner. It aims to provide the means for strategic decision-making in the areas of prevention and early intervention, wider social determinants of health, and reducing health inequalities.

NICCY has had longstanding concerns about the absence of a specific Children’s Lead/ Designate role, including for children and young people with SEND, such as within the Area Integrated Partnership Board structures, particularly in contrast to existing practice in England which is underpinned in statute and guidance.<sup>226</sup> This also demonstrates an absence of a means to ensure participation of and engagement with children and young people in local area planning. The needs of children must be included within ICS, including through the introduction of designated board-level executive leads with responsibility and oversight for children and young people, and enabling the participation and contributions of children and young people within area planning.

### *Encompass*

Encompass aims to ensure the collection of accurate information to assist with evidence-based decision-making, and the provision of official statistics. The NI Electronic Care Record was the previous system used within the health and social care system, which allowed providers to see patient information from a variety of different systems. Encompass has aimed to introduce an electronic health care record / patient record, which is a single, digital record for each person. It will record all the health and social care needs of a person for the whole of their life. The digitalisation of healthcare records aims to ensure quicker access to information about patients and clients and therefore enable quicker, effective and efficient service delivery,

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<sup>224</sup> There was no clear and specific reference, objective, target, or commitment made in respect of CAMHS with the Reset Plan 2025, see Department of Health. (June 2025). “Health and Social Care NI Reset Plan”. Whilst reference was made to mental health within the Three Year Plan 2024, notably at page 20, and commitments made, there was no clear and specific reference, objective, target, or commitment made in respect of CAMHS, see Department of Health. (10 December 2024) “Health and Social Care NI A three year plan to: stabilise reform deliver”.

<sup>225</sup> See for example, Department of Health. (June 2025). “Health and Social Care NI Reset Plan” at page 16.

<sup>226</sup> See NHS England. (2023). “Executive lead roles on integrated care boards”; RCPCH (1 June 2023). “RCPCH responds to guidance on executive lead roles for children and young people within Integrated Care Boards (ICBs)”.

for use by Acute and Community Care services. The rollout of Encompass concluded in 2025, and is to be followed by a two-year period of optimisation and stabilisation.

NICCY had welcomed the introduction of a digital system, recognising that this could improve communications between currently existing IT systems and enhance service delivery. Given NICCY's longstanding calls for enhanced data collection and segregation in the provision of services including paediatric services, including mental health, it is hoped that Encompass will support the standardisation of data and statistics across all Trusts. The period of reduced workforce capacity and increased staff workload caused by the rollout of Encompass and the corresponding impact on data collection and verification was concerning. The confirmation of the two-year optimisation and stabilisation process is also concerning in the context of the importance of accessible, quality data for the purposes of designing and delivery CAMHS.

The COVID-19 pandemic demonstrated the importance of ensuring operational healthcare services; it equally demonstrated the existing structural and systemic issues within the delivery of healthcare services which impact on children's health. Any proposed future transformation proposals including ongoing reconfiguration of healthcare services should be mindful of the possible impact on children's health delivery caused by re-structuring. Moreover, any future programme of reform of systems and structures should make use of the opportunity to incorporate new networks and pathways which can recognise and respond to new child health problems and changing health priorities, and enable the sharing of data and best practice, such as the introduction of paediatric collaborative improvement networks and further development of inter-organisational child health networks. Reconfiguration is a measure of change which directly addresses operational, rather than structural change. As noted previously, instigation of change to healthcare services has tended to stem from addressing narratives relating to cost, waiting lists, and waiting times.<sup>227</sup> However, continued implementation of the Transformation Agenda including via reconfiguration can be undertaken on the basis of necessary, robust, long-term structural change which includes:

- Advancing health progression;
- Protecting and promoting the right to health;
- Enabling full access and enjoyment of the right to health, including timely access to adequate health infrastructure; and
- Redesigning the provider-patient relationship, including enabling participation within healthcare decision-making.

These factors are vital for the design and delivery of mental health services, and particularly in delivery of the Department's early intervention and prevention agenda.

## 9.5 Conclusion

The Transformation Agenda has sought to present a radical shift in the design and delivery of healthcare in NI, primarily transposing care from bricks-and-mortar builds to within the community, and especially increasing the focus on promoting, and securing, prevention and

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<sup>227</sup>See also McKee, M., Healy, J., Edwards, N., and Harrison, A. (2002). "Pressures for change" in M. McKee, J. Healy (Eds.), *Hospitals in a changing Europe* (Open University Press, Buckingham) 36-58.

early intervention in healthcare. Whilst efforts have been made to advance this radical vision, not least to capture the spirit of the Bengoa Report, the progress made has been fragmented to date, hampered by political instability and funding uncertainty. At the time of writing, we are entering the 10<sup>th</sup> anniversary of the publication of the Bengoa Report, which warned political institutions against applying undue focus on addressing waiting lists in the short-term in lieu of commencing the much-needed systemic and systematic transformation within all aspects of the health and social care system in NI. That warning now appears lost, particularly within the context of mental health services reform.

The identification of the Mental Health Strategy as a lynchpin of the Transformation Agenda was welcomed, seemingly indicating a clear political will within the Department to ensure overdue reform of mental health services. However, given the issues facing the future progression of the Mental Health Strategy, documented previously in this report, its role as a driver of change may be hampered – with detrimental impact for the reform and change of issues within CAMHS.

It is NICCY's position that to improve and progress children's health and health outcomes, it is essential that Government, statutory health agencies, healthcare providers, and their partners actively promote the child rights framework enumerated in the UNCRC. This is particularly relevant in the promotion of health and well-being of all children, and their inclusion in the design and delivery of healthcare structures and systems. A CRBA to protecting and promoting children's healthcare, including within the context of redesign of healthcare systems, not least CAMHS, would provide a comprehensive and child-supportive standard for evaluating child-related policies.

NICCY believes that transformation and reconfiguration of the health and social care system in NI should be perceived as a critical moment for the progression of children's health, insofar as working to ensure timely access to adequate health infrastructure for all children and young people, including within the prevention and early intervention context for their mental health. For the Transformation Agenda to be truly radical, the adoption of a CRBA for the future design and delivery of healthcare reform is required.

#### **NICCY recommends:**

- 29. The Department undertakes a mapping exercise to ascertain the positioning of infants, children, and young people within the design and delivery of the Transformation Agenda to date.**
- 30. The Department demonstrates its awareness and understanding of intersectionality within its strategic policy-making, indicating how it is designing mental health services in recognition of specific issues and barriers faced by communities such as LGBTQIA+ young people, disabled young people, ethnic minority young people, neurodiverse young people, rural communities, carers within their families etc.**
- 31. The Department adopts a mainstreaming approach towards the design and delivery of future strategic developments associated with the Transformation Agenda, whereby children's rights and specifically, the standards and norms associated**

**with Article 24 of the UNCRC, are actively incorporated within strategic frameworks.**

## 10. A System at a Crossroads? Recommendations and Conclusion

This report represents the culmination of a Periodic Review of children and young people's mental health services, and their governing key strategic documents. It has sought to assess the current operation of CAMHS and evaluate the status of progression of the Still Waiting recommendations and SWAP actions to gain an understanding of the accessibility and use of CAMHS in accordance with the child's right to health under international law.

This report demonstrates there are systematic issues impacting the mental health system, such as increasing waiting times in accessing services and uncertainty as to funding allocations, which raise concerns regarding delays in ensuring appropriate services and supports for children and young people. It has presented a landscape of mental health services under pressure from increasing service demand, financial strain including limited and uncertain investment, data constraints, a fragmented pathway of progression in accordance with key objectives outlined in relevant strategic frameworks, and marginalisation within key political and policy developments since the restoration of devolved government in NI in February 2024.

Juxtaposed with the relative absence of clear, specific objectives and commitments in respect of children and young people's mental health services, we are faced with a policy landscape which appears to be disengaged and demoralised. It sits at odds with the 2023 recommendations of the UN Committee, and the standards and norms affirmed by Article 24. The consequences for the mental health of children and young people of this situation if it continues are stark.

It is evident that whilst efforts have been made to progress the development and improvement of CAMHS, including in the progression of key SWAP actions, these have been undertaken on a fragmented basis. It is equally evident that more must be done to demonstrate appropriate financial investment will be made on a proactive, and sustained, basis to ensure the full realisation and protection of the child's right to health within children and young people's mental health services, notwithstanding Departmental budgets and corresponding financial constraints.

*A System at a Crossroads* has aimed to convey that the challenges facing the operation of children and young people's mental health services are not only systematic, but also systemic, present within the design and delivery of the strategic policy frameworks serving as the architects for change with the healthcare system in NI. Addressing such challenges requires a systematic and systemic approach to change.

### Recommendations

This report has identified 31 recommendations to support the transformation of children and young people's mental health services.

## **NICCY recommends:**

- 1. The Department, in conjunction with the Public Health Agency, review and clarify its adopted definition of “early intervention” within children and young people’s mental health policy. This review should be grounded on the principle that early intervention is recognised as a lifelong approach - which covers infancy, early childhood, school-based supports and community provision, as well as specialist services. This principle should be embedded within the development of mental health policy including the Early Intervention and Prevention Action Plan, as well as associated funding allocation and workforce design. Public health messaging should also adopt this principle to better address the scale and complexity of mental health and wellbeing issues faced by children and young people.**
- 2. Recognising the need for improvements in the accessibility and quality of disaggregated, basic operational mental health data, the Department and the SPPG should undertake and publish a review of the rollout of the Encompass system and illustrate the progress made towards the standardisation of data collected and utilised by HSCTs for the purposes of planning, commissioning, and delivering CAMHS.**
- 3. The Department examines the potential for a mental health dashboard, as considered by the Scottish Government’s commitment, which is grounded on performance, targets, and indicators.**
- 4. Understanding the mental health landscape for children and young people in NI, that the Department, in conjunction with relevant authorities and stakeholders, commits to developing a mechanism to build capacity and facilitate engagement with children and young people on an ongoing basis, ensuring delivery is based on actual need not presumed need. This mechanism should be designed in accordance with a child rights-model of participation such as the Lundy Model and should reflect the Participation Principles as agreed by all Government Departments.**
- 5. The Department and the SPPG commit to ensuring that child- and young person-friendly, accessible information is made publicly available in order to engage young people in an effective and meaningful way on mental health policy and service planning.**
- 6. The Department incorporates clear and direct reference to Article 24 of the UNCRC within future strategic documents governing the design and operation of children and young people’s mental health services. This should include clearly outlining how these Strategic documents provide for establishment and implementation of a rights-based approach to the design and delivery of children and young people’s mental health services.**
- 7. The Department should include child public health as a specific, individual category within its strategic policymaking, and should incorporate a Child Public Health Approach model which upholds children’s rights in public health awareness and prevention measures.**
- 8. The Department utilises the Childs’ Rights-Based Approach framework within the design and delivery of future strategic documents governing the design and operation of children and young people’s mental health services. This should**

include consideration of workforce capacity, resources, recruitment, retention, and safe working environments.

9. The NI Executive incorporates a Childs' Rights-Based Approach into its Departmental budgeting processes. This should include the undertaking of Child Rights Impact Assessments by all Departments and corresponding agencies in addition to EQIAs, to ensure that all due consideration as to how budgetary decisions will affect children and young people. This is especially critical in the context of continued budgetary pressures.
10. The establishment of an information-exchange system which will enable communication between the Department and NICCY on the status of the Still Waiting recommendations and SWAP actions. This should include the provision of bi-annual updates from the Department on the progression of all outstanding SWAP Actions to enable comprehensive engagement and accountability, and NICCY's engagement within the implementation process.
11. The establishment of a dialogue / monitoring mechanism, involving representatives of the CVS, which will enable the continued monitoring of progress and impact arising from the continued implementation of the SWAP actions. This should include the provision of engagement from the Department, the SPPG, and the HSCTs.
12. The Department clarifies how the SWAP has been incorporated into the Mental Health Strategy, and further clarifies what is meant by its comments that the "intent" of the Still Waiting report is being "met" through the governance and accountability arrangements of the Mental Health Strategy.
13. The Department undertake and publish a mapping exercise which demonstrates the precise incorporation of relevant SWAP Actions within the Mental Health Strategy. This mapping exercise should also detail the exact status of progress of the identified SWAP Actions within the development of their corresponding Mental Health Strategy Actions, and identify actions for future progression within the 2026/2027 financial year.
14. The Department undertakes a robust, refreshed mapping exercise which produces a refreshed funding map for CAMHS services, as well as ascertaining the existing need among the CVS in the mental health support sector, recognising increasing demand on CVS support services.
15. Funding for CAMHS is increased by the Department to sit at 10% of mental health services allocations.
16. The Department, the SPPG, and the HSCTs undertake an internal review of existing referral pathways, which assesses the current design and operation of referral pathways using a CRBA, including recognition of waiting lists and waiting times for access. The review should include the design and application of relevant indicators as an assessment framework. This review should be published within one year, and subsequent review should be undertaken using the same CRBA, including Child Rights-based indicators.
17. That reviews of the pilot programmes undertaken under SWAP Action 3.3 are published, with evidence of learning and recognition of best practice and opportunities for design improvement identified. These reviews should comply with Article 12 of the UNCRC and participation of those engaged in services

provided by the pilot programmes, including in the design of recommendations for future work.

18. The Departments of Health and Education in accordance with the Children's Services Co-Operation (NI) Act 2015, produce a comprehensive action plan for the future design and delivery of specialist mental health support services within schools and educational settings. This action plan should be framed within a CRBA and identify opportunities for collaboration and cooperation across all relevant services, including between the Emotional Health and Wellbeing in Education Framework and the Emotional Health and Wellbeing Framework (when finalised).
19. The Department engage in a stakeholder consultation exercise to understand the needs of the CVS, and to work alongside the CVS to ensure sufficient funding is provided in order to realise the ambitions of the Mental Health Strategy, and the role identified for the CVS within this, as well as the (draft) Emotional Health and Wellbeing Framework.
20. The Regional Mental Health Crisis Service is rolled out as a matter of urgency.
21. The Department advises of the status of implementation of recommendations made within the 2024 GIRFT review report, "The Emergency Departments of NI" and particularly in relation to those made in respect of the Royal Belfast Hospital for Sick Children, and further, confirms what work has been undertaken within the Belfast HSCT region to progress on ensuring a safe ED environment for children and young people experiencing mental health crisis and/or requiring CAMHS assessment.
22. The development of a clear, regionally consistent, and child rights-based transitions pathway is upgraded to a priority by the Department, and undertaken as a matter of urgency.
23. The Department undertakes a robust, refreshed mapping exercise which produces a refreshed funding map for CAMHS services, as well as ascertaining the existing need among the CVS in the mental health support sector, recognising increasing demand on CVS support services.
24. Funding for CAMHS is increased to sit at the identified 10% of mental health services.
25. The Regional Mental Health Crisis Service is rolled out as a matter of urgency.
26. The development of a clear, regionally consistent, and Child Rights-based transitions pathway is upgraded to a priority by the Department, and undertaken as a matter of urgency.
27. The refreshed Infant Mental Health Framework is published by the Public Health Agency without further delay.
28. The Department to consider producing updates to its 2025 Deliverability Review within each financial year.
29. The Department undertakes a mapping exercise to ascertain the positioning of infants, children, and young people within the design and delivery of the Transformation Agenda to date.
30. The Department demonstrates its awareness and understanding of intersectionality within its strategic policy-making, indicating how it is designing mental health services in recognition of specific issues and barriers faced by communities such as LGBTQIA+ young people, disabled young people, ethnic

minority young people, neurodiverse young people, rural communities, carers within their families etc.

31. The Department adopts a mainstreaming approach towards the design and delivery of future strategic developments associated with the Transformation Agenda, whereby children's rights and specifically, the standards and norms associated with Article 24 of the UNCRC, are actively incorporated within strategic frameworks.

## **Appendices**

**Appendix 1: Review of the Still Waiting Action Plan, February 2023 – February 2025**

**Appendix 2: Review of CAMHS Data, 2021 -2024**

**Appendix 3: Review of the Mental Health Strategy March 2025**

**Appendix 4: Review of the Delivering Together Strategy February 2026**

