Educational Disadvantage Centre Briefing Paper:

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A critical evaluation of the implementation of 'A Vision for Change: Report of the Expert Group on Mental Health Policy' from a Children's Rights perspective[1].

Introduction

In 1992, the Republic of Ireland (RoI) ratified the United Nations Convention on the Rights of the Child (CRC or the Convention) (United Nations (UN), 1989). This signalled Ireland's formal agreement to be legally bound by the 54 Articles of the Convention which encompass children's political and civil rights and economic, social, humanitarian and cultural rights (McGoldrick, 1991). More recently in March 2018, the Republic of Ireland ratified the Convention on the Rights of Persons with Disabilities (CRPD) (UN, 2008), making it the last state in the European Union to do so, eleven years after first signing the treaty. Both the CRC and CRPD specify that children are to be recognised as rights holders and both place a legal responsibility on 'duty bearers' including the State to secure and protect those rights. This has clear implications for the formulation of policy and the design and delivery of children's services, including those relating to mental health.

[1] For economy, and in line with Article 1 of the United Nations Convention on the Rights of the Child (UNCRC), the term child refers to all persons under the age of 18.

A Vision for Change: Report of the Expert Group on Mental Health Policy (AVFC), outlined a comprehensive and ambitious ten-year national policy for mental health in Ireland between 2006 and 2016 (Department of Health (DoH), 2006). Having reached the end of its term, AVFC is currently under review with recommendations expected in December 2018 (Kane, 2018). In light of this and Ireland's ratification of the CRC and CRPD, it is both timely and relevant to consider the implementation of this policy from a children's rights perspective. A broad array of issues have emerged from the implementation of AVFC, all of which potentially merit consideration. These include the lack of user involvement and advocacy services for children, multiple barriers to access leading to low take-up of services, fragmented provision due to poor inter-departmental and inter-agency collaboration plus a lack of outcome monitoring for children's mental health services (Children's Mental Health Coalition (CMHC), 2015). For the purposes of this paper, the focus will be on two critical areas in which implementation of AVFC has fallen short of expectations and which have particular significance from a children's rights perspective: 1) the admission of children to adult psychiatric wards and 2) the inadequate provision of child and adolescent mental health (CAMH) services. In the following section, AVFC will be outlined briefly, providing the context for a detailed consideration of the relevant policy recommendations. The implementation of these recommendations will be critically evaluated from a children's rights perspective and recommendations for the direction of future policy will be offered.

'A Vision for Change'

AVFC was based on an extensive three-year consultation process incorporating the views of a wide range of stakeholders including professionals, service users and their families. The result was a comprehensive 284-page report incorporating 208 recommendations addressing the mental health needs of individuals from childhood to old age, as well as the needs of particular groups including the homeless and those with an intellectual disability. Unusually, a sizeable section of the report was also dedicated to the issue of implementation and it recommended the appointment of an Independent Monitoring Group to oversee the implementation of the policy (Johnston, 2014). AVFC endorsed a recovery-oriented approach and a view of service users as active participants in their own care who should be afforded autonomy, dignity and respect. The policy adopted a holistic view of mental health recognising the range of factors that contribute to an individual's wellbeing, thereby moving beyond a narrow medical model. Building on earlier policy, it also renewed the commitment to the development of integrated, multi-disciplinary, community-based mental health services

and a move away from institutionalised care (DoH, 2006). The policy enjoyed widespread support on publication, being "hailed as one of international and progressive standing, accepted by politicians of all hues as well as by mental health professionals, public servants and user groups" (Johnston, 2014, p6). Its value was also affirmed in the second periodic report of the Committee on the Rights of the Child (the Committee) which called for the recommendations to be implemented in full (Mental Health Reform, 2015; UN, 2006).

Key recommendations made by AVFC

AVFC outlined ten recommendations in relation to children's mental health, four of which relate specifically to the admission of children to adult psychiatric wards and the availability of services. The first of these recommendations was wide-ranging and addressed provision at all levels within the system, recognising the very low starting point for children's services (Johnston, 2014). A three-tiered model structures the provision of children's mental health services in Ireland, enabling a staged response to progressive levels of need. Tier 1 consists of primary and community care services including the General Practitioner, community psychologists and counselling services. Tier 2 services refer to multi-disciplinary child and adolescent mental health teams whilst Tier 3 services offer intensive community based and inpatient care (DoH, 2006). A major recommendation made in AVFC was the need "to prioritise the full range of mental health care, from primary care to specialist mental health services for children and adolescents" (DoH, 2006, p90).

In addition, recommendations were made to dramatically increase the number of CAMH teams from 39 to 77, a figure later amended to 99 based on more accurate estimates of Ireland's child population (UN, 2016). Minimum staffing was also outlined for these teams and it was recommended that the services they provided should be made universally available to children up to the age of 18, thereby ending the practice in many areas of transferring children to adult services at 16 or 17. Attention was also drawn to the inadequate provision of inpatient mental health beds for children in AVFC. In 2006, there were just 20 CAMH beds in Ireland; it was recommended that this should be expanded to 100 as a matter of urgency by building four 20 bed units in the main urban centres of Dublin, Cork, Galway and Limerick. In addition, the policy stated that these in-patient facilities should incorporate "large, spacious rooms for activities and possibly even classroom facilities, so children can continue their school curriculum work during their stay….they should be user friendly and sensitive to the needs of children and adolescents" (DoH, 2006, p88).

Evaluating implementation of AVFC from a children's rights perspective

Ireland's ratification of the CRC and CRPD signified a commitment to engage with a process of periodic reporting, this being the chief mechanism by which States Parties are held legally accountable for progress in meeting their responsibilities under both Conventions (Lundy, 2012). Ireland's recent ratification of the CRPD in March 2018 means that it is yet to submit its first periodic report which becomes due within two years of the initial ratification date (Office of the United Nations High Commissioner for Human Rights (OHCHR), 2011). Since ratifying the CRC, Ireland has submitted three periodic reports to the Committee: in 1996 (1st periodic report, due in 1994); 2005 (2nd periodic report, due in 1999) and 2015 (combined third and fourth periodic report, due in 2009) (UN, 2015; 2005; 1996). In response, the Committee has issued three detailed reports, known as 'Concluding Observations' which outline positive aspects of implementation and recommendations where further action is needed (OHCHR, 2018). Concern about the admission of children to adult psychiatric wards and the availability of children's mental health services has been highlighted in consecutive reports by the Committee (UN 2016; 2006). In the the most recent periodic report issued in the final year of AVFC, the Committee again urged the State to "undertake measures to improve the capacity and quality of its mental health-care services for children and adolescents" including improvements to the capacity of its inpatient treatment services for children (UN, 2016, para 54). However, evidence from the numerous reviews of AVFC suggests that the above recommendations have failed to be fully realised during the ten-year term of the policy (Seanad, 2017; Mental Health Reform, 2015; Children's Mental Health Coalition, 2015; Johnston, 2014). The following sections will draw on this evidence in detail to critically evaluate the implementation of AVFC from a children's rights perspective.

Admission of children to adult psychiatric wards

Some progress was made in expanding the number of inpatient beds for children over the term of AVFC. New inpatient facilities were built in Cork, Galway and Dublin, more than tripling capacity since 2006 and bringing the total number of potentially useable beds to 66 in 2017 (Browne, 2017; Mental Health Reform, 2015; Independent Monitoring Group, 2011). However, these facilities have not been able to operate consistently at full capacity due to chronic difficulties in recruiting and retaining clinical staff, partly a consequence of less favourable pay and conditions in Ireland compared to other English speaking jurisdictions

(Seanad, 2017). Therefore, in 2017 just 48 of the 66 inpatient CAMH beds were available for a child population that had increased by 21% since the recommendations were initially made in 2006 (Seanad, 2017).

The impact of this shortfall of CAMH beds continues to be clearly discernible, and most concerning, in the numbers of children admitted as inpatients to adult psychiatric wards. In 2008, 63% of all child inpatient admissions were to adult wards. By 2016, whilst the figure had fallen to 13%, this equates to 68 children admitted to an adult psychiatric ward, with an average length of stay of six days (Ombudsman for Children's Office (OCO), 2018). The Mental Health Commission's Code of Practice required that this practice was completely discontinued by the end of 2011, however the voluntary nature of the Code has limited its influence and is one of the reasons that the practice persists (Seanad, 2017).

Availability of services

At the end of July 2017, 6,811 children were on a waiting list to see a primary care community-based psychologist, of which 2,186 had been waiting for more than 12 months (OCO, 2018). In some areas of the country, such as North Dublin, this service is entirely absent due to difficulties with staff recruitment (Seanad, 2017). In 2017, just 69 CAMH teams were in operation falling considerably short of the recommended 99 teams (OCO, 2018). Staffing in these teams was at just 51.6% of the levels recommended by AVFC and some CAMH teams were functioning with just one third of the required staff (Seanad, 2017). This was in the context of sharply rising demand for CAMH services; between 2011 and 2014 referrals increased by more than 50% putting further pressure on already over-stretched services (Mental Health Reform, 2015). The combined impact of these factors is apparent in the lengthy waiting lists to access Tier 2 CAMH services. In the first quarter of 2017, 2,818 children were on the waiting list for a CAMH appointment and 218 of these had been waiting for over 12 months (Seanad, 2017). The response has been for many CAMH services to operate highly restrictive referral criteria whereby referrals are only accepted from a general practitioner, a practice that has been "flagged as highly problematic in terms of equity of access" (CMHC, 2015, p50). Furthermore, many CAMH services continued to refuse referrals for children aged 16 -18; in 2014 just 31 of the 63 CAMH services accepted referrals of children up to the age of 18 (Mental Health Reform, 2015). This situation is further compounded by the fact that 15 of Ireland's 32 counties have no out of hours service for those needing to access support after 5:30pm or at weekends, forcing a reliance on accident and emergency services which do not have the expertise to respond to children's acute mental health difficulties (Seanad, 2017).

Article 24

There are a number of ways in which the admission of children to adult psychiatric wards and the inadequate provision of CAMH services outlined above contravenes Ireland's obligations under the CRC and CRPD. Perhaps the most obvious breach relates to Article 24 of the CRC which requires that:

> States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services (UN, 1989, Article 24).

A recent report by the United Nation's Special Rapporteur confirmed that Article 24 provides a "framework for the full realization of the right of everyone to mental health" (UN, 2017, para 11). The Committee also indicated the significance of this article for mental health services in its guidance, urging States to develop primary care approaches to enable the early identification and treatment of children's mental health problems (UN, 2013b). The right to health is similarly affirmed in Article 25 of the CRPD in relation to persons with a disability, which includes those with long-term mental health difficulties. It contains the additional stipulation that States Parties shall "provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children" (UN, 2008, Article 25).

Lengthy waiting lists for community psychology and Tier 2 CAMH services alongside insufficient inpatient capacity means that large numbers of children are being deprived of their right to access the mental health services they need in order to enjoy their rights under Article 24 of the CRC and Article 25 of the CRPD. The evidence indicates that the time spent waiting is not trivial, with a high proportion of children facing a delay of more than 12 months before receiving an initial appointment. In particular, the continuing inadequacy of Tier 1 primary care services means that opportunities for early intervention are missed making a deterioration in the child's mental health more likely and placing additional pressure on Tier 2 CAMH services (Seanad, 2017). The serious lack of preventative and community-based supports is also a factor in the ongoing practice of admitting children to adult psychiatric units when children are in crisis (OCO, 2017). Staff in such wards are not trained to meet the needs of children with mental health difficulties, nor do they have the necessary facilities to do so (Seanad, 2017). Anecdotal evidence from parents of children admitted to adult psychiatric wards highlights that "there were no activities appropriate to their children's needs or age (e.g. therapy, education, leisure) and a lack of interaction with peers, both of which had a negative impact" (OCO, 2017, p3). Placing children in an environment that is not designed to meet their needs and which lacks the necessary therapeutic and social supports is neither conducive to recovery nor in line with a child rights-based approach. In addition, where such admission is on an involuntary basis, the requirements of Article 37 also need to be observed. This article clearly states that "every child deprived of liberty….shall be separated from adults unless it is considered in the child's best interest not to do so" and that they "shall be treated…. in a manner which takes into

account the needs of persons of his or her age" (UN, 1989, Article 37c). Many involuntary admissions of children to adult psychiatric wards are therefore in direct breach of this article.

Furthermore, this failure to sufficiently prioritise service development disproportionately impacts a particularly vulnerable segment of the population and includes children who would be considered disabled due to the long-term nature of their difficulties. Inadequate service provision therefore also represents a failure to comply with Article 7 of the CRPD relating to non-discrimination which requires that "States Parties shall take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children" (UN, 2008, Article 7). According to the CRC, the avoidance of discrimination must also be a key factor guiding decisions in relation to budget allocation and spending. States should "strive to ensure availability, accessibility, acceptability and quality of essential children's health services for all, without discrimination" (UN, 2013b, para 104). This is echoed in comments made by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health who stated that mental health services must be both financially and geographically accessible to all without discrimination (UN, 2017, para 57). Uneven access to children's mental health services for those living in rural as opposed to urban areas of Ireland is therefore a further example of children's right to non-discrimination not being appropriately upheld.

In Ireland's second report to the Committee it was acknowledged that CAMH services have developed more slowly than adult services, confirming the need to prioritise current and future spending on children's mental health (UN, 2005). Yet, the percentage of the overall health budget that is allocated to mental health in Ireland has decreased dramatically from 13% in 1984 to 7.3% in 2004 and 6.1% in 2017. This compares unfavourably with other jurisdictions, such as Germany, France and the United Kingdom where spending on mental health is between 10% and 12% of the overall health budget and suggests a lack of financial commitment to delivering improvements in this area (Seanad, 2017; Faedo and Normand, 2013).

Article 3

The admission of children to adult psychiatric wards and the inadequate provision of CAMH services arguably also contravenes Article 3 of the CRC. Article 3(1) is one of four general

principles of the Convention that underpin the implementation and interpretation of all other rights and therefore its reach is wide-ranging (UN 2013a).

Article 3(1) states that:

> In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration (UN, 1989, Article 3).

The Committee specifies that children's best interests should be placed "at the centre of all decisions affecting their health and development, including the allocation of resources, and the development and implementation of policies and interventions that affect the underlying determinants of their health" (UN, 2013a, para 13). The principles of Article 3 are also reiterated in Article 7(2) of the CRPD in relation to persons with disabilities (UN, 2008).

When assessing and determining the best interests of a child, Article 3(2) places an obligation on the State to ensure the child "such protection and care as is necessary for his or her well-being" (UN, 1989, Article 3(2)). The meaning of this phrase is not limited to protecting children from immediate harm but, it is explained, also refers to ensuring "children's well-being, in a broad sense [and] includes their basic material, physical, educational, and emotional needs, as well as needs for affection and safety". (UN, 2013a, para 71). Furthermore, where inpatient care is considered necessary, the best interests of the child must be assessed before a decision is taken giving due priority to the child's views (UN, 2013a). However, in their most recent concluding observations on Ireland, the Committee indicated concern about the lack of awareness among public bodies of the right of the child to have his or her best interests taken as a primary consideration and that this right has not yet been properly implemented as a "positive obligation in all relevant legislation and administrative procedures and decision-making processes" (UN, 2016, para 29).

In Ireland, there is very little research or data that sheds light on children's experience of being admitted to an adult psychiatric ward, despite the frequency of this practice (CMHC, 2015). Arguably, this in itself is indicative of a failure to engage seriously with children's views on this matter and it makes it difficult to judge whether children's rights are being protected in this area (Kilkelly, 2006). The need for such data is underscored in guidance from the Committee which calls for "a continuous process of child impact assessment (predicting the impact of any proposed law, policy or budgetary allocation which affects children and the enjoyment of their rights) and child impact evaluation (evaluating the actual

impact of implementation)" to ensure that children's best interests are being fully realised (UN, 2003, para 45).

Common sense suggests that children being admitted to an inpatient psychiatric ward are already experiencing a high level of distress and that to admit them to a ward containing other highly distressed adults is unlikely to be in their best interests. This is supported by personal accounts from children and parents in Ireland as well as small-scale research findings which offer some insight into the nature of the experience for children. Anecdotal evidence is provided by the comments of children contacting the OCO directly who described "feelings of fear and distress caused by the environment in adult facilities" (OCO, 2017, p3). Similarly, in an oral submission to the Seanad Committee one parent described her 17-year-old son's admission to an adult ward during which "he was told he would not be allowed to leave his room because he would be in danger from other patients there" (Seanad, 2017, p31). The findings of a consultation report published by the Children's Commissioner for England echoes these personal accounts, stating that children often felt extremely unsafe on adult psychiatric wards, with some reporting being at risk of aggression or sexual harassment from other patients. Inadequate monitoring by staff also meant that unsafe practices such as self-harm and drug use occurred in such settings (Office of the Children's Commissioner, 2007) . Similar fears about personal safety and feelings of trauma are reported in a qualitative study of children's experiences of admission to adult psychiatric wards in Ireland (Buckley et al., 2012). This evidence suggests a failure to assess and give appropriate consideration to the child's best interests at the most basic level of their physical and emotional safety. Furthermore, this failure to ensure the child's safety represents a breach of Article 19 of the CRC which defends children's right to protection from physical and mental violence (UN, 1989).

The Children's Commissioner report also highlighted that staff in adult wards do not have the training or experience to meet the needs of children with mental health difficulties and many children reported that staff seemed unwilling to engage with them and appeared to lack interest in the child's difficulties. Also mentioned were the lack of activities, educational opportunities and boredom experienced by many, combined with difficulties in making friendships on the ward due to the age gap (Buckley et al., 2012; Office of the Children's Commissioner, 2007). This latter point is of particular concern since peer relationships have been identified as a crucial source of support by young people with mental health difficulties

admitted to hospital, helping to combat feelings of isolation (OCO, 2018; Buckley et al., 2012). A review of mental health services in Ireland reached similar conclusions about adult wards, stating that they were unable to meet children's educational, recreational and developmental needs (Bonnar, 2010). This is perhaps an unsurprising finding given that CAMH inpatient facilities were specifically developed to respond to children's differing needs, to ensure their safety and to provide appropriately skilled staff (Worral et al. 2004). This evidence suggests that children's best interests, including their needs for affection and safety and their educational, recreational and emotional needs are not appropriately prioritised when the decision is made to admit them to adult psychiatric wards. (UN, 2013a). This is particularly concerning given that children experiencing mental health difficulties are a vulnerable group who may find it hard to articulate their own best interests and advocate on their own behalf. Those charged with making decisions about children's care and wellbeing need to be particularly aware that "if the interests of children are not highlighted, they tend to be overlooked" (UN, 2013a, para 32). It is therefore incumbent on service providers to take concerted action to ensure that such oversights do not occur.

It has been argued that the broad and rather fluid wording of Article 3 contributes to difficulties in both interpreting and monitoring compliance since what constitutes a child's best interest is not concretely defined (Kilkelly and Lundy, 2006). McGoldrick argues that the concept "can be exceptionally difficult to apply because of the range of personal, social, economic and other factors that determine the perception of what is in the 'best interests' of the child" (1991, p136). Furthermore, by requiring children's best interests to be *a* primary consideration, rather than *the* primary consideration, the force of this article has been considerably weakened, potentially allowing competing considerations to take precedence (Freeman, 2000). For example, decision makers may recognise as a primary consideration, that it is in the best interests of a child to be admitted to an age-appropriate ward, whilst competing clinical, funding or political priorities continue to be *the* over-riding determinant in reality. When applying the concept of the child's best interests the Committee advises that it should be "adjusted and defined on an individual basis, according to the specific situation of the child or children concerned, taking into consideration their personal context, situation and needs". (UN, 2013a, para 32). The flexibility and responsiveness of the best interests concept may be considered a strength by encouraging a consideration of the issues on a case by case basis, however it may also allow governments the "discretion to avoid the legal commitment to their implementation" (Kilkelly and Lundy 2006, p335). As an example,

inpatient CAMH beds are only available in the three urban centres of Cork, Galway and Dublin. Despite known shortcomings, admission to a nearby adult ward might be argued to be in the best interests of a 17-year-old compared to admission to a distant CAMH hospital where they would be cut off from the regular support of family and friends, a factor known to place additional strain on both child and parents (Seanad, 2017). Arguably, such a decision also upholds the child's right to be treated and cared for in their local community (UN, 2013a, para 78). In addition, some inpatient admissions to adult wards are crisis admissions where speedy assessment is required. It is conceivable that a pragmatic decision on this basis may also be presented as being in a child's best interests in the current climate where CAMH beds are scarce (Mental Health Reform, 2015). Thus, the flexibility of the concept means that it may be used to justify short-term decisions made at a local level which do not represent the long-term best interests of children more broadly. These examples highlight that in the absence of a clear definition there is a danger that the best interests concept may end up meaning "all things to all people or, at the very least, that opinions as to whether and to what extent the principle has been implemented in areas such as child care, education and youth justice vary considerably" (Kilkelly and Lundy, 2006, p336).

Conclusion and recommendations

Evidence suggests that children in Ireland currently experience high levels of mental ill health (Coughlan et al., 2014; Cannon et al., 2013; Lynch et al., 2006; Martin et al., 2006). According to recent data, 1 in 3 children in Ireland will have experienced some form of mental ill-health by the age of 13 (Cannon et al., 2013). It is also accepted that 75% of all mental health problems begin before the age of 25 and that mental ill health now represents a "major contributor to the burden of disease in young people" (McGorry et al., 2011, p2). Yet just 29% of those with a mental health difficulty have contact with support services (Sawyer et al., 2000). Ensuring that tailored mental health services are available to all children is therefore an urgent priority as well as a pressing children's rights issue in Ireland.

This paper sought to critically evaluate the implementation of Ireland's recent mental health policy from a children's rights perspective. Two aspects of policy implementation were selected for particular attention: 1) the admission of children to adult psychiatric wards and 2) the inadequate provision of CAMH services. On its launch, AVFC was welcomed as a comprehensive and forward-looking mental health policy for Ireland. However, in successive reports between 2006 and 2012, the policy's Independent Monitoring Group

repeatedly expressed concern about the "slow paced and disjointed nature of implementation" (Johnston, 2014, p32). A number of reasons have been advanced for this piecemeal progress including lack of resources, the moratorium on recruitment in the public service, lack of dedicated leadership within the Health Services Executive and the low public and political priority given to mental health (Johnston, 2014; Independent Monitoring Group, 2011). Against this disappointing backdrop the limited improvements made in the provision of CAMH services, including increasing the number and staffing of CAMH teams and expanding inpatient capacity for children, have been hailed as achievements of AVFC (Johnston, 2014; Mental Health Commission, 2009). Yet, lengthy waiting lists for community CAMH services and the continuing practice of admitting children to adult psychiatric wards continue to be significant barriers to children receiving appropriate care when it is needed.

This paper has illustrated various ways in which inadequate policy implementation has served to diminish the realisation of children's rights in relation to mental health. Considering the national context more broadly, a significant barrier to the realisation of children's rights has been Ireland's limited progress in integrating the CRC into domestic law (Lundy et al., 2012). The visibility of children's rights has been improved by the inclusion of Article 42a in the Irish Constitution with its provision that the State "recognises and affirms the natural and imprescriptible rights of all children" and requires that the State "shall, as far as practicable, by its laws protect and vindicate those rights" (Government of Ireland, 2015). However, in common with many States, Ireland has taken the approach of incorporating just one or two select provisions of the CRC into law, particularly focused on Articles 3 and 12, rather than integrating the treaty in full (Lundy et al., 2013). This means that the CRC has limited force within Irish law and arguably reduces opportunities to realise children's rights in areas such as mental health.

Having evaluated selected issues arising from the implementation of AVFC, two recommendations are now offered which aim to strengthen the realisation of children's rights in relation to mental health. Firstly, in accordance with demands from the OCO (2017), the United Nations (2016) and the Children's Mental Health Coalition (2015), it is recommended that the practice of admitting children to adult psychiatric wards ceases. Related to this, the private members Mental Health (Amendment) Bill is currently making its way through the Oireachtas. Its key provision is that "all children must be admitted to child appropriate

inpatient psychiatric units and providing that no child shall be admitted to an adult psychiatric inpatient unit (voluntarily or involuntarily) save in exceptional circumstances where such admission is in the child's best interests" (Government of Ireland, 2018). This positive development is a recognition of the State's obligations under Article 4 of the CRPD to "take all appropriate measures, including legislation, to modify or abolish existing …. practices that constitute discrimination against persons with disabilities" (UN, 2008, Article 4). If passed into law, it will help to ensure that this recommendation is finally realised.

However, a focus on expanding inpatient facilities is not itself sufficient to address the broader needs of children with mental health difficulties (UN, 2017; CMHC, 2015). The second recommendation is therefore to develop primary care and specialist community mental health services in line with the goals outlined in AVFC and international best practice (WHO, 2008). This means recruiting sufficient numbers of community psychologists to ensure that a responsive early intervention service is available to all children across the State without protracted delays between referral and appointment. It also means developing the number of community mental health teams in line with the targets set by AVFC and revised by the Government and ensuring that all teams have the required number of multi-disciplinary staff (UN, 2016; DoH, 2006). Finally, it includes taking action to ensure that CAMH services are made universally available to all children up to the age of 18.

Arguably, these changes are urgently needed in the short term to address stark deficiencies in children's mental health services that continue to diminish children's rights. However, there is a danger that recommendations which focus on treating individuals by targeting 'disorders' perpetuate a narrow medical conception of mental health problems. Recently, a more radical path has been proposed by the United Nations which contends that "the crisis in mental health should be managed not as a crisis of individual conditions, but as a crisis of social obstacles which hinders individual rights". Therefore, full realisation of children's rights demands more robust and transformative mental health policy that is capable of addressing "the 'power imbalance' rather than the 'chemical imbalance'"(UN, 2017, p87).

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