NORTHERN IRELAND HUMAN RIGHTS COMMISSION

Response to Public Consultation on the Draft Mental Health Strategy 2021 – 2031 for Northern Ireland

April 2021

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Summary of Recommendations

The Northern Ireland Human Rights Commission (NIHRC):

2.12. recommends that the Draft Mental Health Strategy contain an express commitment to realising the highest attainable standard of mental health for all persons in Northern Ireland and that all treatments and detentions will comply with the rights and obligations as set out in the ECHR.

2.13. recommends that the four guiding principles underpinning the delivery of the right to health (availability, accessibility, acceptability and quality) are clearly referenced where relevant throughout the Draft Mental Health Strategy.

2.14. recommends that the Rural Screening Impact Assessment and the Equality and Human Rights Impact Assessment Screening be updated to include an examination of the compatibility of the Draft Mental Health Strategy with the requirements of availability, accessibility, acceptability and quality of healthcare which underpin the right to the highest attainable standard of mental health.

2.15. recommends that relevant training on human rights law be provided to all staff and professional working in mental health services.

3.6. recommends further information is published on what the envisaged total funding is required to meet the remainder of the needs and aims as outlined within the Draft Mental Health Strategy. A 10% target for CAMHS is an improvement. Nonetheless it would be more valuable than setting a target which entails additional resources being made available without actually addressing whether it will be sufficient to meet need.

3.7. recommends that the Department of Health publish the actual financial resources required to meet the aims and objectives of the strategy and continues to benchmark and publish actual expenditure against the cost of effectively meeting need.

3.8. recommends that key budgetary documents and information be made publicly available as part of the consultation process so that civil society and the wider public have the opportunity to make a meaningful contribution.

4.9. recommends that the Draft Mental Health Strategy contain an express commitment that the CRC's four guiding principles (non-

discrimination, best interests principle, right to life survival and development, and the right to participate) will underpin the delivery and implementation of all policies that will affect children and young people.

4.10. recommends that the Children's Rights Screening and Impact Assessment be updated to account for how the CRC's four guiding principles will be complied with in relation to the delivery of the Draft Mental Health Strategy.

4.11. recommends that the Draft Strategy contain a clause which states that in all actions, decisions, policies, laws, and regulations which are enacted, that the best interests of the child shall be a primary consideration.

4.12. recommends that the child's right to express their views in all matters which affect them, pursuant to Article 12 UNCRC is expressly included within the Draft Mental Health Strategy.

4.13. recommends that all relevant training about children's rights and in particular their right to be heard, be provided to all staff and professionals working across the mental health services in Northern Ireland.

5.7. recommends that the Department of Health expand, improve and synchronise its data collection mechanisms so that robust and comprehensive disaggregated data in relation to mental health can be collected in Northern Ireland.

5.8. recommends that all relevant data should be disaggregated by characteristics such as sex, gender, age, race, ethnicity, disability, religion, socio-economic status, and other relevant characteristics to ensure that current and future policies can reflect and respond to current and emergent issues.

5.9. recommends that Theme Three, 'New Ways of Thinking' within the Draft Strategy contain an express clause which ensures that all five HSC Trusts in Northern Ireland introduce updated data collection systems to enable the collection of regionally consistent mental health statistics.

5.10. recommends that the Department of Health publish guidance on a human rights-based approach to data collection to assist in the shift towards an improved and reformed delivery of mental health services in Northern Ireland.

6.4. recommends that the Draft Mental Health Strategy contain an express commitment that the issues of dementia and loneliness will be factored into the delivery of care for older people.

6.5. recommends that the Department of Communities update and revise their Active Ageing Strategy to reflect the impact which loneliness has on the right to health for older people.

7.3. recommends that the Draft Mental Health Strategy contain an express clause which states that the delivery of future mental health services will reflect and remedy the impact which Covid-19 has had on the delivery of mental health services in Northern Ireland.

7.4. recommends that the Department of Health engage with the Department of Education, the Department of Communities and other relevant government and statutory bodies to identify and ascertain areas of priority in relation to the delivery of mental health services across Northern Ireland which may have been adversely impacted by Covid-19.

Background

1.0. The Northern Ireland Human Rights Commission (NIHRC) pursuant to Section 69(1) of the Northern Ireland Act 1998, reviews the adequacy and effectiveness of law and practice relating to the protection of human rights in Northern Ireland. In accordance with this function the following statutory advice is submitted to the Department of Health in response to its consultation on the Draft Mental Health Strategy 2021 - 2031 for Northern Ireland (NI).[1]

1.1. The NIHRC bases its advice on the full range of internationally accepted human rights standards, including the European Convention on Human Rights, as incorporated by the Human Rights Act 1998 and the treaty obligations of the Council of Europe (CoE) and United Nations (UN) systems.[2] The relevant regional and international treaties in this context include:

- European Convention on Human Rights 1950;[3]
- International Convention on the Elimination of All Forms of Racial Discrimination 1965[4]
- UN International Covenant on Economic, Social and Cultural Rights 1966 (ICESCR);[5]
- UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW),[6]
- UN Convention on the Rights of the Child 1989 (CRC);[7]
- UN Convention on the Rights of Persons with Disabilities 2006 (CRPD);[8]

1.2. In addition to these treaty standards, there exists a body of 'soft law' developed by the human rights bodies of the CoE and UN. These declarations and principles are non-binding but provide further guidance in respect of specific areas. The relevant standards in this context include:

- UN Declaration on the Rights of Mentally Retarded Persons (1971)[9]

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[1] NI Office, 'New Decade, New Approach' (NIO, 2020) 6.
[2] The Northern Ireland Executive (NI Executive) is subject to the obligations contained within the specified regional and international treaties by virtue of the United Kingdom (UK) government's ratification. In addition, the Northern Ireland Act 1998, Section 26(1) provides that "if the Secretary of State considers that any action proposed to be taken by a Minister or Northern Ireland department would be incompatible with any international obligations… [s]he may by order direct that the proposed action shall be taken". The NIHRC further recalls that the Northern Ireland Act 1998, Section 24(1)(a) states that "a Minister or Northern Ireland department has no power to make, confirm or approve any subordinate legislation, or to do any act, so far as the legislation or act… is incompatible with any of the Convention rights".
[3] Ratified by the UK in 1951
[4] Ratified by the UK in 1969.
[5] Ratified by the UK in 1976.
[6] Ratified by the UK in 1986
[7] Ratified by the UK in 1991.
[8] Ratified by the UK in 2009.
[9] Proclaimed by General Assembly resolution 2856 (XXVI) of 20 December 1971

- UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991)[10]
- The Standard Rules for the Equalization of Opportunities for Persons with Disabilities (1993)[11]
- The Declaration of Madrid (1996)[12]
- The WHO Guidelines for the Promotion of Human Rights of Persons with Mental Disorders (1996)[13]
- UN Committee on Economic, Social and Cultural Rights, General Comment No 5[14]
- UN Committee on Economic, Social and Cultural Rights, General Comment No 14[15]
- UN Committee on the Rights of the Child, General Comment No 7[16]
- UN Committee on the Rights of the Child, General Comment No 9[17]
- UN Committee on the Rights of the Child, General Comment No 5[18]
- UN Committee on the Rights of the Child, General Comment No 4[19]
- UN Committee on the Rights of the Child, General Comment No 14[20]
- UN Committee on the Rights of the Child, General Comment No 15[21]
- UN Committee on the Rights of the Child, General Comment No 19[22]
- UN Committee on the Rights of the Child, General Comment No 20[23]
- UN Committee on the Rights of Persons with Disabilities, General Comment No 4[24]
- Concluding Observations of the UN Committee on the Rights of Persons with Disabilities to the UK[25]
- Concluding Observations of the UN Economic and Social Council[26]

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[10] Adopted by General Assembly resolution 46/119 of 17 December 1991.
[11] Adopted by the United Nations General Assembly, forty-eighth session, resolution 48/96, annex, of 20 December 1993
[12] World Psychiatric Association, Declaration of Madrid (Madrid, Spain, Aug. 25, 1996
[13] World Health Organization. Division of Mental Health and Prevention of Substance Abuse. (1996). Guidelines for the promotion of human rights of persons with mental disorders. World Health Organization
[14] E/1995/22, UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 5: Persons with Disabilities, 9 December 1994.
[15] E/C.12/2000/4, UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000.
[16] CRC/C/GC/7, UN Committee on the Rights of the Child (CRC), General comment No. 7 (2005): Implementing child rights in early childhood, 1 November 2005.
[17] CRC/C/GC/9, UN Committee on the Rights of the Child (CRC), General comment No. 9 (2006): The rights of children with disabilities, 27 February 2007.
[18] CRC/GC/2003/5, UN Committee on the Rights of the Child (CRC), General comment no. 5 (2003): General measures of implementation of the Convention on the Rights of the Child, 27 November 2003
[19] CRC/GC/2003/4, UN Committee on the Rights of the Child (CRC), General comment No. 4 (2003): Adolescent Health and Development in the Context of the Convention on the Rights of the Child, 1 July 2003.
[20] CRC /C/GC/14, UN Committee on the Rights of the Child (CRC), General comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1), 29 May 2013.
[21] CRC/C/GC/15, UN Committee on the Rights of the Child (CRC), General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), 17 April 201
[22] CRC/C/GC/19, UN Committee on the Rights of the Child (CRC), General comment No. 19 (2016) on public budgeting for the realization of children's rights (art. 4), 20 July 2016.
[23] CRC/C/GC/20, UN Committee on the Rights of the Child (CRC), General comment No. 20 (2016) on the implementation of the rights of the child during adolescence, 6 December 2016
[24] CRPD/C/GC/4, UN Committee on the Rights of Persons with Disabilities (CRPD), General comment No. 4 (2016), Article 24: Right to inclusive education, 2 September 2016.
[25] CRPD/C/GBR/CO/1, Concluding observations on the initial report of the United Kingdom of Great Britain and Northern Ireland, 3 October 2017
[26] UN Committee on Economic, Social and Cultural Rights, Concluding observations on the sixth periodic report of the United Kingdom of Great Britain and Northern Ireland', 14 July 2016.

- Concluding Observations of the UN Committee on the Rights of the Child[27]

1.3. The NIHRC welcomes the introduction of the Draft Mental Health Strategy following the commitment given in 'New Decade New Approach'.[28] This builds on previous developments in the area of mental health including the appointment of an interim Mental Health Champion for NI in April 2020,[29] and the publication of the Department of Health's Mental Health Action Plan in May 2020.[30] The Draft Mental Health Strategy contains three overarching themes, which are underpinned by 29 high-level action points aimed at improving the framing and delivery of mental health services in NI.

1.4. In view the range of practical and legal issues which arise in this consultation, the NIHRC has sought to highlight relevant human rights standards and principles, where they may be of assistance in developing the Department's Draft Mental Health Strategy. Therefore, the NIHRC's response to some of the consultation questions have been grouped together for ease of reference.

A RIGHTS-BASED APPRAOCH TO THE RIGHT TO HEALTH

2.0. The right to the highest attainable standard of health, which includes both physical and mental health, is enshrined in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), Article 24 of the Convention on the Rights of the Child (CRC) and Article 25 of the Convention on the Rights of Persons with Disabilities (CRPD). In recognition of the enabling significance of the right to the highest attainable standard of health, the Committee on Economic, Social and Cultural Rights has stated, "Health is a fundamental human right indispensable for the exercise of other human rights".[31]

2.1. The right to the highest attainable standard of health, as an economic, social and cultural right, is subject to the legal principle of progressive realization. This means that in practice, and in recognition of the resource disparities and constraints which exist within and across states, contracting states are afforded a legal and practical latitude within their maximum available resources in which to realise the right in question. This legal principle finds expression in Article 2(1) ICESCR, Article 4 CRC and Article 4(2) CRPD.

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[27] CRC/C/GBR/CO/5, UN CRC 'Concluding observations on the fifth periodic report of the United Kingdom of Great Britain and Northern Ireland', 12 July 2016.
[28] NI Office, 'New Decade, New Approach' (NIO, 2020), at 27.
[29] University of Ulster, 'Press Release: Professor Siobhán O'Neill appointed interim Mental Health Champion for NI', 24 June 2020.
[30] Department of Health, 'Mental Health Action Plan' (DoH, 2020).
[31] E/C.12/2000/4, 'CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)', 11 August 2000, at para 1.

2.2. However, the principle of progressive realization also contains several identifiable legal components. First, according to the Committee on Economic, Social and Cultural Rights, states are expected to "move as expeditiously and effectively as possible"[32] and take "deliberate, concrete and targeted"[33] steps towards the realisation of the right in question. Secondly, states must use their 'maximum available resources' in furtherance of their human rights obligations to realise the right to health. In addition to financial resources, states must also use their "human, technological, organizational, natural and information resources".[34] Thirdly, the principle of progressive realization is subject to full compliance with the principle of non-discrimination. Finally, states must adhere to the principle of non-retrogression in furtherance of their obligations to progressively realise the right to health. This means that any actions or measures taken by the state must not result in any diminution or backsliding in terms of the enjoyment of existing rights The Committee on Economic, Social and Cultural Rights has stated that any such retrogressive measures "would require the most careful consideration and would need to be fully justified by reference to the totality of the rights provided for in the Covenant and in the context of the full use of the maximum available resources".[35]

2.3. Closely connected with the principle of progressive realization, is the concept of the minimum core content of socio-economic rights. In its endorsement of adopting a minimum core approach within the ICESCR, the Committee on Economic, Social and Cultural Rights stated that: "If the Covenant were to be read in such a way as not to establish such a minimum core obligation, it would be largely deprived of its raison d'etre".[36] Correspondingly, in their support of the minimum core approach, the Committee on the Rights of the Child stated that it stands "parallel to the concept of progressive realization"[37]and that satisfaction of such minimum levels of enjoyment are integral for a dignified existence.

2.4. The right to the highest attainable standard of health has been interpreted by the Committee on Economic, Social and Cultural Rights as requiring states to ensure that the right to health, including mental health, is available, accessible, acceptable and of good quality. [38] In terms of availability, health facilities "have to be available in sufficient quantity within the State party".[39] In its 2016 concluding observations, the Committee on Economic, Social and Cultural Rights expressed concern regarding "the lack

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[32] United Nations, Committee on Economic, Social and Cultural Rights, General Comment No. 3, The nature of States parties obligations (Art 2, para 1) (1990), at para 9.
[33]Ibid at para 2.
[34] Committee on the Rights of the Child, Day of General Discussion on Resources for the Rights of the Child – Responsibility of States**",** 5 October 2007, at para 24.
[35] United Nations, Committee on Economic, Social and Cultural Rights, General Comment No. 3, The nature of States parties obligations (Art 2, para 1) (1990), at para 9.
[36] Ibid, at para 10.
[37] Committee on the Rights of the Child, Day of General Discussion on Resources for the Rights of the Child – Responsibility of States**",** 5 October 2007, at para 48..
[38] E/C.12/2000/4, 'CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)', 11 August 2000, at para 12.
[39] Ibid.

of adequate resources provided to mental health services" across the UK.[40] In terms of accessibility, states are under an obligation to ensure that health facilities and services are available to everyone within the state on a non-discriminatory basis. This includes physical, economic, and informational accessibility.[41] Furthermore, health services should be acceptable in terms of their respect for cultural and medical ethics and "be scientifically and medically appropriate and of good quality".[42]

2.5. The Commission welcomes the commitment given within the Draft Mental Health Strategy for the development of a mental health system "that ensures consistency and equity of access to services, regardless of where a person lives".[43] According to Action Mental Health: "financing of mental health services in NI is a systemic and long-term issue that is set to exacerbate in coming years, particularly in rural areas".[44] While the Commission welcomes the fact that the Department of Health has carried out a Rural Impact Assessment Screening,[45] the Commission remains concerned that the screening did not specifically engage with the questions of availability, accessibility, acceptability and quality in relation to the delivery of the Draft Mental Health Strategy in the rural areas of NI. Similarly, while the Commission further welcomes that an Equality and Human Rights Impact Assessment Screening[46] was carried out, it further notes that this also did not engage with the issues of availability, accessibility, acceptability and quality which are central to the delivery of the right to health.

2.6. In terms of its delivery, the right to the highest attainable standard of health extends "not only to timely and appropriate health care but also to the underlying determinants of health",[47] which according to the World Health Organization encapsulate the wider societal conditions which affect health. These include "the prevailing political structure, income, education, occupation, family structure, service availability, sanitation, exposure to hazards, social support, racial discrimination, and access to resources linked to health".[48]

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[40] E/C.12/GBR/CO/6, 'UN Committee on Economic, Social and Cultural Rights, Concluding observations on the sixth periodic report of the United Kingdom of Great Britain and Northern Ireland', 14 July 2016, at para 57.
[41] /C.12/2000/4, 'CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)', 11 August 2000, at para 12.
[42] Ibid.
[43] Department of Health, 'Draft Mental Health Strategy' (DOH, 2021), at para 27.
[44] http://www.amh.org.uk/wp-content/uploads/2010/06/AMH-QUB-report-summary_AW.pdf, 3
[45] https://www.health-ni.gov.uk/sites/default/files/consultations/health/doh-mhs-impact-assessment-screening-rural-needs.pdf
[46] See Screening flowchart and template (health-ni.gov.uk)
[47] https://www.health-ni.gov.uk/sites/default/files/consultations/health/doh-mhs-impact-assessment-screening-rural-needs.pdf at para 11.
[48] World Health Organization, 'Commission on Social Determinants of Health, Globalization, Global Governance and the Social Determinants of Health: A review of the linkages and agenda for action', (WHO, June 2017) 16.

2.7. According to the NI Assembly, mental health "is the single largest cause of ill health and disability"[49] in NI, with NI possessing significantly higher levels of mental ill health than any other region in the UK with 1 in 5 adults suffering from a mental condition at any one time, "which is a 25% higher overall prevalence of mental illness than England".[50] In its 2016 concluding observations, the Committee on the Rights of the Child expressed concern regarding the steadily increasing rate of child suicide in NI.[51] The Committee additionally recommended that the state invest in child and adolescent mental health services and develop strategies with particular attention accorded "to children at greater risk, including children living in poverty, children in care and children in contact with the criminal justice system".[52] Moreover, NI also possesses one of the highest related trauma-disorders in the world.[53]

2.8. In addition to the international human rights standards, the European Convention on Human Rights (ECHR) as incorporated into domestic law via the Human Rights Act 1998 sets out several core duties and obligations in respect of the right to mental health. While the Draft Mental Health Strategy does not explicitly refer to these duties, a deeper interrogation of the practical and legal operation of many of the envisaged high-level action points clearly engage these obligations. These include the human rights obligations that arise in the context of Article 3 (the prohibition of torture, inhuman and degrading treatment), Article 5 (the right to liberty) and Article 8 (the right to respect for personal and family life) of the ECHR. These duties principally manifest themselves in the context of in-patient treatment and for individuals who have been detained under the Mental Health Order, and are therefore particularly relevant in the context of the Draft Strategy's Theme Two, 'Providing the right support at the right time'.

2.9. In the context of the intersection of mental health and Article 3 ECHR, the European Court of Human Rights (ECtHR) stated, "the mentally ill are in a position of particular vulnerability, and clear issues of respect for their fundamental human dignity arise whenever such persons are detained by the authorities".[54] The ECtHR has also found that excessive measures of restraint violate the prohibition on torture or inhuman and degrading treatment.[55] Similarly, in the case of *Slawomir Musial v Poland*,[56] where the applicant alleged that his medical care and treatment in custody was inadequate in view of his epilepsy, schizophrenia and other mental disorders, the court found a violation of Articles 3 and 8 ECHR on the basis

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[49] Northern Ireland Assembly, Research and Information Research Service Paper, 'Mental Health in Northern Ireland: Overview, Strategies, Policies, Care Pathways, CAMHS and Barriers to Accessing Services', 24 January 2017, 9.
[50] Ibid.
[51] CRC/C/GBR/CO/5, UN CRC 'Concluding observations on the fifth periodic report of the United Kingdom of Great Britain and Northern Ireland', 12 July 2016, at para 60 (b).
[52] Ibid at para 61 (b).
[53] Northern Ireland Affairs Committee, 'Health funding in Northern Ireland First Report of Session 2019', (House of Commons, 2 November 2019) at para 109.
[54] *M.S. v The United Kingdom,* (Application No. 24527/ 08), 11 May 2012, at para 39.
[55] For example: Henaf v France (27 November 2003) 40 EHRR 990 (shackling to a bed amounted to degrading treatment) or Mouisel v France (14 November 2002) 38 EHRR
[56] Application No. 28300/06 (20 January 2009)

of the nature, level and severity of the treatment received. All cases arising under Article 3 ECHR will depend on the distinct factual situations which arise in each case and are therefore context-specific in nature.

2.10. In adhering to the states Article 5 ECHR obligations, the ECtHR in *Winterwerp v Netherland*[57] stated, "In the court's opinion, except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of "unsound mind". The very nature of what has to be established before the competent national authority – this is, a true mental disorder – calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder".[58] Similarly, in the case of *Megyeri v Germany*[59] the ECtHR affirmed the importance of legal assistance for detained individuals and stated, "where a person is confined in a psychiatric institution on the ground of the commission of acts which constituted criminal offences but for which he could not be held responsible on account of mental illness, he should - unless there are special circumstances - receive legal assistance in subsequent proceedings relating to the continuation, suspension or termination of his detention. The importance of what is at stake for him - personal liberty - taken together with the very nature of his affliction – diminished mental capacity – compel this conclusion".[60]

2.11. Furthermore, those with mental illness continue to enjoy their right to personal and family privacy under Article 8 ECHR. In the case of *Bensaid v The United Kingdom*[61] the ECtHR stated, "Mental health must also be regarded as a crucial part of private life associated with the aspect of moral integrity … The preservation of mental stability is in that context an indispensable precondition to effective enjoyment of the right to respect for private life".[62] Similarly, in the context of administering medication for psychiatric illness, the ECtHR has stated that, generally, the individual's right to refuse medication falls within the legal purview of Article 8 ECHR.[63] Additionally, in situations involving the removal of children from a mentally ill person, the ECtHR has stated that an obligation arises under Article 8 ECHR to ensure the participation of mentally ill persons in the context of proceedings regarding the placement of their children.[64]

2.12. The Commission recommends that the Draft Mental Health Strategy contain an express commitment to realising the right to the highest attainable standard of mental health for all persons in

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[57] 6301/73 [1979] ECHR 4
[58] Ibid, at para 39.
[59] 13770/88 [1992] ECHR 49
[60] Ibid, at para 23.
[61] (*Application no. 44599/98*) 6 February 2001
[62] Ibid at para 47.
[63] *X v Finland (Application no. 34806/04) 3 July 2012.*
[64] *K and T v Finland*, (Application no. 25702/94) 12 July 2001

Northern Ireland and that all treatments and detentions will comply with the rights and obligations as set out in the ECHR.

2.13. The Commission further recommends that the four guiding principles underpinning the delivery of the right to health (availability, accessibility, acceptability and quality) are clearly referenced where relevant throughout the Draft Mental Health Strategy.

2.14. The Commission recommends that the Rural Screening Impact Assessment and the Equality and Human Rights Impact Assessment Screening be updated to include an examination of the requirements of availability, accessibility, acceptability and quality of healthcare which underpin the right to the highest attainable standard of mental health.

2.15. The Commission further recommends that relevant training on human rights law be provided to all staff and professional working in mental health services.

BUDGETING AND RESOURCES

3.0. The Commission welcomes the scale and breadth of the proposals and action points contained within the Draft Mental Health Strategy. These include the expansion of talking therapy hubs to ensure NI wide coverage,[65] increased investment in child and adolescent mental health services,[66] the extension of mental health services for adults beyond the age of 65,[67] the development of in-service mental health services,[68] and the development and creation of specialist mental health services including perinatal mental health services, personality disorder services and regional eating disorder services.[69]

3.1. However, the Commission is concerned about the lack of detail on budgetary and resource considerations on the implementation of the strategy. Although it refers to the sustainable resourcing of the talking therapy hubs,[70] the use of "digital resources"[71] to support mental health and well-being and the use of "the range of available community resources" [72] to support the development of mental health services within local communities, the strategy is otherwise silent on how its aims and objectives are to be realised, and within what timeframes these are to happen.

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[65] Department of Health, 'Draft Mental Health Strategy' (DOH, 2021), Action 2.
[66] Ibid, at Actions 5 – 7.
[67] Ibid, at Action 8.
[68] Ibid, at Actions 16 – 18.
[69] Department of Health, 'Draft Mental Health Strategy' (DOH, 2021), Actions 21 – 24.
[70] Ibid, at Action 2.
[71] Ibid, at para 10.
[72] Ibid, at para 91.

3.2. In the context of the right to health, the Committee on Economic, Social and Cultural Rights has stated, "…If resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above. It should be stressed, however, that a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are non-derogable".[73] According to General Recommendation No.24 (1999) of the Committee on the Elimination of Discrimination against Women (CEDAW), "States parties should allocate adequate budgetary, human and administrative resources to ensure that women's health receives a share of the overall health budget comparable with that for men's health, taking into account their different health needs."[74]

3.3. In their discussion of the use of public budgeting in the context of implementing children's rights, the Committee on the Rights of the Child has stated, "The implementation of the rights of the child requires close attention to all four stages of the public budget process: planning, enacting, executing and follow-up. The rights of all children should be given consideration by States parties throughout the budget process, in accordance with the general principles of the Convention and the budget principles outlined in the present general comment". [75] Similarly, in their 2016 concluding observations, the Committee on the Rights of the Child recommended that the state party "Ensure transparent and participatory budgeting through public dialogue, including with children"[76] and further that they: "Define budgetary lines for children in disadvantaged or vulnerable situations that may require affirmative social measures and make sure that those budgetary lines are protected even in situations of economic recessions".[77]

3.4. In their 2016 concluding observations, the Committee on Economic, Social and Cultural Rights expressed concern "about the lack of adequate resources provided to mental health services"[78] within the state while simultaneously urging the state party to "allocate sufficient resources to the mental health sector".[79]

3.5. In NI, funding for CAMHS is approximately £20-25m per year, which equates to between 6.5% and 8.5% of the total mental health budget. According to the draft Mental Health Strategy, this must increase to 10% per annum to

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[73] /C.12/2000/4, 'CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)', 11 August 2000, at para 47.
[74] CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health), 1999, A/54/38/Rev.1, chap, at para 30.
[75] CRC/C/GC/19, UN Committee on the Rights of the Child, General comment No. 19 (2016) on public budgeting for the realization of children's rights (art. 4) At para 26.
[76] CRC/C/GBR/CO/5, UN CRC 'Concluding observations on the fifth periodic report of the United Kingdom of Great Britain and Northern Ireland', 12 July 2016, at para 13(a).
[77] Ibid, at para 13(b).
[78] E/C.12/GBR/CO/6, 'UN Committee on Economic, Social and Cultural Rights, Concluding observations on the sixth periodic report of the United Kingdom of Great Britain and Northern Ireland', 14 July 2016, at para 57.
[79] Ibid, at para 58.

meet the needs of children and young people.[80] Overall however, funding for mental health services in NI remains disproportionately low in comparison to the rest of the UK. According to the NI Affairs Committee, "funding for mental health as a proportion of the health budget in Northern Ireland has remained comparatively low, despite the higher prevalence of need".[81] Similarly, according to Action Mental Health "Between 2008 and 2014, actual spend on mental health services by Trusts has been around 25% less than previously proposed"[82] and "In comparison with other types of healthcare (like primary care which has had funding increased by 136.2% over the same period), mental health services have experienced year on year decreases in funding since 2009".[83]

3.6. The Commission recommends further information is published on what the envisaged total funding is required to meet the remainder of the needs and aims as outlined within the Draft Mental Health Strategy. A 10% target for CAMHS is an improvement. Nonetheless it would be more valuable than setting a target which entails additional resources being made available without actually addressing whether it will be sufficient to meet need.

3.7. The Commission recommends that the Department of Health publish the actual financial resources required to meet the aims and objectives of the strategy and continues to benchmark and publish actual expenditure against the cost of effectively meeting need.

3.8. The Commission recommends that key budgetary documents and information be made publicly available as part of the consultation process do that civil society and the wider public have the opportunity to make a meaningful contribution.

CHILDREN'S RIGHTS PRINCIPLES

4.0. The Commission welcomes the commitment within the Draft Mental Health Strategy to improving the provision of child and adolescent mental health services across NI. In particular, the Commission welcomes:

- The commitment to the promotion of "positive social and emotional development throughout the period of childhood",[84]
- The provision of "enhanced and accessible mental health services for those who need specialist mental health services",[85]

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[80] Department of Health, 'Draft Mental Health Strategy' (DOH, 2021), at para 68.
[81] See https://publications.parliament.uk/pa/cm201919/cmselect/cmniaf/300/30008.htm
[82] See http://www.amh.org.uk/wp-content/uploads/2010/06/AMH-QUB-report-summary_AW.pdf
[83] Ibid.
[84] Department of Health, 'Draft Mental Health Strategy' (DOH, 2021), Action 3.
[85] Ibid, at Action 4.

- The commitment to meeting "the needs of vulnerable children and young people when developing and improving CAMHS"[86] by putting in place a "No Wrong Door Approach",[87]
- The commitment to increase the funding for CAMHS to 10% of the adult mental health budget,[88] and
- The pledge to create clear and regionally consistent "urgent, emergency and crisis services to children and young people".[89]

4.1. However, the Commission is concerned regarding the absence of express children's human rights within the Draft Mental Health Strategy. Under the Convention on the Rights of the Child (CRC) (1989), states are under an obligation to comply with the conventions four guiding principles when developing and enacting laws and policies.[90] These include:

- The principle of non-discrimination (Article 2),
- The child's best interests principle (Article 3),
- The child's right to life, survival and development (Article 6), and
- The child's right to participate in matters which affect them (Article 12).

As guiding principles, this means that all other convention rights, including the right to the highest attainable standard of mental health, must be realised according to these principles. In addition to their status as guiding principles, they are also free-standing independent entitlements. While the Commission welcomes that reference to these principles are included within the Children's Rights Screening and Impact Assessment which accompanies the Draft Mental Health Strategy,[91] it remains concerned that insufficient attention and engagement was accorded to them. In particular, the Commission is concerned with the lack of information on how the Draft Strategy ensures that these principles are complied with and given effect to, in all matters that affect children.

4.2. With regards to the best interests principle, Article 3 CRC 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". The Committee on the Rights of the Child in General Comment No. 14 have further stated that the guarantee contained in Article 3 'is aimed at ensuring both the full and effective enjoyment of all the rights recognized in the convention and the holistic development of the child'.[92]

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[86] Ibid, at Action 6.
[87] Ibid.
[88] Ibid, at Action 6.
[89] Ibid, at Action 7.
[90] CRC/GC/2003/5UN Committee on the Rights of the Child (CRC), General comment no. 5 (2003): General measures of implementation of the Convention on the Rights of the Child, 27 November 2003.
[91] See doh-mhs-impactassessment-screening-childrens-rights.pdf (health-ni.gov.uk)
[92] Committee on the Rights of the Child, General Comment No. 14 on the right of the child to have his or her best interests taken as a primary consideration (art.3, para.1)(2013) at paragraph 4.

4.3. The Committee on the Rights of the Child has further articulated a three-fold legal framework, which underpins the delivery and operation of the best interests principle. Article 3 entails, first, a substantive right; that is the individual personal right of the child to have his or her best interests taken as a primary consideration; secondly, a fundamental, interpretative legal principle; where a legal provision is open to more than one meaning, it must be construed in a manner which best serves the child's best interest's; and thirdly, a rule of procedure where any decision likely to impact upon the best interests of the child must include an evaluation as to the probable impact such a decision will have on the child's best interests.[93]

4.4. In relation to the right of children to participate in matters which affect them, Article 12(1) CRC states, "States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child". Further to this, the Committee on the Rights of the Child has stated that in the context of the right to health and healthcare, the right to participate "applies to individual health-care decisions, as well as to children's involvement in the development of health policy and services".[94]

4.5. In their 2016 concluding observations, the Committee on the Rights of the Child expressed concern that "the right of the child to have his or her best interests taken as a primary consideration is still not reflected in all legislative and policy matters and judicial decisions affecting children".[95] The Committee also stated that in relation to the child's right to participate and for their views to be given due weight in relation to their age and maturity, that: "Children's views are not systematically heard in policymaking on issues that affect them".[96]

4.6. In 2018, the NI Commissioner for Children and Young People (NICCY) published its rights based review into mental health services for children and young people in NI.[97] This concluded that mental health services were "under significant pressure, finding it difficult to respond to the scale of need, and the complexity of issues children and young people are presenting".[98] It also found a system characterised by "chronic under-investment, 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".[99] In February 2021, the NI Commissioner for Children and Young People published its

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[93] Ibid, at para 6.
[94] CRC/C/GC/12UN Committee on the Rights of the Child (CRC), *General comment No. 12 (2009): The right of the child to be heard*, 20 July 2009, at para 98.
[95]CRC/C/GBR/CO/5, UN CRC 'Concluding observations on the fifth periodic report of the United Kingdom of Great Britain and Northern Ireland', 12 July 2016, at para 26.
[96] Ibid, para 30(a).
[97] NI Commissioner for Children and Young People, 'Still Waiting: A Rights Based Review of Mental Health Services and Support for Children and Young People' (NICCY, 2018).
[98] Ibid, 8.
[99] Ibid,

second monitoring report analysing the NI Executive's response to the recommendations set out in their review. Regarding progress to date, the NI Commissioner for Children and Young People has expressed concern that the waiting times for accessing Child and Adolescent Mental Health Services and Psychological Therapies were in fact increasing, that A&E attendance continued to be commonplace for children and young people in crisis, that 40% of children and young people were discharged from CAMHS without their goals being achieved and the level of prescription of anti-depressants among children and young people was still concerning.[100] More recently, the 2020 Youth Wellbeing Prevalence Survey indicated that not only did NI have higher levels of mental ill health in comparison to the other UK jurisdictions, with 1 in 8 (12.6%) of children in NI suffering from an emotional disorder such as anxiety or depression in comparison with 1 in 12 (8.1%) in England, but that NI also possessed higher levels of child suicide that any other regions within the UK.[101]

4.7. Similarly, in March 2020, the NI Commissioner for Children and Young People (NICCY) published its rights-based review into Special Educational Needs Provision in Mainstream School in NI. This concluded that the current framework governing the provision of special educational needs "points to a system under extensive and sustained pressure".[102] In the context of mental health, the report found evidence that the impact of the overstretched system governing special educational needs was having a clear and negative impact on children's mental health and well-being.[103]

4.8. Additionally, within the context of children's rights, the Committee on the Rights of the Child has previously highlighted the importance of training and capacity-building for those working with children and young people. It has stated that, "Training needs to be systematic and ongoing - initial training and re-training. The purpose of training is to emphasize the status of the child as a holder of human rights, to increase knowledge and understanding of the Convention and to encourage active respect for all its provisions".[104]

4.9. The Commission recommends that the Draft Mental Health Strategy contain an express commitment that the CRC's four guiding principles (non-discrimination, best interests principle, right to life survival and development, and the right to participate) will underpin the delivery and implementation of all policies that will affect children and young people.

4.10. The Commission recommends that the Children's Rights Screening and Impact Assessment be updated to account for how the CRC's

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[100] NI Commissioner for Children and Young People, 'Still Waiting: Monitoring Report' (NICCY, 2021).
[101] RCPCH State of Child Health. Northern Ireland (2020) p23.
[102] NI Commissioner for Children and Young People, 'Too Little, Too Late' (NICCY, 2020).
[103] Ibid, 54.
[104] CRC/GC/2003/5UN Committee on the Rights of the Child (CRC), General comment no. 5 (2003): General measures of implementation of the Convention on the Rights of the Child, 27 November 2003, at para 53.

four guiding principles will be complied with in relation to the delivery of the Draft Mental Health Strategy.

4.11. The Commission recommends that the Draft Strategy contain a clause which states that in all actions, decisions, policies, laws, and regulations which are enacted, that the best interests of the child shall be a primary consideration.

4.12. The Commission recommends that the child's right to express their views in all matters which affect them, pursuant to Article 12 CRC is expressly included within the Draft Mental Health Strategy.

4.13. The Commission recommends that all relevant training about children's rights and in particular their right to be heard, be provided to all staff and professionals working across the mental health services in Northern Ireland.

IMPLEMENTATION AND MONITORING

5.0. While the Commission welcomes the stated objectives within the Draft Mental Health Strategy, it is however concerned about the lack of detail regarding how the Strategy is to be implemented and monitored. In particular, the Commission remains concerned about the absence of any mention of how data is to be collected in a robust, thorough, and disaggregated manner so as to permit the effective monitoring and implementation of the Strategy.

5.1. Disaggregated data collection is an integral aspect of human rights monitoring and implementation and can ensure that the principles of non-discrimination and equality are at the heart of law and policy. According to the Committee on Economic, Social and Cultural Rights: "States parties are obliged to monitor effectively the implementation of measures to comply with article 2, paragraph 2, of the Covenant. Monitoring should assess both the steps taken and the results achieved in the elimination of discrimination. National strategies, policies and plans should use appropriate indicators and benchmarks, disaggregated on the basis of the prohibited grounds of discrimination".[105] However, state parties should also monitor instances of multiple or intersectional discrimination in the enjoyment of the right to health, which include instances of discrimination which engage one or more protected characteristic. As the Committee on Economic, Social and Cultural Rights have further stated: "Some individuals or groups of individuals face discrimination on more than one of the prohibited grounds, for example women belonging to an ethnic or religious minority. Such cumulative discrimination has a unique and specific impact on individuals and merits particular consideration and remedying".[106]

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[105] E/C.12/GC/20, UN Committee on Economic, Social and Cultural Rights, General Comment No. 20, Non-discrimination in economic, social and cultural rights (art. 2, para. 2, ICESCR), at para 41.
[106] Ibid, at para 17.

5.2. From a children's rights perspective, the Committee on the Rights of the Child has stated in General Comment No.5 (2003) that, "Collection of sufficient and reliable data on children, disaggregated to enable identification of discrimination and/or disparities in the realization of rights, is an essential part of implementation. The Committee reminds States parties that data collection needs to extend over the whole period of childhood, up to the age of 18 years"[107]. The Committee has further stated, "It is essential not merely to establish effective systems for data collection, but to ensure that the data collected are evaluated and used to assess progress in implementation, to identify problems and to inform all policy development for children. Evaluation requires the development of indicators related to all rights guaranteed by the Convention".[108]

5.3. In the context of disability, Article 31 of the CRPD sets out clear obligations on contracting states to ensure the effective monitoring and implementation of the convention. With Article 31 (1) stating, "States Parties undertake to collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the present Convention". Article 31 (2) further asserts, "The information collected in accordance with this article shall be disaggregated, as appropriate, and used to help assess the implementation of States Parties' obligations under the present Convention and to identify and address the barriers faced by persons with disabilities in exercising their rights". Moreover, in General Comment No.6 (2018) on the right of persons with disabilities to equality and non-discrimination, the Committee on the Rights of Persons with Disabilities have further stated that: "Data collection and analysis are essential measures to monitor anti-discrimination policies and laws. States parties should collect and analyse data, which must be disaggregated on the basis of disability and of intersectional categories. Data collected should provide information on all forms of discrimination. The data collected should be broad and cover statistics, narratives and other forms of data such as indicators to assess implementation and monitor progress and effectiveness of new or ongoing initiatives and policies".[109]

5.4. Additionally, the Committee on the Elimination of Discrimination against Woman has stated that from a woman's rights perspective, "States parties should make every effort to ensure that their national statistical services responsible for planning national censuses and other social and economic surveys formulate their questionnaires in such a way that data can be disaggregated according to gender, with regard to both absolute numbers and percentages, so that interested users can easily obtain information on

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[107] CRC/GC/2003/5UN Committee on the Rights of the Child (CRC), General comment no. 5 (2003): General measures of implementation of the Convention on the Rights of the Child, 27 November 2003, at para 48.
[108] Ibid.
[109] CRPD/C/GC/6, UN Committee on the Rights of Persons with Disabilities General Comment No.6 on the right of persons with disabilities to equality and non-discrimination, 9 March 2018, at para 70.

the situation of women in the particular sector in which they are interested".[110]

5.5. The lack of disaggregated data in relation to mental health services in NI been frequently highlighted by international treaty monitoring bodies. In 2016, the Committee on the Rights of the Child urged the state party to "Regularly collect comprehensive data on child mental health, disaggregated across the life course of the child, with due attention to children in vulnerable situations and covering key underlying determinants".[111] Similarly, in their recognition of the uneven level of access to healthcare for those with disabilities within the state, the Committee on the Rights of Persons with Disabilities recommended the state party to "Develop a targeted, measurable and financed plan of action aiming at eliminating barriers in access to health care and services, and monitor and measure its progress, especially in relation to persons with intellectual and/or psychosocial disabilities and those with neurological and cognitive conditions". [112] Correspondingly, in their 2016 concluding observations, the Committee on Economic, Social and Cultural urged the state party to "continue its efforts to guarantee the effective implementation of the mental health legislation in all jurisdictions of the State party and to ensure the accessibility, availability and quality of mental health care, including for persons in detention".[113]

5.6. Evidence at the local level is NI further reveals significant gaps in the data pertaining to mental health. According to the NI Commissioner's for Children and Young People, no accurate register of the number of people with a learning disability in NI despite the fact those with a learning disability are "are much more likely to experience mental health problems, compared to their peers".[114] Similarly, according to the Mental Health Foundation, NI has more limited data on mental health in comparison to the rest of the UK and possesses a "significant absence of research and data addressing mental health for different groups and populations such as BAME groups, homeless people, transgender individuals, older adults, and refugees and asylum seekers".[115]

5.7. The Commission recommends that the Department of Health expand, improve and synchronise its data collection mechanisms so that robust and comprehensive disaggregated data in relation to mental health can be collected in Northern Ireland.

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[110] A/44/48, Committee on the Elimination of Discrimination against Women General recommendation No. 9 on Statistical data concerning the situation of women (1989).
[111] CRC/C/GBR/CO/5, UN CRC 'Concluding observations on the fifth periodic report of the United Kingdom of Great Britain and Northern Ireland', 12 July 2016, at para 61(a).
[112] CRPD/C/GBR/CO/1, Concluding observations on the initial report of the United Kingdom of Great Britain and Northern Ireland, 3 October 2017, at para 55(a).
[113] CRC/C/GBR/CO/5, UN CRC 'Concluding observations on the fifth periodic report of the United Kingdom of Great Britain and Northern Ireland', 12 July 2016, at para 58.
[114] NI Commissioner for Children and Young People, 'Still Waiting: A Rights Based Review of Mental Health Services and Support for Children and Young People' (NICCY, 2018), 151.
[115] Mental Health in Northern Ireland: Fundamental Facts (February 2016), https://www.mentalhealth.org.uk/northern-ireland, 22.

5.8. The Commission recommends that all relevant data should be disaggregated by characteristics such as sex, gender, age, race, ethnicity, disability, religion, socio-economic status, and other relevant characteristics to ensure that current and future policies can reflect and respond to current and emergent issues.

5.9. The Commission recommends that Theme Three, 'New Ways of Thinking' within the Draft Strategy contain an express clause which ensures that all five HSC Trusts in Northern Ireland introduce updated data collection systems to enable the collection of regionally consistent mental health statistics.

5.10. The Commission further recommends that the Department of Health publish guidance on a human rights-based approach to data collection to assist in the shift towards an improved and reformed delivery of mental health services in Northern Ireland.

THE RIGHTS OF OLDER PEOPLE

6.0. The Commission welcomes the commitment within the Draft Mental Health Strategy that the rights and needs of older people will be accommodated for and in particular that the automatic cut off point in adult services at 65 years of age will cease and that people will be supported by a rights based service which responds to their individual health needs. [116] However, the Commission is concerned that the rights of older people and the contributory factors with impact on their mental health, namely the social determinants of the right to health, are not adequately addressed within the Draft Strategy.

6.1. NI stands apart in terms of its unique demographic profile. Approximately "39% of the population in Northern Ireland reported experiencing a traumatic event relating to the Troubles"[117]. According to the Draft Strategy: "A person who was 18 at the beginning of the conflict will be 68 years old in 2020 and may present to older adults' services where there is an under provision of psychologically informed, recovery strengths focused interventions".[118] In their 1995 General Comment on the Rights of Older Persons, the Committee on Economic, Social and Cultural Rights stated that: "States parties should bear in mind that maintaining health into old age requires investments during the entire life span, basically through the adoption of healthy lifestyles (food, exercise, elimination of tobacco and alcohol, etc.)".[119]

6.2. According to Age UK, the incidence rate of mental health conditions is disproportionally higher among specific groups of older people. "40% of older people who are living in care homes have depression; 30% of older

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[116] Department of Health, 'Draft Mental Health Strategy' (DOH, 2021), Action 8.
[117] Ibid, at para 3.
[118] Ibid, at para 83.
[119] E/1996/22, N Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 6: The Economic, Social and Cultural Rights of Older Persons*, 8 December 1995, at para 35.

carers experience depression at some point; and older people going through a bereavement are up to four times more likely to experience depression than older people who haven't been bereaved".[120] Moreover, for older people the twin issue of dementia and loneliness are both catalysts for the occurrence of mental ill-health with Age UK highlighting that dementia not only triggers mental health but that it also makes treatment more challenging.[121] Similarly, the issue of loneliness which can trigger both dementia and depression is expected to affect over 2 million people over the next decade.[122]

6.3. While the Draft Mental Health Strategy makes a singular reference to dementia, the Commission is concerned overall, that insufficient attention is given to the issues of dementia and loneliness, both of which have a direct and immediate impact on the right to health for older people. Although the Executive's 'Active Ageing Strategy' has been extended to 2022, it too is silent on the issue of loneliness.[123]

6.4. The Commission recommends that the Draft Mental Health Strategy contain an express commitment that the issues of dementia and loneliness will be factored into the delivery of care for older people.

6.5. The Commission recommends that the Department of Communities update and revise their Active Ageing Strategy to reflect the impact which loneliness has on the right to health for older people.

COVID-19 AND MENTAL HEALTH

7.0. The advent of the Covid-19 global pandemic has resulted in an unprecedented disruption to the delivery of mental health services on the domestic front. As acknowledged by the Department of Health: "Lockdown, shielding and social distancing, the closure of schools, working from home, increased deaths, reduction in face to face services, as well as the restrictions on funeral rites during the pandemic have had an impact on the emotional wellbeing of many, including those with existing mental health conditions. In addition, evidence has shown increased levels of acuity presenting to acute mental health services. It is highly likely that we will see increased levels of need for a number of years due to the ongoing impact of the pandemic on our society's mental health".[124]

7.1. In recognition of the incalculable impact which Covid-19 has had on the right to the highest attainable standard of mental health, the United Nations has stated that not only must mental health actions "need to be considered

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[120] https://www.ageuk.org.uk/globalassets/age-uk/documents/policy-positions/health-and-wellbeing/ppp_mental_health_england.pdf, 2.
[121] Ibid, 3.
[122] Ibid.
[123] Department of Communities, 'Active Ageing Strategy 2016 – 2022' (DoC, November 2020).
[124] Department of Health, 'Draft Mental Health Strategy' (DOH, 2021), at para 5.

essential components of the national response to COVID-19"[125] but that states should prioritise the widespread delivery of emergency mental health and psychosocial support and build mental health services for the future.[126]

7.2. The Commission is concerned that, in view of the devastating impact which Covid-19 has had on NI, that an express Action or Theme is not dedicated to recovery from Covid-19 within the Draft Mental Health Strategy.

7.3. The Commission recommends that the Draft Mental Health Strategy contain an express clause which states that the delivery of future mental health services will reflect and remedy the impact which Covid-19 has had on the delivery of mental health services in Northern Ireland.

7.4. The Commission recommends that the Department of Health engage with the Department of Education, the Department of Communities and other relevant government and statutory bodies to identify and ascertain areas of priority in relation to the delivery of mental health services across Northern Ireland which may have been adversely impacted by Covid-19.

[125] United Nations, 'Policy Brief: COVID-19 and the Need for Action on Mental Health' (13 May 2020), 3.
[126] Ibid.

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