Mental 2021-2031 Health Strategy

Department of Health
An Roinn Sláinte
Männystrie O Poustie
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Mental Health Strategy 2021-2031
Consultation Response Document

FROM: Fiona Ryan, Commissioner for Survivors of Institutional Childhood Abuse

The principal responsibility of the Commissioner for Survivors of Institutional Childhood Abuse is to promote the interests of Victims and Survivors of historical institutional childhood abuse. The Commissioner's role, responsibilities, duties and powers are outlined in the Historical Institutional Abuse (Northern Ireland) Act 2019. The Act places certain duties on the Commissioner regarding provision of services for Victims and Survivors of historical institutional childhood abuse (see Appendix A below).

The Draft Mental Health Strategy acknowledges the need to target approaches to groups "more likely to be adversely affected by mental ill health..., [and] people with a specific trauma exposure." The Commissioner would observe that Victims and Survivors of historical institutional childhood abuse come within that definition and therefore they and their mental health needs, based on their experiences, must be recognised, responded to and provided for in the context of the proposed mental health strategy.

Victims and Survivors of Institutional Childhood Abuse

- Victims and Survivors were subjected to physical abuse, emotional abuse, sexual abuse and neglect while children while resident in institutions. This

systemic abuse of children was perpetrated in institutional settings over decades

- Victims and Survivors can have experienced more than one form of abuse as well as neglect in one or more institutions. They can also have witnessed the abuse of other children within institutions which is in itself abuse and a source of trauma

- Victims and Survivors of institutional childhood abuse in Northern Ireland may have additional compounded trauma as the abuse perpetrated on them as children may intersect with experiencing Troubles-related trauma

- Victims and Survivors of institutional childhood abuse are primarily over the age of 50 (but they can be younger) with survivors in their 50, 60s, 70s and 80s; this has implications for mental health and services provision as there can be increased mental health issues associated with aging. The latter is particularly true for Victims and Survivors who may be living with but not receiving treatment for trauma-related conditions resulting from their abuse or psychiatric disorders exacerbated by abuse-related trauma

- Victims and Survivors' needs around mental health are varied and subject to a complex intersection of factors. In common with other Victims and Survivors of childhood abuse, Victims and Survivors of historical institutional abuse can experience anxiety, depression, substance misuse issues, psycho-social challenges, post-traumatic stress disorder and other trauma-related disorders

As Commissioner, I would observe the following: there appears to be a relatively low level of population-wide research in Northern Ireland in relation to the mental and physical health needs of Victims and Survivors of historical institutional childhood abuse from which to inform evidence-based policy making and service provision to address these needs.

For example, the Scottish Child Abuse Inquiry (SCAI) commissioned a research project to document the outcomes of institutional abuse in long-term child care in

Scotland. It found among Victims and Survivors of institutional childhood abuse that 95.6% had experienced physical abuse; 85.3% had experienced emotional abuse; and 60.4% had experienced sexual abuse; 51.1% had experienced emotional neglect and 37.3% had experienced physical neglect. It found that across Victims and Survivors' lifespans that 96% had experienced negative outcomes in psychosocial adjustment; 84% in mental health and 43% in physical health (retrieved from Survivors of institutional abuse in long-term child care in Scotland - PubMed (nih.gov))

Recommendations

Therefore, I am recommending:

1. **Recognition** of Victims and Survivors of historical institutional childhood abuse in the context of the proposed mental health strategy as a potentially at risk group of people, based on what we know of childhood abuse-related mental health issues and outcomes. The strategy itself references that Adverse Childhood Experiences (ACEs) have been found to account for 29.8% of mental disorders.

    1.1. (I would suggest that Victims and Survivors of childhood abuse where abuse took place in other contexts outside institutions should also be recognised as an at risk group in reflection of negative mental health impact of childhood abuse for individuals)

2. **Realise and acknowledge** the existence of Victims and Survivors' mental health needs with reference to the compounding trauma of potentially multiple abuses being perpetrated on Victims and Survivors, and potential intersection with Troubles-related trauma.

    Respond with appropriate quality general and specialist, appropriately resourced services for Victims and Survivors of historical institutional childhood, that have been co-designed with Victims and Survivors. Victims and Survivors may benefit from community and focused, but non-specialised, support services but may also

require specialist services as a result of their mental health needs and/ or the type of abuse they experienced (for example, CBT psychological interventions and specific counselling supports around experiences of child sexual abuse). The strategy itself notes that one of the weaknesses of the mental health system here is the lack of specialist supports.

These needs around specialist services and potentially acute services will also intersect with the needs of Victims and Survivors as they age, which will potentially be at the more resource intensive end of the services-provision spectrum.

My emphasis on services provided by the State, is not to devalue the crucial role of community and peer-to-peer supports. For many Victims and Survivors, peer-to-peer supports i.e. supports of other Victims and Survivors have been their key supports. It is rather to underline the type and quality of services that the State needs to provide in response to the compound and intersecting trauma Victims and Survivors experienced as a result of institutional childhood abuse; the trauma which they have carried with them through their adult lives and their resulting mental health needs. The State could consider services provision in the context of overall accountability to Victims and Survivors as envisaged under the Hart recommendations.

3. **Respond** to Victims and Survivors' mental health needs by adopting a Victim and Survivor-centred, trauma-informed approach to services provision informed by engagement with Victims and Survivors. Trauma-informed is a widely used term, in this context, the recommendation is based on the SAMSHA (US Substance Abuse and Mental Health) Principles which define trauma-informed as:

    3.1. Realises the widespread impact of trauma and understands potential paths for recovery;
    3.2. Recognises the signs and symptoms of trauma in clients, families, staff and others involved in the system;
    3.3. Responds by fully integrating knowledge about trauma into policies, procedures and practices and;
    3.4. Seeks to actively resist re-traumatisation.

Adopting a trauma-informed approach is particularly important as Victims and Survivors of historical institutional childhood abuse, in common with other Victims and Survivors of abuse, may be reluctant to disclose their experience of abuse even to loved ones. Therefore creating a greater onus on the State to adopt a trauma-informed approach in order to meet these presenting but potentially unexpressed needs.

The reasons for non and limited disclosure of abuse are many and varied. A Victim and Survivor may have disclosed as a child and been disbelieved and/or punished for their disclosure or had their experiences minimised. Disclosure as an adult may have elicited similar responses. There may also be a fear on the part of a Victim and Survivor that by disclosing their experiences they will alienate people, particularly those whom they love. Victims and Survivors may also have denied or minimised their experiences for themselves in order to cope "It wasn't that bad…" or "It wasn't as bad…" Or they may have had to re-tell their experiences so many times to different service providers/ agencies that this becomes a source of trauma in itself, where re-telling has brought no improvement instead increasing a Victim and Survivor's feelings of powerlessness.

4. **Research** in order to understand the existing and future mental health needs of Victims and Survivors, and in order to inform provision of needs-led, person-centred, rights-based, trauma-informed services. (Together these may also have the additional benefit of creating greater understanding of the mental health and arising services needs of Victims and Survivors of other forms abuse in childhood). Victims and Survivors should be included in the different research phases.
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5. **Reach-out** to Victims and Survivors of historical institutional childhood abuse by mental health services, potentially via awareness initiatives, recognising that based on childhood abuse experiences Victims and Survivors are potentially at risk of poorer mental health; their needs going unmet and at risk of reduced health outcomes.

Finally, as Commissioner I would also observe that State initiatives involving Victims and Survivors of historical institutional childhood abuse could have potential consequences for mental health services including increased disclosures in a therapeutic setting and increasing demand for these services and that mental health services may need to plan accordingly.

Conclusion

Victims and Survivors of institutional childhood abuse did not have their physical or mental health needs responded to as children. It was their treatment and abuse by institutions that created or exacerbated mental health needs. Many Victims and Survivors would say their mental health needs as adults have still yet to be adequately met. The Mental Health Strategy is an opportunity to make a difference. Victims and Survivors of historical institutional childhood abuse deserve to have their mental health needs responded to now and going forward the future.

Appendix A

Legislation relating to Provision and Co-ordination of Services to Victims and Survivors of Childhood Abuse

Section 26 of the Historical Institutional Abuse (Northern Ireland) Act 2019 requires the Commissioner to encourage the provision, and the coordination of the provision, of relevant services in Northern Ireland to victims and survivors. Such relevant services are set out in the legislations as the following:

(a) to improve a person's physical or mental health,
(b) to help a person to overcome an addiction,
(c) to provide a person with counselling,
(d) to improve a person's literacy or numeracy,
(e) to provide a person with other education or training, or
(f) to enable a person to access opportunities for work.

The Commissioner is further required to take account of the current provision of relevant services to victims and survivors and to identify any gaps in the provision of

those services and to provide, or secure the provision of, advice and information to victims and survivors on:

(a) the relevant services that are available to them and the facilities that are available for the provision of those services, and

(b) how to obtain those services and access those facilities.

Section 27 of the Act requires the Commissioner to monitor the operation of whatever facilities there are currently available in Northern Ireland which are solely for providing victims and survivors with;

(a) counselling and supplementary information about how to access health services, housing services, education services or employment services,

(b) help to improve literacy or numeracy, or

(c) advice on opportunities for education or work or on entitlements to housing or social security benefits.

Personal details		
Name	**Fiona Ryan**	
Email address	commissioner@cosica-ni.org	
Are you responding on behalf of an organisation?		Yes/~~No~~ *(delete as applicable)*
Organisation *(if applicable)*	**Commissioner for Survivors of Institutional Childhood Abuse**	
Vision and Founding Principles		
Do you agree the vision set out will improve outcomes and quality of life for individuals with mental health needs in Northern Ireland? Fully Agree / ~~Mostly Agree / Neither Agree nor Disagree / Mostly Disagree / Fully Disagree~~ *(delete as applicable)*		
Please add any further comments you may have The vision as set out from a Victim and Survivor perspective contains admirable goals in that it recognises the need for equity of access to services. Establishing equity as a core principle recognises that access to health can be dependent on cultural, gender, ethnic, ability and economic factors. It addresses the social determinants of health defined by the World Health Organization (WHO) as "the conditions in which people are born, grow, live, work and age…"		

Victims and Survivors of historical institutional childhood abuse have potentially experienced adversity in each of these areas which taken together impact negatively on physical and mental health outcomes.

The vision goes on to say that "we aspire to have mental health services that are compassionate and able to recognise the effect of trauma, that are built on real evidence of what works…" In relation to historical institutional childhood abuse there appears to be a lack of Northern Ireland research around Victims and Survivors' health needs, health experiences or outcomes in order to inform policy or an evidence base from which to provide targeted and effective services. There is research from Scotland and the Republic of Ireland which could inform service provision.

Do you agree the founding principles set out provide a solid foundation upon which to progress change?

~~Fully Agree~~ / Mostly Agree / ~~Neither Agree nor Disagree / Mostly Disagree / Fully Disagree~~ *(delete as applicable)*

Please add any further comments you may have

It is not that we disagree with core founding principles outlined underlying the vision of the strategy rather we would caveat them with an awareness of the needs of Victims and Survivors of historical institutional childhood abuse.

In relation to Principle III: *Care that considers and acknowledges the impact of trauma*; we would highlight the trauma of abuse experienced in childhood and its potential lifelong impact; the potentially intersectional nature of trauma, for example, trauma of historical institutional childhood abuse intersecting with trauma related to the Troubles

In relation to Principle V: *Early intervention, prevention and recovery as a key focus* – this is established best practice principle in health and social care policy and services provision and delivery. We would observe that for Victims and Survivors of historical institutional childhood abuse that recovery in the context of mental health needs to be the key focus.

Allied with this, however, there needs to be a realisation that Victims and Survivors have been living the impact of abuse and trauma for their whole lives; they are aging population and thought must be given to how their needs are to be met in a range of therapeutic settings: community, focused, specialist, psychological and psychiatric.
Nonetheless Victims and Survivors should not be left out of an early intervention strategy around their mental health needs where it can be used to address unmet mental health needs and prevent escalation of mental health problems.

In relation to Principle VI: we have already addressed the issue of research and evidence informed decision-making; albeit that research has been carried in Scotland and the Republic of Ireland.

In relation to Principle VII: *Specific needs of particularly at risk individuals and the barriers they face in accessing mental health services, should be recognised and addressed*…

Again we would highlight the challenges for Victims and Survivors of historical institutional childhood abuse in potentially every social determinant of health and associated negative impact on health outcomes. Therefore we would recommend a comprehensive, evidence-informed services response to take these specific needs into account which addresses the barriers they may face in accessing mental health services.

Barriers can include but are not limited to: previous negative experience with State services in general and specifically, mental health services; lack of understanding by services of childhood-abuse and related trauma with Victims and Survivors being left feeling more disempowered; fear of disclosure; denial or minimisation of experiences as coping mechanisms; substance misuse as coping mechanism; accessibility issues due to disability, literacy (many Victims and Survivors were not able to progress with education because of their experiences of institutional abuse and intersecting socio-economic reasons such as poverty); mental health conditions exacerbated by abuse-related trauma such as bi-polar disorder etc

Theme 1: Promoting wellbeing and resilience through prevention and early intervention

Do you agree with the ethos and direction of travel set out under this theme?

~~Fully Agree~~ / Mostly Agree / ~~Neither Agree nor Disagree / Mostly Disagree / Fully Disagree~~ *(delete as applicable)*

Please add any further comments you may have

Victims and Survivors of historical institutional childhood abuse should be added to the groups targeted for health promotion campaigns aimed at awareness of mental health issues and advice. Please see previous recommendations and observations.
As noted in the draft Strategy 'adverse childhood experiences (ACEs) have been found to account for 29.8% of mental disorders'. Victims and Survivors of historical institutional childhood abuse can be included in these numbers.

Do you agree with the actions and outcomes set out under this theme?

~~Fully Agree~~ / Mostly Agree / ~~Neither Agree nor Disagree / Mostly Disagree / Fully Disagree~~ *(delete as applicable)*

Please add any further comments you may have
Action 1: Regarding "groups disproportionately affected by mental ill health which often struggle to access early intervention"
Again we would refer to our earlier comments regarding Victims and Survivors of historical institutional childhood abuse and the potential life-long legacy of trauma. We would view early intervention as set out as primarily around meeting unmet needs of victims and survivors and preventing escalation of mental health problems.

Theme 2: Providing the right support at the right time

Do you agree with the ethos and direction of travel set out under this theme?

~~Fully Agree~~ / Mostly Agree / ~~Neither Agree nor Disagree / Mostly Disagree / Fully Disagree~~ *(delete as applicable)*

Please add any further comments you may have

Prevalence of mental ill health is common among older adults in Northern Ireland and it is estimated that a mental health problem is present in 40% of older adults seeing a GP, 50% of older adults in general hospitals and 60% of care home residents (Strategy Consultation Document p.31)
Some general comments before moving on to specifics: The strategy observes that 85% of older adults with depression receive no help from statutory services. Victims and Survivors of institutional childhood abuse are an aging population. This fact combined with the other barriers previously referenced in terms of accessing services suggests that the mental health needs of Victims and Survivors may be at further risk of going unmet because the resulting trauma of institutional childhood abuse is now intersecting with their becoming older and the mental and physical health challenges this brings in itself.

At paragraph 81 it is stated that older adults with mental illness are more likely to require domiciliary or institutional care. For those adults who were institutionalised as children and abused by those who were entrusted to care for them, the fear of being re-institutionalised at the later part of their lives is real.

Challenges encountered by some of the aging adult population including isolation, bereavement and economic deprivation, are more prevalent for Victims and Survivors of historical institutional childhood abuse and therefore again, targeting this group is essential in any mental health strategy.

Evidence of the long lasting impacts of institutional childhood abuse need to be considered and effective services put in place now. The figures on waiting lists to access mental health services are significantly beyond any acceptable level. Delay in accessing appropriate supports is a risk factor to mental health in itself. It may also require the State to provide more resource intensive services due to late intervention.

More resources need to be placed in both mainstream services and specific, appropriate services established for those groups requiring specific support provisions, including Victims and Survivors of historical institutional childhood abuse.

At paragraph 83, it states that the legacy of trauma related to the Troubles poses a particular challenge in Northern Ireland, the strategy goes on to say that a person "may present to older adults' services where there is an under-provision of psychologically informed, recovery strengths focused interventions". It could be asked if the same assessment could be applied to Victims and Survivors of historical institutional childhood abuse?

Do you agree with the actions and outcomes set out under this theme?

~~Fully Agree~~ / Mostly Agree / ~~Neither Agree nor Disagree / Mostly Disagree / Fully Disagree~~
(delete as applicable)

Please add any further comments you may have

Actions 8, 11 and 12 are particularly to be welcomed from the perspective of Victims and Survivors of historical institutional childhood abuse as recognition of the Community and Voluntary sector's supports to Victims and Survivors as well as embedding psychological services into mainstream mental health services.

In relation to Action 9, Focussing the provision of services through GP services could be appropriate for some historical institutional childhood abuse Victims and Survivors.

However, this needs to be matched with widespread awareness raising among GPs and the associated support networks (Trusts and Community and Voluntary sector) about identification of the longer term impacts of childhood abuse in the older cohort of the population and how to reach out effectively to this group.

Trauma informed practise needs to be normalised in each engagement that takes place. What is the timeframe for this reform? Plans need to be put in place quickly, engagement needs to take place with representative bodies, including Victims and Survivors' representatives, without delay and timeframes monitored.

Actions 14 and 15 are particularly to be welcomed in the context of Victims and Survivors of historical institutional childhood abuse where as an aging population physical and mental health issues may arise so monitoring and screening for both sets of issues in either setting is to be welcomed,

We would give a general welcome to remaining actions in that they involve infrastructural development and services development including addressing community supports, improved in-patient care, crisis, suicide and "dual diagnosis" i.e. co-occurring substance misuse and mental health problem, personality disorder etc.

In terms of Victims and Survivors of institutional childhood abuse experiencing these issues and then presenting to services, improvements that reduce waiting times, reduce barriers to accessing services and provision of targeted, appropriate, person-centred services are to be welcomed in principle. As the Commissioner's office is not a mental health specialist it is not within our remit to go further on commenting on clinical service provision and delivery.

Theme 3: New Ways of Working

Do you agree with the ethos and direction of travel set out under this theme?

Fully Agree / ~~Mostly Agree /~~ ~~Neither Agree nor Disagree / Mostly Disagree / Fully Disagree~~ *(delete as applicable)*

Please add any further comments you may have

Embedding psychological therapies across all steps of care is to be supported. They can no longer sit outside mainstream healthcare and need to be visible to all. The plans for improving in-patient mental health facilities and care are also to be viewed positively. Again, attention is drawn the childhood experiences of HIA survivors and the need to ensure that any care provided in a hospital or rehabilitation unit seeks to avoid re-traumatisation of an individual.

Do you agree with the actions and outcomes set out under this theme?

~~Fully Agree~~ / Mostly Agree ~~/ Neither Agree nor Disagree / Mostly Disagree / Fully Disagree~~ *(delete as applicable)*

Please add any further comments you may have

Again we would refer to earlier comments regarding welcoming in principle services that provide the aforementioned benefits of improved service provision and the emphasis on a trauma-informed workforce. We would again highlight the lack of research into the

experiences and mental health needs of Victims and Survivors of historical institutional childhood abuse and their associated health outcomes.

We would highlight that Victims and Survivors have experienced childhood abuse(s) which is/ are classed as Adverse Childhood Experiences (ACEs) and the impact we know these experiences have in developing mental health problems. Combined with the aging profile of victims and survivors, barriers to accessing services etc. then we would assert that research is needed to more fully understand Victims and Survivors' health needs, including mental health, as they are getting older. (Paragraph 169. We need to build on existing and new evidence to allow us to be ambitious and innovative as we seek to bring about lasting change.)

Action 26 regarding the mental health workforce, we would again reiterate the need for the workforce to be trauma-informed

Action 27 – create a peer support and advocacy model across mental health services, we would observe that this peer to peer support has been a key support for Victims and Survivors of historical institutional childhood abuse. State services may benefit from engaging with Victims and Survivors representative groups around this peer to peer process.

Action 28 – again we would agree in principle with an outcomes- framework involving service users and professionals but would caveat that due to their experiences Victims and Survivors of historical institutional childhood abuse may be reluctant to become involved and that efforts should be made to engage with Victims and Survivors who use mental health services in order to learn from their experiences and improve services.

Prioritisation

If you had to prioritise the actions set out above, which top 5 actions would you take forward (with 1 being the most important to you, and 5 being the 5th most important to you)?

1	Ensure adult mental health services cater for older adults with mental ill health, provide adequate support and structures and are mindful of the particular challenges older people face.
2	Embed psychological services into mainstream mental health services. Psychological therapies will be available across all steps of care.
3	Fully integrate community and voluntary sector in mental health service delivery across the lifespan including the development of a protocol to make maximum use of the sector's expertise
4	Expand talking therapy hubs, which are resourced sustainably, to ensure Northern Ireland wide coverage.
5	Refocus and reorganise primary and secondary care mental health services around the GP Federations to ensure a person centred approach, working with statutory and community and voluntary partners to create local pathways within a regional system.

Finally, is there any one key action which you feel is missing from the draft Strategy?

Specialist Interventions – paragraphs 149-156 highlight the need for specialist interventions. The draft strategy indicates that this is a structural weakness of the Northern Ireland mental health services. Despite paragraph 150 stating "**Going forward we will address the shortfall in Northern Ireland and will provide specialist mental health**

services when they are needed." It is not listed as an action except with reference to perinatal specialist services. We would ask why it is not listed as an action? A specific action around the reduction of waiting times for accessing mental health services is essential. COSICA invites mental health policy makers to consider commissioning research and gathering evidence from at risk populations including Victims and Survivors of historical institutional childhood abuse in order to inform policy making, resources allocation and service provision and delivery.
Impact Assessments/Screenings
Do you agree with the outcome of the Impact Assessment screenings? Fully Agree / Mostly Agree / Neither Agree nor Disagree / Mostly Disagree / Fully Disagree *(delete as applicable)*
Please add any further comments you may have
Do you agree with the Equality Impact Assessment (EQIA)? Fully Agree / Mostly Agree / Neither Agree nor Disagree / Mostly Disagree / Fully Disagree *(delete as applicable)*
Please add any further comments you may have

Thank you for taking the time to respond to the consultation.

Please submit your completed response by **5pm on 26 March 2021** using the details below:

E-mail:

mentalhealthstrategy@health-ni.gov.uk

Hard copy to:

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Please note: To allow for the full 12 week consultation period required, responses relating to the **EQIA** will be accepted after the close of the main consultation, but must be received by 5pm on Monday 12 April 2021.