

**Northern Ireland Commissioner for Children and Young People's
Submission to the Committee on the Rights of the Child for the
General Comment on the right of the child to enjoyment of the
highest attainable standard of health, 6 January 2012.**

Introductory note

The office of the Northern Ireland Commissioner for Children and Young People (NICCY) was created in accordance with 'The Commissioner for Children and Young People (Northern Ireland) Order' (2003) to safeguard and promote the rights and best interests of children and young people in Northern Ireland.

The powers and duties of the Commissioner include promoting awareness and understanding of children's rights; keeping under review the adequacy and effectiveness of law, practice and services relating to the rights and best interests of children; assisting with individual complaints; bringing or intervening in legal proceedings, and conducting investigations. The remit of the office is children and young people from birth up to 18 years, or 21 years where a young person is care experienced or has a disability. The Commissioner is a member of the European Network of Ombudspersons for Children (ENOC) and currently holds the ENOC Chair.

As a signatory to the United Nations Convention on the Rights of the Child (UNCRC) the UK State party, which includes the UK Government and devolved administrations, has agreed to uphold the rights of children and young people based on the Convention. This submission outlines examples of barriers to children's right to enjoy the highest standard of attainable health and highlights where government could take further action to secure the effective implementation of article 24 for children in Northern Ireland.



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1.0 The realisation of children and young people's right to health

Northern Ireland is a jurisdiction of the UK State party where the devolved political institutions hold responsibility for many areas relating to children's health. There is compelling evidence that Northern Ireland has particular health needs in comparison with other parts of the UK, for example, there is a higher incidence of disability, lower standard of dental health, increased levels of mental health disorders and higher rate of persistent poverty among children.¹

As Northern Ireland continues to transition from a period of prolonged conflict, it is important to recognise the impact of this, which includes ongoing exposure to violence, community tension and recovery from trauma, on children's health and wellbeing. There has also been historic underinvestment in public services in Northern Ireland including significantly lower expenditure on children and families within the health and social services budget.² These examples demonstrate that the right to health must be considered against the geographical context and lived experience of children not only in each States party but across jurisdictions in devolved systems.

Article 24 is underpinned by a holistic understanding of health as encompassing physical, mental and social wellbeing which is concerned with both material and socioeconomic conditions that influence children's health.³ In also promoting a life course understanding of health, the UNCRC requires that healthcare provision reflects the different stages of a child's development. In Northern Ireland, absence of a comprehensive early years strategy and gaps in support for adolescents in relation to sexuality and reproductive health issues point to weaknesses in provision which can impede children's right to health.

An integrated perspective to health should reflect a commitment to equality and acknowledge that children should not only be afforded the right of access to primary and secondary healthcare but more holistically access to the key determinants of health. The ethos of the progressive realisation of the UNCRC must also be central to the right to health, with States parties taking action to ensure that where progress has been made, this is consolidated and strengthened. Across the UK, there is considerable concern about the exposure of children to austerity measures and government must meet its obligation to

¹ NICCY (2008) Children's Rights: Rhetoric or Reality, A Review of Children's Rights in Northern Ireland 2007/08, (Belfast: NICCY).

² NICCY, DFP, OFMDFM (2007) An Analysis of Public Expenditure on Children in Northern Ireland, (Belfast: NICCY).

³ UNICEF (2007) Implementation Handbook for the UNCRC, (Geneva: UNICEF).



ensure resources are available to the maximum extent to realise children's rights.⁴ For example, in Northern Ireland there has been no commitment to protect funding for children's social care within the health budget.

2.0 The guiding principles of the UNCRC in relation to article 24

The indivisibility and interdependence of rights within and across the UNCRC is one of its great strengths and children's right to health pervades all elements of the UNCRC. For instance, rights to protection from violence and neglect, to an adequate standard of living and special protection rights for vulnerable groups and those with complex needs all relate directly to children's material, physical and emotional health.

It is vital that the four articles which represent the guiding principles of the UNCRC are fully integrated into government action to promote children's right to health. For example, articles 2 and 6 in setting out commitments to non discrimination and to survival and development, should ensure that where there is inequality, as seen in the substantially poorer child mortality rates for children from the Traveller community in Northern Ireland, effective action is taken to remedy this.⁵ The ongoing concern about difficulties faced by children with disabilities in accessing health and social care services also highlights that certain groups of children remain unable to enjoy their right to health.

In turn, articles 3 and 12 enshrine the principles of the best interests of the child and ensuring their voice is heard in all matters concerning them. We have repeatedly stated that particularly vulnerable groups, such as those accommodated in mental health facilities, separated children subject to immigration processes and young people detained within youth justice or secure care settings, should have access to forms of advocacy. Decisions concerning children's health should take account of both their views and their best interests.

In further considering article 12, participants in a NICCY review of children's rights raised concerns that health professionals often failed to effectively engage children in decisions about their health.⁶ It is important that the promotion of article 24 reflects the UNCRC ethos of evolving capacity, including addressing issues such as providing information and education, understanding children's capacity to make decisions and give consent and ensuring access to complaints mechanisms. Further to this, the right to be heard, in recognising that children are active subjects, must extend to their

⁴ UK Children's Commissioner's (2011) Midterm Report to the UK State Party on the UNCRC, (Belfast: NICCY).

⁵ ECNI (2007) Statement on Key Inequalities in NI, (Belfast: ECNI).

⁶ NICCY (2008) Children's Rights: Rhetoric or Reality, A Review of Children's Rights in Northern Ireland 2007/08, (Belfast: NICCY).



participation in the development of provision and services, including current reviews of health and social care by the Northern Ireland government.

3.0 The normative content of article 24

Article 24 is underpinned by a recognition of children's right to health and to access to services for treatment and rehabilitation. A holistic understanding of health and wellbeing requires approaches that go further to address health inequalities and invest in health promotion to minimise illness and harm to children and to foster positive outcomes.

In considering persistent inequalities in health, there are many ways in which examples of this impact on children's health. For example, child poverty in Northern Ireland is associated with lower rates of breastfeeding and immunisation, greater risk of obesity and increased levels of suicide.⁷ In relation to health inequalities experienced by children with disabilities, we have called for measures to address this including a regional strategy for disabled children and well resourced community provision to reduce inappropriate residential placements.

In reflecting on the normative content of article 24, it is important that States parties ensure they meet their UNCRC obligations to a standard which is in accordance with the country's stage of development. For instance, the UK State party must take account of how it has been assessed by UNICEF as delivering in relation to child wellbeing and equality in comparison to other OECD nations and take action to remedy this.⁸

In considering the suggested criteria for healthcare services we would raise concerns in relation to the availability and accessibility of provision. For example, while 1 in 5 children here will experience significant mental health problems and there has been a substantial increase in youth suicide, gaps in provision for adolescents remain.⁹ This includes services for eating disorders, addiction treatment and therapeutic support for children who have experienced abuse or have sexually harmed others. This lack of provision can lead to lengthy delays in treatment or children being accommodated on adult wards or in other parts of the UK.

These examples also call into question the quality and effectiveness of provision for children in the context of a healthcare system which, for some, is characterised by an absence of specialist professional support and delays in

⁷ Ibid.

⁸ UNICEF (2010) A League Table of Inequality in Child Wellbeing in the World's Rich Countries, (Italy: UNICEF).

⁹ Bamford, D. (2006) The Review of Mental Health and Learning Disability (Northern Ireland), A Vision of a Comprehensive Child and Adolescent Mental Health Service, (Belfast: DHSSPS).



accessing support. These failures deny children meaningful access to article 24 and often contribute to, or escalate, their experiences of poor health.

4.0 Priority concerns for the implementation of article 24

It is important to acknowledge that all action by States parties to enhance children's enjoyment of the highest attainable standard of health is to be welcomed. However, government must take particular care to improve the realisation of the right to health of those who experience the poorest health and wellbeing outcomes.

For instance, in considering child mortality rates, while these have decreased overall, differential rates for Traveller children in particular but also for those living in deprived areas remains a concern.¹⁰ We have recently called on the Northern Ireland government to meet its commitment to review information relating to all child deaths so that this is comprehensively assessed.

In seeking to remedy persistent barriers to children's enjoyment of the right to health, government must address the underlying determinants of health and target interventions at those most at risk of experiencing health inequalities. As outlined earlier, NICCY has particular concerns about barriers to the right to health for particular groups of children who represent the most vulnerable children in our society and those with complex needs. This includes children who are 'looked after' by the state or accommodated in state facilities, children with disabilities and with mental health needs. In one example of the challenges to article 24, a recent review of the Young Offenders Centre stated it was not suitable for young people under 18 years and did not adequately meet their physical or mental health needs.¹¹

Prioritising prevention and early intervention to safeguard children's health and wellbeing across all stages of their life in accordance with their particular needs or vulnerabilities will minimise the impact of poor health and adverse experiences not just for individuals and families, but more widely for society as a whole. This approach should be integrated into all aspects of healthcare whether in relation to the early diagnosis of disability or chronic disease in infancy, the provision of therapeutic services for adolescents at the onset of mental health problems or in ensuring specialist support is available to at risk groups such as children in care.

5.0 Measures for the implementation of article 24

¹⁰ DHSSPS (2009) Health and Social Care Inequalities Monitoring System, Third Update Bulletin, (Belfast: DHSSPS).

¹¹ CJINI, HMIP and RQIA (2011) Hydebank Wood Young Offenders Centre, Unannounced Follow-up Inspection, (Belfast: CJINI).



While considerable effort has been made at a strategic level to progress children's health and wellbeing, we remain concerned that this must be reinforced with effective implementation in order to meaningfully impact on the children's access to article 24. A NICCY commissioned report identified a range of barriers to government delivery of children's rights and recommended a number of measures to improve this including: mainstreaming children's rights, ensuring coordinated and joined up government, making children visible in budgets, and child impact assessing policy and budgetary decisions.¹² Committing to these actions would demonstrate government's determination to realise children's right to health and improve the poor health outcomes experienced by many children in Northern Ireland.

In addition to this, a comprehensive strategy and framework for children's health should be developed. Work in this area is now being established and the strategy or framework must have a rights based ethos and direct the commissioning and delivery of healthcare services. The strategy or associated action plans should include concrete and time bound actions and be appropriately resourced. This must be accompanied by the development of regional protocols to remove current inconsistencies in the treatment of children within healthcare settings and address concerns such as the accommodation of children on adult acute and psychiatric hospital wards.

The development of measures of implementation, such as national frameworks or action plans, should be undertaken on a multiagency basis which includes non governmental organisations, be informed by a robust evidence base and maintain a focus on improving outcomes in children's health and wellbeing. In turn, there must be a clear line of accountability from local health and social care provision and delivery to government departments and ministers.

In considering the implementation of healthcare provision the principles of availability, accessibility, and quality and effectiveness should be integrated into healthcare services and supports. The promotion of a child rights impact assessment as an implementation tool to be used in healthcare policy and service planning, monitoring and evaluation would support States parties in embedding children's right to health in their work. This range of measures, underpinned by the principles of the Convention, should ensure that children in Northern Ireland are able to enjoy their right to the highest attainable standard of health.

¹² Byrne B. And Lundy L. (2011) Barriers to Effective Government Delivery for Children in Northern Ireland, (Belfast: NICCY).

