

## **CHAPTER THREE**

### **HEALTH, WELFARE AND MATERIAL DEPRIVATION**

## INTRODUCTION

Social and economic rights are well established as crucial in the protection of human rights. In addition to the CRC which specifically protects children's social and economic rights, there are many international human rights standards relating to these rights. The World Health Organisation (founded over 50 years ago) has been central to the development and promotion of the right to health and health care. Its constitution states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." Among the rights developed are specific rights for people with mental illness (Principles for the protection of persons with mental illness and the improvement of mental health care).

The United Nations Universal Declaration of Human Rights (UDHR) promotes a world where people are free from "fear and want" (Preamble, 1948). The International Covenant on Economic, Cultural and Social Rights (ICESCR, 1966) also proclaims that freedom from fear and want can only be achieved "if conditions are created whereby everyone may enjoy his economic, social and cultural rights, as well as his civil and political rights" (Preamble). In 2002, the United Nations Commission on Human Rights appointed a Special Rapporteur (currently Paul Hunt) whose mandate focuses on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The Special Rapporteur has noted that the right to health contains both freedoms and entitlements:

Freedoms include the right to control one's health, including the right to be free from non-consensual medical treatment and experimentation. Entitlements include the right to a system of health protection (i.e. health care and the underlying determinants of health) that provides equality of opportunity for people to enjoy the highest attainable standard of health. (United Nations Economic and Social Council 2003: paras 23 & 24).

The European Social Charter (Council of Europe) includes rights to housing, employment, social protection (eg welfare benefits and social services) and non-discrimination. The Northern Ireland Human Rights Commission's preliminary proposals for a Bill of Rights for NI (2001) included proposals for social and economic rights. Public opinion surveys in Northern Ireland have consistently shown that people want stronger enforceable rights in this area.

Art. 6 CRC states that "every child has the inherent right to life" and that "state parties shall ensure to the maximum extent possible the survival and development of the child". This recognition of the child's right to life, survival and development (Art. 6) is supplemented by the right to effective health and health care services (Art. 24). Children with disabilities have a specific right to effective health and health care (Art. 23). In pursuance of this, the state must promote the exchange of appropriate health care and medical information on the treatment of children with disabilities. However, provision for children with disabilities in the Convention is acknowledged to be poor and in this area, it is important to look beyond the CRC to documents like the UN Standard Rules on the Equalization of Opportunities for the Disabled in advance of the long-awaited adoption of the UN's treaty on disability.

Art. 24 CRC provides for children's right to the highest attainable standard of health and health care. States must take appropriate measures to diminish infant and child mortality; ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; combat disease and malnutrition, ensure the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution; ensure appropriate pre-natal and post-natal health care for mothers; ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents; develop preventive health care, and guidance for parents and family planning education and services.

Art. 27 recognises the "right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development." The role of parents to take responsibility for the child's standard of living is recognised "within their abilities and financial capabilities." State parties are tasked with assisting parents and others to implement this right and "in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing".

In its Concluding Observations on the UK implementation report in 2002, the Committee on the Rights of the Child welcomed the adoption of new homelessness legislation; noted positive moves towards analysing budgets

to reveal expenditure on children; national objectives to halve child poverty by 2010 and to eradicate it within a generation; and strategies and policies tackling child poverty and social exclusion through locally targeted services for children. The Committee was concerned however, that the Convention is not implemented to the “maximum extent of available resources” (UN, 2002: 10-11).

The Committee was also concerned that the principle of non-discrimination is not fully implemented for all children in all parties – particularly noting “unequal enjoyment of economic, social, cultural, civil and political rights for children with disabilities, children from poor families, Irish and Roma Travellers children, asylum and refugee children, children of minority groups, children in the care system, detained children and children aged between 16 and 18 years” (ibid.: 22)

The Committee welcomed the reduction of infant mortality rates and the focus on children in the planning of the national health service. It remained concerned about persisting inequalities in health and access to health services, including mental health services linked to social and economic status and ethnicity (e.g. the high rate of infant mortality among Irish and Roma Travellers). Concern was also expressed at the relatively low rate of breastfeeding; a high level of teenage pregnancies; the rising incidence of sexually transmitted infections (STI’s) among young people; and suicides of young people. The Committee was concerned that gay and trans young people do not have access to appropriate information, support and protection. (ibid.: 41).

The Committee was concerned at the high proportion of children living in poverty and high incidence among poor children of mortality, accidents, teenage pregnancy, poor housing and homelessness, malnutrition, educational failure or suicide. It noted the lack of effective and coordinated poverty eradication strategy and recommended better coordination to address the causes of youth homelessness. The Committee was also concerned at the absence of a minimum wage for young people and a review of legislation and policies concerning welfare benefits was recommended. (ibid.: 53 & 54)

## **CHILDREN’S HEALTH ISSUES - GENERAL**

*Non-discrimination (Art. 2) Implementation of Rights (Art. 4) Survival and development (Art. 6) Children with disabilities (Art. 23) Health and health services (Art. 24) Social Security (Art. 26), Standard of Living (Art. 27),*

### **Context**

#### **Information and planning**

There is an overall lack of information about children’s health in Northern Ireland. Although there has been a range of surveys by Boards and Trusts on specific issues, there is no definitive guide to the health of children in Northern Ireland. There is a particular gap in information on young children’s health with Departments collecting more information on the older children and teenagers. The NISRA Young People’s Behaviour and Attitudes Survey (NISRA, 2004) examined over 7,000 post-primary school (aged 11-16) children’s views and experiences including on health related issues. The DHSSPS Health and Social Well-Being Survey includes information on over-16 year olds regarding alcohol, drug use and health behaviour (DHSSPS, 2001). The British Medical Association (BMA) has commented on the need for more information on children’s health throughout the UK: “We recommend that an Annual report on the health of children, similar to the Chief Medical Officer’s report *On the State of the Public Health*, should be published by the Departments of Health with a view to monitoring health trends in children so that remedial action can be taken where needed and progress monitored” (BMA website).

There was agreement among interviewees on the need for an overarching approach to children’s health reaching across departments. In particular, it was agreed there needs to be more coordination of children’s health promotion and health care between the Department of Education and the DHSSPS.

Government has launched a National Service Framework for Children, Young People and Maternity Services which will set standards for children’s and young people’s services in England: “The standards will outline what support should be available to children and their parents in managing a wide range of conditions and problems. This will emphasise the promotion of evidence-based clinical guidelines and will provide examples of good practice. In addition, the NSF will include a small number of exemplars, which use particular problems to illustrate what the standards mean for children and their families. These will include asthma, autism, chronic fatigue syndrome, and epilepsy in pregnancy” (Answer to PQ, 13 Jan 2004, Hansard Col WA81).

A statistical survey of social and health well being in Northern Ireland (McWhirter, 2002: 20) revealed that: "The Northern Ireland infant mortality rate, which was the worst in the UK, is now among the best, and people are taller and straighter than ever before with better and more teeth. However, there are a few downsides to this story. These include: decreased levels of physical activity, increased obesity; increasing incidences of diabetes and asthma; and perhaps higher levels of (more minor) mental ill health." An NGO health expert interviewed for the current research summarised developments in children's health:

"Overall, children's material well-being is improving compared to 50 years ago - for example many infectious diseases are no longer seen. Nutritional deficiencies are more controlled so for example you don't see rickets. There is better access to nutrition, better housing etc. There have been specific initiatives like immunizations being fairly universal. For the vast majority of children from their time in the womb on, their health is better than 50 years ago. Fewer babies are dying in child-birth, children are growing up bigger and stronger".

However, the picture was not universally positive as:

"Bad health is now more or less linked to poverty and disadvantage. Young mothers from poor families are more likely to have unhealthy babies. It's hard to separate children's health from family, poor nutrition and physical inactivity" (NGO Representative).

McWhirter comments that "... not only do affluent people live longer, but they also spend a greater proportion of their longer lives in good health" (McWhirter, 2002: 82). Her research confirmed that "children in Northern Ireland ... experience a range of social and economic disadvantage. As a consequence, the impacts of deprivation can be expected to impact disproportionately on the health and well being of future generations of adults in Northern Ireland" (ibid.: 77). Health care professional interviewees agreed that poverty was a major influence on children's health, citing poverty in rural areas; the impact of poverty on diet; and "poverty of opportunity" and associated low self-esteem as crucial negative contributors.

## **Breastfeeding**

The World Health Organisation recommends that where possible babies should be fed exclusively on breast milk for six months from birth and should continue receiving breast milk as part of their evolving diet for up to two years and beyond. The Committee on the Rights of the Child commenting on low breastfeeding rates in the UK recommended that the state take measures to promote breastfeeding (UN, 2002: 40). DHSSPS published a Breastfeeding Strategy for NI in 1999 aimed at improving breastfeeding rates in Northern Ireland, and recent promotional campaigns have been launched in pursuit of this. However, Northern Ireland continues to have one of the lowest breast-feeding rates not only in Europe but in the world. According to the Health Promotion Agency, in Northern Ireland over half of new mothers start to breastfeed but this falls off rapidly and by six weeks it is down to 25% and by six months to 10%. In comparison, in Norway 99% of new mothers start feeding their baby and after six months 80% are still going strong"(Health Promotion Agency, 2004). Research commissioned by the Health Promotion Agency for Northern Ireland indicates that "a lack of social acceptability for breastfeeding is one of the main reasons that mums here resort to bottle feeding. While over half of mums here do start off breastfeeding, very few continue past the first few weeks. When mums encounter difficulties, quite often they choose to stop breastfeeding because of a lack of support and the sense that breastfeeding is still not considered to be acceptable" (ibid.)

A midwife commented that:

"there has been work done on a strategy to deal with this but change comes slowly. Young teenage mothers are more likely to have premature babies and when they see their baby so ill they may be prepared to express milk, but they feel they stand out if they breastfeed. In terms of facilities out there - shopping centres that do have facilities are model ones but every shopping mall doesn't have that. There is an argument against that too in that if you make people breastfeeding hide away then nobody sees them. Young teenage mothers may never have seen anyone breastfeeding".

Breastfeeding is a class related issue as the incidence of breastfeeding is associated with high maternal socio-economic status and educational attainment (DHSSPS, 1999a:2). Research by the Health Promotion Agency found that unemployed women were less likely to breastfeed than women in employment (HPA, 2003a).

### **Infant Mortality**

From 1971 - 1994, Northern Ireland had the highest rate of infant mortality in the UK. However, this has been decreasing over the years, and has fallen from 22.7 (per 1,000 live and still births) in 1971 to 5.7 per thousand births in 2001. The infant mortality rate is higher in rural areas (6.0 in 2001) than non-rural areas (DHSSPS, 2004a). Life expectancy at birth is related to socio-economic status. In Northern Ireland, average life expectancy is 74.5 for men and 79.6 for women, but in the most deprived wards this falls to 71.4 for men and 77.1 for women (McWhirter, 2002: 86). The life expectancy of Travellers however, is almost 20 years less than that of the settled community (ibid.: 84). The Committee on the Rights of the Child commented on the high rate of infant mortality among the Irish and Roma Travellers in the UK (UN, 2002: 39). McWhirter notes "it is poorer people who have borne the brunt of the Northern Ireland 'Troubles' either in their areas or on their lives" (McWhirter, 2002: 83) and this impacts on both physical and mental health (DHSSPS, 2004a: Chapter 3). Government research found that Catholics were more likely than Protestants to report experiencing adverse effects of conflict-related violence on their own lives and that of their families (ibid.: para 3.50). Research found that the consequences of the conflict on young people's psychological well-being is not clear and understanding of the long-term effects of such violence is very poor (ibid.: 3.4). People in high violence areas reported more symptoms of physical illness than those living in low violence areas (ibid.: para 3.13.). A much higher proportion of people living in areas of high intensity violence reported having poor health compared with those living in areas of low violence (ibid.: para 3.23.).

### **Children's health problems**

Key health issues relating to young children's health raised by interviewees were a lack of physical exercise (in part caused by concerns about road safety) and poor diet leading to obesity and potentially to other health problems such as diabetes, and poor dental care; while for older children and teenagers the main issues raised were drug and alcohol related problems, sexual health and mental health.

The HPA has reported that increasing levels of obesity in the population is associated with an increase in Type 2 diabetes in young people (DHSSPS, 2004a: para 5.25). Obesity is attributed to a number of factors including the increased consumption of a high calorie diet, increased time spent watching TV or computer games, the advertising and promotion of an unbalanced diet, the availability of convenience food, the cost of healthy food options, inadequate cooking skills and transport and planning decisions (Cole et al., 2000). The effects of childhood obesity are far reaching and can have both physical and psychological consequences. Obesity can lead to coronary heart disease, cancer, diabetes, high blood pressure and osteoarthritis. In Northern Ireland, there are thought to be 450 deaths per years as a direct result of obesity. Weight problems can also have a detrimental impact on the emotional well being of children with particular impact on their levels of self-esteem, as well as placing children at a greater risk of bullying, and social isolation (House of Commons Health Select Committee, 2004).

Research has found that 16% of 13 and 14 year olds boys and girls in Northern Ireland are overweight (Yarnell et al., 2001 cited in DHSSPS, 2004a: para 5.70) and 4% of boys and 2% of girls at this age were clinically obese. Yarnell (2001) (cited in DHSSPS, 2004a: para 5.70) found that although there was a high correlation between the height of boys and girls to their fathers' social class, the children's BMI (Body Mass Index) showed no such correlation to the social class of their parents. One third of obese girls were dieting compared with one sixth of obese boys.

Obesity in children is monitored through the Child Health System records based on examinations carried out by the School Nurse at the Primary One Health Appraisal. In 2002/03, 19% of boys aged 4-5 years of age were overweight with figures standing at 25% for girls (Investing for Health Northern Ireland, 2004). In response to these figures the Minister with responsibility for Health, announced a new strategy to tackle this health problem in August 2004. The initiative entitled *Fit Futures Focus on Food, Activity and Young People* has four main objectives;

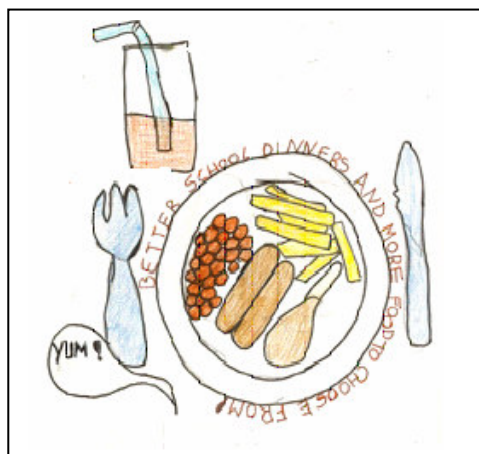
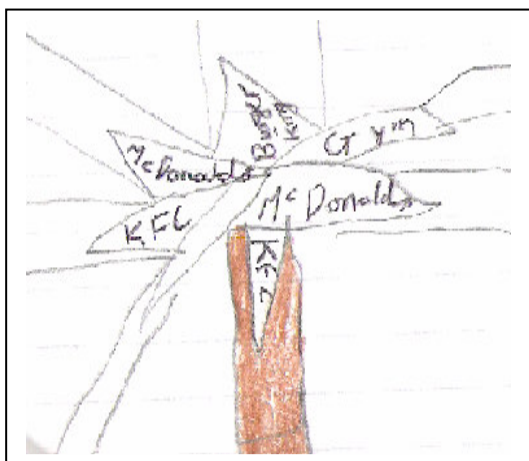
- Review the factors that impact on the levels of overweight and obesity and, in light of best practice, consider and evaluate options for preventing the development of over weight and obesity;

- Consider and assess the extent to which, in tackling over weight and obesity, action needs to be targeted to take account of the needs of specific groups within society and ensure that social need is targeted effectively;
- Engage with stakeholders to stimulate action to tackle over weight and obesity
- Make recommendations to the Ministerial Group on Public Health on priorities for action.

*Fit Futures* will be focusing on obtaining the views of children and young people to obtain their ideas on how to encourage healthier eating patterns and more physical activity. The Taskforce is expected to report back to the Ministerial Group on Public Health with recommendations before the end of 2004..

Chief Medical Officer, Dr Henrietta Campbell has warned that “currently over half our population have a weight problem and as many as one in five are obese. Obesity in children is increasing at an alarming rate and it is projected that in 15 - 20 years, one in five boys and one in three girls will be obese unless drastic action is taken now” (DHSSPS news release, 23 March 04).

The Office of National Statistics has reported that children in Northern Ireland have a higher risk of tooth decay than their counterparts in England or the Republic of Ireland. Whilst the disease is almost completely preventable through good oral hygiene it was the most common reason cited for children receiving hospital general anaesthetics with almost 8,000 children requiring general anaesthetic for dental treatment in 2003 in Northern Ireland. (DHSSPS, 2004a). In 2000, five year olds living in the Western Board area had the worst dental health in Northern Ireland (McWhirter, 2002: 46). In response to the problem the Minister for Health, Social Services and Public Safety launched a 10-year Oral Health Strategy aimed at preventative measures to combat tooth decay. The strategy aims to improve oral health for the entire population but has acknowledged that levels of tooth decay are higher among people from poor backgrounds, older people, people from ethnic minority communities, Travellers and homeless people. The Minister commented that: "Tooth decay levels among Northern Ireland children are approximately double those in England and the Republic of Ireland. This completely preventable disease is the most common reason for children receiving hospital general anaesthetics. Last year, in Northern Ireland, almost 8,000 children, some as young as 2-years-old, had a general anaesthetic for dental treatment” (21/09/04). The new Oral Health Strategy (DHSSPS, 2004f) sets the context for the forthcoming Primary Care Dental Strategy). It is an aim of the Oral Health Strategy that by 2013 at least 50% of children should be free from dental decay (baseline value 36% in 2002) (DHSSPS, 2004f: 13). The contribution of schools will play an important role in ensuring the success of the strategy in terms of providing healthy option meals for children's lunches and ensuring that all schools are free from vending machines selling sugary snacks and drinks (DHSSPS, 2004f: 5). Other initiatives aimed at tackling tooth decay and improving the health of children in schools include 'Fresh Fruit in Schools', whereby fresh fruit is provided to P1 and P2 children with in selected schools as a means of encouraging them to sustain healthy eating patterns (Investing for Health Northern Ireland, 2004). Those interviewed emphasised the importance of good diet for children and the roles of the food industry and schools. The availability of healthy food was also a concern raised by children who participated in the NICCY schools research many of whom were critical of the standard and choice of food served in their school canteen and the general availability of junk/take away fast food restaurants as potentially injurious to the health of young children.



"As health professionals we can't do much on our own without the food industry. Sometimes you feel as if you're banging your head against the wall ... unless we have the food industry who are targeting young children and adolescents ... doing something about changing people's behaviours" (Health Care Professional).

Another health care professional noted the Scottish model of making the idea of healthy schools mandatory so that every school has to be a health promoting school. That means it adopts an ethos of encouraging a healthy well being focus – for staff and pupils - much wider than physical health, safety, mental well-being, bullying etc. In Northern Ireland this approach has been voluntary. If we had a much stronger health promoting schools concept – where you're looking to work with schools to develop healthy schools, dept working well with the schools to promote the policy, developing that culture - it would be much better".

The Young Person's Behaviour and Attitudes Survey (NISRA, 2004) found that while 96% of young people said they had been taught about health eating, only 36% said that they ate the recommended five or more portions of fresh fruit or vegetables daily. Although three quarters had engaged in sport or exercises on at least two days of the week prior to the survey, this conversely means that one quarter had not done so.

Asthma, eczema and hay fever are among the most common chronic diseases of childhood (national statistics online). In England and Wales, hospital admission rates for childhood asthma increased substantially during the 1960s, 1970s and early 1980s but declined steadily in the 1990s. Similar figures are reported from GP surgeries (national statistics online). The BMA has called for research into the reason for high rates of asthma in the UK. Healthy Cities Belfast (an inter-agency partnership) noted that "air pollution can have a significant adverse impact upon human health. Some of the main health effects are chronic bronchitis and emphysema; cardio-respiratory death; lung and other cancers; asthma and allergies" (Healthy Cities Belfast, 2003: 20 citing Belfast City Council, 2001).

A BMA representative interviewed strongly made the case for a ban on smoking in public places. BMA has been campaigning for 20 years for legislation to ban smoking in public places (BMA website). The World Health Organisation states that "second hand smoke causes asthma, respiratory disease and ear infection in children" (WHO, 1999 cited in BMA press statement 15 Sep 04, BMA website). There is strong research evidence to support a link between exposure to smoke (both during pregnancy and within the home) and Sudden Infant Death Syndrome (SIDS or cot death) (Foundation for Study of Infant Deaths website, 2004). In Northern Ireland there were 5 "cot deaths" in 2003 (ibid.) The rate of SIDS has fallen substantially since the 1990s when a campaign to reduce the risks was launched. Health education for young pregnant women is important as research found that women aged 20 or under were more likely to smoke before or during pregnancy than those aged 35 and over (61% and 30% respectively) (DHSSPS, 2004a: 6). The NISRA survey of young people found that 41% lived in households where adults smoke in the house (NISRA, 2004).

For teenagers, drugs and alcohol can pose serious health threats. The Young Person's Behaviour and Attitudes Survey (NISRA, 2004) of 11-16 yr olds found that 59% of pupils have drunk alcohol of which 42% drink alcohol at least a few times a month (Barometer, 2004). Research on alcohol consumption among young adults found that "in Northern Ireland, drinkers and younger drinkers in particular are concentrating their drinking into a small number of sessions at the weekend. Analysis of consumption revealed that these few sessions were heavy sessions, which would indicate a binge drinking culture" (HPA, 2003: 5). The HPA warns that "heavy drinking over time will increase the risk of chronic health effects such as cirrhosis. However, those who consume relatively small amounts but who occasionally binge drink contribute substantially to acute alcohol problems, such as impaired driving, alcohol-related family trouble or difficulties in employment, in addition to other problems in society" (HPA, 2003: 4). The HPA research found there was significant variation in the incidence of binge drinking between men and women in different socio-economic groups. Those from semi-skilled and unskilled socio-economic groups were more likely to binge drink. Women in the lowest income group, while least likely to drink overall, were most likely to binge when they did drink (HPA, 2003: 5).

An Omnibus survey found that 37% of 16-24 year olds in Northern Ireland reported using drugs, 23% were currently using them and 5% were frequent users (McWhirter, 2002: 61). The use of inhalants by young people was more commonplace among teenagers in NI than in GB (ibid.: 62). More boys (60%) than girls (54%) have ever taken an alcoholic drink (DHSSPS, 2004a: 8). More children in receipt of free school meals are current drug users than those not in receipt of free school meals 12% and 8% respectively (DHSSPS, 2004a). Seventeen percent of children getting free school meals had tried cannabis compared to 12% of other children (ibid.).

Mental health and sexual health of young people were also frequently referred to by interviewees (adult and children) as key issues and these are discussed in separate sections below.

## Key issues

- Lack of coordinated collection of information on children's health, especially young children;
- Established link between poverty and poor health;
- Inequalities in health;
- Low breastfeeding rate;
- Lack of physical exercise and poor diets for children across social classes;
- Growth in obesity among children especially younger children;
- Poor dental health linked with poverty;
- Drug and alcohol related problems;
- Sexual health care and mental health care for adolescents;

## CHILD-FRIENDLY SERVICES AND THE RIGHT TO PARTICIPATION

*The child's opinion and the right to participation (Art. 12) Access to appropriate information (Art. 17) Protection from abuse and neglect (Art. 19)*

### Context

The UNCRC should be used as the basis for all health-related decision making involving children and young people. It requires professionals to increase the young person's understanding and encourage their active participation in the decision-making processes that affect them, and, whilst the balance may be difficult on occasions, aims to accomplish this without violating *either* their rights to protection *or* their parents' rights to exercise parental guidance. In the context of children and young people with mental health and learning disabilities, looked after children, those from ethnic minority communities and those with complex health needs especially, the implementation of a robust regional advocacy framework is a prerequisite to realising their procedural rights in decision-making processes.

Whilst a child's competence needs to be assessed in developmental terms as a function of four broad categories - chronological age; cognitive level; emotional maturity and socio-cultural factors, the overall summation of which may be described as psychological maturity and competence - fundamentally, the question of a child's competence to make informed decisions about care and treatment should not be viewed in terms of whether and when they should be treated as adults. Rather, it is crucial that young people are treated with respect and that the decision making process is aimed at sensitive and appropriate assessment of their abilities and wishes, for the purpose of trying to serve their best interests. Recent DHSS&PS guidance on seeking consent in working with children has stated that:

“You should never automatically assume that a child with learning disabilities is not competent to take his or her own decisions: many children will be competent if information is presented in an appropriate way and they are supported through the decision-making process... (and) if a child...is not competent to take a particular decision for him/herself...the child should still be involved as much as possible...children should never feel that decisions are being made over their head”(DHSSPS, 2003e).

Interviewees for this research pointed to the importance of 'child-friendly' health care services and for children's participation in decision making about both their own health and health services in general (Art. 12 CRC). BMA policy states that: “Children should be seen as important contributors to our understandings of appropriate care and their views should be taken into consideration when developing NHS Services” (BMA website, 2004). A participant in a focus group of health professionals commented on the lack of play therapy for sick children:



"We're not good on this in NI. It's seen as a luxury rather than essential component. Yet the support of a play therapist to explain difficult issues can be vital ... [what exists] doesn't come from core funding. Staff may be from core funding but the toys etc come from voluntary sources".

Another reaffirmed the importance of talking to children about what services should be like, particularly in terms of health education: "We need to ask young people. As adults we don't know what works best for young people in terms of education. That's why peer education is good".

Article 12 CRC requires professionals to promote the young person's understanding and facilitate their active participation in decision-making processes that affect them, and aims to accomplish this without violating *either* their rights to protection *or* their parents' rights to exercise parental guidance. The issue of consent was agreed to be critical by professionals and by young people. Despite the existence of Departmental guidelines on gaining children's consent (including a version for children's use) a health professional wondered how genuine health professionals were in general about listening to children. She gave the example of,

"... children coming from day surgery and the parents haven't prepared the young child adequately for the procedure [in terms of information] and nursing staff are having to prepare them for the procedure but when the child still decides that no they don't want to have this minor op - e.g. tooth extraction - there are occasions where the child would still say no and parents are still maybe pushing that. And I think it's sometimes questionable whether they [medical staff] listen to the parent or the child. We haven't really addressed the issue of what do we do if a child is totally against the procedure".

Another commented that: "a big issue is the language we use with young people. Young people are very vocal about medical staff who have swallowed a dictionary. Young people find it frustrating when a discussion is taking place between parents and medical staff at the end of their bed. You have examples of young people pulling out their records, reading them and changing what has been written".

For children with learning disabilities advocacy is essential to ensure full enjoyment of participation rights. As a submission from an NGO in the disability sector commented: "They [children with disabilities] are people whose participation in the things that affect their lives have been limited both by the attitudes of others and by the difficulties faced by people who have problems with communication and understanding... They are people who have tended to have things, good and bad, done to them, rather than enjoying personal rights and choices". This evidence is supported by Monteith et al.'s, (2002) study. It is essential that there is a commitment to fund and support the development of effective advocacy and self-advocacy services for children with disabilities (see Chapter 1).

The right to appropriate information (Art. 17) was raised by interviewees in the context of the needs of teenagers to health and welfare services. Many young people and those working with and for children supported the recommendation for a "one stop shop" for services for young people – a drop in centre, mobile bus or other place where young people could get advice on health, welfare, education and a range of services. BMA policy also supports the idea of a one stop shop for health, education, social services (BMA website, 2004).

It is also important to consider the need for advocacy services where appropriate to ensure that children's right to participate is met in relation to decisions about their health care. Scottish legislation defines these services thus: '*Advocacy services are services of support and representation made available for the purpose of enabling the person to have as much control of, or capacity to influence [their own] care and welfare as is, in the circumstances, appropriate*' (Section 259 (4) Part 17, Ch. 2, Mental Health (Scotland) Act 2003). The meaning of advocacy depends on the context in which it is applied. In the field of health, especially mental health, the concept of advocacy is a wider one encompassing not only 'legal advocacy' but also a spectrum of advocacy models each of which has a particular role in addressing the needs of the individual it serves. The Royal College of Psychiatrists have said that whilst advocacy is commonly understood as meaning speaking up for someone else, in fact, in relation to people with mental health and learning disabilities, it has the rather different meaning of helping people to be heard, and ensuring what they say influences the decisions of clinical staff (Royal College Psychiatrists, 1999).

In relation to services for life-limited children in Northern Ireland, the case was strongly made by supporters of the Children's Hospice that more public funding is urgently needed for the Hospice and associated services. There is just one Children's Hospice in Northern Ireland, situated just outside Belfast. An assessment of need (Northern Ireland Hospice Children's Service, 2000) highlighted the "large number of children in Northern

Ireland with life-limited and life-threatening conditions such as cystic fibrosis, muscle disorders and malignant disease” (ibid.: iii). Approximately 860 such children were identified (ibid.: iii). This number was more than anticipated (circa 500) using accepted formulae (ibid.: 1). Research was carried out in the late 1990’s into the mortality rate for children aged 0-19 years from life-limiting conditions in Northern Ireland for the years 1992-96. This found that the average mortality rate for this group was 1.92 per 10,000 compared to the UK rate of 1 per 10,000. It was noted that “there is no scientific evidence as to why Northern Ireland has a higher prevalence of children with life-limiting conditions than the UK as a whole” (ibid.:25) The Hospice aims to provide a service for children and their families which meets their “physical, mental, emotional and spiritual needs” (ibid.: iii). At present it is entirely funded by voluntary contributions.

### **Key Issues**

- Appropriate services and life chances for life-limited children;
- Need for greater participation of children and young people in decision making;
- Recommendation for one stop shop for children’s services.

## **YOUNG PEOPLE’S SEXUAL AND REPRODUCTIVE HEALTH**

*Best interests (Art. 3), Child’s opinion (Art. 12), Right to protection (Art. 19), Right to Health and Healthcare (Art. 24). Right to private and family life (Art. 8 ECHR and Human Rights Act 1998).*

### **Context**

In its concluding observations on the UK’s report, the CRC stated that “while noting efforts undertaken by the state party to reduce the numbers of teenage pregnancies, the Committee remains concerned at the high rate of teenage pregnancies”. The Committee expressed concern that gay and trans young people did not have access to “appropriate information, support and necessary protection to enable them to live their sexual orientation.” The Committee was also concerned at the rising incidence of sexually transmitted infections (STI’s) among young people (UN, 2002: 41).

To tackle these concerns the Committee made recommendations including further measures to prevent teenage pregnancies such as making health education part of the school curriculum, sex education for all children and the availability of free contraception/protection measures and improved access to confidential and adolescent-sensitive advice, information and support; and provision of adequate information and support for gay and trans young people (ibid. : 42 (a) and (d)).

DHSSPS notes that:

Sexual health in Northern Ireland is generally regarded as poor, with high levels of teenage pregnancy and sexually transmitted infection. In 2001, there were 21,962 live births to women in Northern Ireland, of which 1524 (6.9%) were to teenagers aged 19 and under. In 2001/02, there were 19,765 new outpatient cases presenting to genitourinary medicine (GUM) clinics in Northern Ireland, including 17 new cases of HIV (DHSSPS, 2003f: para 1.5).

Furthermore, “regional surveys show considerable ignorance about issues relating to sex and sexuality, resulting in confusion, unhappiness and the breakdown of relationships” (DHSSPS, 2003f: para 1.6). The links between poverty and teenage pregnancy and poor sexual health are well established in research (DHSSPS, 2003f).

Northern Ireland has one of the highest rates of teenage pregnancy in Europe. Rates are highest in areas of social and economic deprivation (DHSSPS, 2002: 1.3). The rate for 1998-2000 was 19.5 per 1,000 women aged 19 years and under and 4.1 per 1,000 girls aged under 17 years. In answer to a question asked in the Northern Ireland Assembly about the cost resulting from teenage pregnancies in Northern Ireland, the Minister responded that:

“The estimated annual cost of teenage pregnancies is £27 million. This is made up of an estimated £24 million in Social Security Benefits and administration plus tax revenue foregone over 1½ years, together with £2.5 million direct hospital delivery costs, and an estimated £0.5 million on actions aimed at reducing the number of teenage pregnancies” (Response to Parliamentary Question asked by Iris Robinson MLA, 16 March 2004).

The overall rate of STIs in Northern Ireland is lower than in England (FPANI, 2003 Factsheet: 4). However, there has been a recent increase in diagnoses in teenagers and young adults under 25 years of age (FPANI, 2003, Factsheet: 1). Throughout the UK rates of chlamydia among females aged 16-24 have steadily increased between 1993 and 2001 (FPANI, 2003:3). It is difficult to accurately assess the prevalence of chlamydia as the infection often shows no symptoms and remains undiagnosed. Untreated it can lead to infertility in women. A focus group of health professionals agreed that in Northern Ireland chlamydia is a "big issue".

The Executive's Programme for Government gave a commitment to tackling teenage pregnancy. The 'Investing for Health' Strategy identifies teenage pregnancy and sexual health as important areas for action. Teenage parenthood is also identified as an issue to be addressed under the Promoting Social Inclusion initiative. In November 2000, DHSSPS put out for consultation the report of a Working Group on Teenage Pregnancy and Parenthood, 'Myths and Reality'. In November 2002, the Department published its 'Teenage Pregnancy and Parenthood Strategy and Action Plan 2002-2007' following from this consultation. A commitment to implement the strategy is included within the OFMDFM Draft Children's Strategy (OFMDFM, 2004). Success is to be measured through numbers of births to mothers aged under 18 and low birth weight. The DHSSPS notes that:

"Many young people are successful in adapting to the role of parenthood and have happy, healthy children. For too many, however, unplanned teenage pregnancy and early motherhood is associated with poor educational achievement, poor physical and mental health, social isolation and poverty. For those who are particularly young with little or no family or financial support teenage pregnancy can cause considerable distress, not only for the young persons concerned, but also for their families" (DHSSPS, 2002: para 1.4).

The Teenage Pregnancy and Parenthood Strategy includes the following targets:

- A reduction of 20% in the rate of births to teenage mothers by 2007;
- A reduction of 40% in the rate of births to teenage mothers under 17;
- 75% of teenagers should not have experienced sexual intercourse by the age of 16.

There will be a particular focus on areas of socio-economic deprivation and in particular the needs of young people living in rural areas will be taken into account (ibid.: 7).

While it is important to reduce rates of teenage pregnancy and STIs, it is important to stress that young people's sexuality should not be viewed solely as a problem to be solved. The Family Planning Association has described sexual health as "the capacity and freedom to enjoy and express sexuality without exploitation, oppression, physical or emotional harm" (FPA, 1999, cited in FPANI, 2002: 9). Interviewees working in the field of young people's health noted the hostile attitude shown by sections of the media and public in Northern Ireland towards young people's sexuality:

"The media have a massive influence. There is also an issue around how young people are viewed by NI society: 'seen and not heard, have to stay within their place'. If we put our heads in the sand and say we don't want young people to have sex that's fine... but who is dealing with the consequences?" (Health Professional).

The DHSSPS principle that "all young people have the right to be treated in a non-judgemental manner" is welcome in this respect (DHSSPS, 2002: 7).

The most comprehensive survey of young people in Northern Ireland's attitudes to sexual health was carried out by the FPANI in 2002 (FPANI, 2002a & FPANI, 2002b). This provided the first Northern Ireland wide data on young people's sexual attitudes. The report noted that previous attempts to include Northern Ireland in national surveys of sexual attitudes had failed and that prior to the FPA study little information existed on young people's attitudes and sexual behaviour in Northern Ireland (FPANI, 2002a: 9). The study found that in key indicators such as age of first sexual intercourse, number of sexual partners and contraceptive uptake there was little difference between the experience of young people in Northern Ireland and Great Britain. However, young men in Northern Ireland were significantly less likely to use a condom at first sex (ibid.: 65). Over a third of respondents had their first sexual experience before the legal age of consent (17 years) (ibid.: 67).

The study found that 68.5 % of 14 -16 year olds said that they found it easy to access contraception and they were most likely to access contraception over the counter in chemists, shops or in bars. However, the FPANI noted that recent outbreaks of STIs meant that there is "no room for complacency about safer sex messages" (ibid.: 68). No major difference was found between the four health board areas in relation to reported

accessibility of contraception although young people living in the Western and the Southern Board areas reported slightly more difficulties. In relation to emergency contraception these differences were significant (ibid.: 63). The Brook Advisory Centre in Belfast received positive feedback especially from female clients (ibid.: 62).

The FPANI found that young gay and lesbian people's rights to equality were being breached and that although guidance from the Department of Education specifically advocates that homosexuality be addressed in the classroom, young people reported that this was not happening.

The FPANI study found that "with regard to sex education ... even schools which operated an otherwise comprehensive and long-term sex and relationships education programme often asked teachers not to discuss homosexuality and bisexuality in the classroom" (FPANI, 2002a: 47)

Loudes' study of the experiences of young gay, lesbian and bisexual people in Northern Ireland confirmed that the lack of information for these young people was considered a big problem. Young people commented that "Things that are important to us are never explained" and "There isn't enough information about STDs [sexually transmitted diseases]" (Loudes, 2003: 24). Loudes concludes that LGBT young people are "made invisible" by a system that caters mainly for heterosexual people. Issues specific to young lesbians and bisexual women were often overlooked, for example dental dams were not freely available, whereas young gay men could access condoms easily (Loudes, 2003: 24).

The sectarian divide in Northern Ireland also raises issues relating to the sexual health of young people. The FPANI found that young people were not enabled to establish relationships across the socio-religious divide:

"One of the most depressing findings of the survey was the impact that socio-religious segregation has on the sexual health of young people. Social deprivation and religious segregation impacted on their friendship and relationship patterns. The religious division of the education sector further exacerbated this" (FPANI 2002a: 66).

A priority issue raised in focus groups of those working with young people and young people themselves, was the lack of access to sexual and reproductive health services in Northern Ireland. There are four sexual health clinics (genitourinary medicine – GUM) in Northern Ireland. However, the Brook Advisory Service in Belfast is the only specialist clinic in Northern Ireland for young people and has been picketed by opponents since its inception. The Nucleus Centre in Derry/Londonderry was also picketed when it commenced providing sexual health services to its young clients. A health care professional spoke for many interviewees in bemoaning the lack of services:

*"Teenagers need something immediate. In Belfast there is Brook but outside Belfast there is nothing. I live in [town in Co Antrim] and in order for a child to go to the family planning clinic they would have to go to Coleraine [some miles away]. There's no anonymity there. We need health services so that these youngsters do not start their reproductive lives so early when they have all the odds stacked against them. I feel very sorry for people who live in rural areas of NI. One health centre in Lisnaskea - its miles for anyone to travel to this, same in Strabane"*

Professionals and young people recommended in interviews and focus groups that 'one stop shops' based on the model of the Door Project would be useful in providing access for young people to sexual and reproductive health services along with other services such as mental health facilities, education on health, welfare benefits, education provision etc. "... even some sort of bus going round that doesn't say I'm mentally ill, I want contraception - but just has youth services, really is the best way forward" (Health Care Professional).

Difficulties for young people in accessing emergency contraception were raised as a problem by health care professionals: "in Dungannon there was trouble getting even one GP who would prescribe emergency contraception". The cost (£25) of purchasing emergency contraception from pharmacies and the fact that pharmacists were prohibited from providing the 'morning after pill' to under 16's were barriers in the way of young people accessing this form of contraception. Professionals pointed to schemes in other parts of the UK (such as Manchester) where innovative schemes were being pursued in this area.

Young people in a focus group in Derry/Londonderry commented on the inadequacy of sex education in school. They described how the 'chastity people' (an American pro-abstinence group) had visited the school to give them sex education. Professionals working with young people felt that school children were not all being treated

equally in terms of sex education. The situation for gay children in relation to sex education in schools was raised "what happens to their rights?" (Health Care Professional).

Health care professionals felt that maternity services were not necessarily 'adolescent friendly' and that pregnant teenagers sometimes felt out of place attending regular maternity clinics. They commented that there should be a particular service for this age group.

Lack of baseline information was commented on, in particular it was noted that there is no baseline STI screening for young people (the only information available is that coming from sexual health clinics). Therefore, "in Northern Ireland we have no idea, for example, how much chlamydia is around" (Health Professional).

The lack of services for young men was seen as a gap by health professionals and NGO representatives. While some health providers, particularly in the non-statutory sector, had been initiating projects with young men, these were too few in number. Interviewees noted the importance of involving young men in taking responsibility for their own sexual health and fertility. A health professional noted: "There aren't the facilities for young men - there needs a lot more work in promoting male responsibilities". Another interviewee stated that: "We need to encourage our young women to talk to our young men".

A focus group of workers with Travellers raised concerns about sexual health services for young people from that community. It was noted that ante-natal health care was often not utilized by Traveller women and girls and where they did use this service there was often no follow up appointment. Workers commented that they thought that Traveller girls would like more information on sexual health issues and contraception but staff could not provide this because of difficulties in obtaining parental consent. Health professionals in interviews and focus groups raised issues faced by girls and young women in Northern Ireland in relation to the termination of pregnancy.

This has been a controversial issue in Northern Ireland with strongly held views on each side of the debate. Of particular relevance here are the right to appropriate information (Art. 17) and right to health care (Art. 24). The right of non-discrimination (Art. 2) also comes into play as the situation is different for young people in Northern Ireland from that of young people in the rest of the United Kingdom. Currently, abortion is only permissible in Northern Ireland where the mother's life is in danger or there is a serious threat to her mental or physical health (the law is based on the 1861 Offences against the Person Act and the 1945 Criminal Justice (NI) Act). Since the 1967 Abortion Act was passed in England, some 64,000 women from Northern Ireland have had abortions in England or Wales (BBC News website 8 October 2004). The FPANI recently took a judicial review of the DHSSPS for its failure to provide adequate guidelines for medical staff on the law in relation to termination of pregnancy in Northern Ireland and in October 2004 the Court of Appeal in Belfast ordered the Department to draw up guidelines on when abortions can be carried out under existing law.

Issues for young people raised by interviewees for this research included the high cost of getting an abortion if they travelled to England, when if they were from another part of the UK this would be provided free on the NHS; and the situation facing these young women on their return:

"... their rights are contravened. Young people do have terminations. They are coming back into an environment where they may be forced to hear a talk on abortion is murder [in their school]. There should be a right to hear both sides of the coin" (Health Professional).

In 2002 the FPANI saw 578 women for counselling who were considering termination. Of these 2.6% (15) were under 16 and 21% (122) were aged 16-19 (FPANI, 2003). Children under 17 considering a termination are not seen by the FPANI without a 'significant adult' (preferably a parent) accompanying them, so that the young person does not return to Northern Ireland to face isolation.

The attitude of some (but by no means all) GP's to emergency contraception and abortion was a threat to young people's rights in the view of some health professionals. One health professional told of a young woman who had come back from having an abortion in England only to be told by her boyfriend that he had an STI. When she went to her GP she was allegedly told to go elsewhere if she'd had an abortion (Health Professional).

The age of consent for sex was raised by young people and health professionals as discriminatory against young people in Northern Ireland. Since 2001, in the rest of the United Kingdom the age of consent has been 16 years for both gay and straight sex. In Northern Ireland it is 17. It was suggested by one professional that the revisions of the Sexual Offences Bill would provide an opportunity to tackle this, "Young people can be married at 16 but can't have sex until they're 17!" (Health Professional). In the case of Sutherland versus United Kingdom case the European Court ruled that an unequal age of consent is a violation of the European Human Rights Convention (European Commission Human Right, 1997).

#### **Key issues:**

- Access to sexual and reproductive health services;
- Need for adolescent-friendly maternity Services for Teenage Mothers;
- Access to emergency contraception;
- Access to services in rural areas;
- Need for more information on young people's sexual health;
- Lack of appropriate information for young gay, lesbian and bisexual people on sexual health services;
- Scarcity of sexual health services aimed at young men;
- Access to termination of pregnancy for young women;
- Need for appropriate sex and relationship education relating to gay, lesbian and bisexual young people's experiences;
- Discrimination in comparison to GB regarding age of consent.

### **CHILD AND ADOLESCENT MENTAL HEALTH**

*Highest attainable standard of health (mental health services that are culturally acceptable, medically appropriate, provided in a safe environment (Art. 24)); survival and development (Art. 6) views of the child (Art 12) protection of privacy (Art. 16 & ECHR Art. 8); access to appropriate information (Art. 17) psychological recovery (Art. 39) disabilities, special needs provision and community integration (Art. 23).*

#### **Context**

Mental health is central to 'promoting the physical, intellectual and social development of babies and young children – particularly those who are disadvantaged – so that they can flourish at home, when they get to school and during later life' (Sure Start, Core Brief, 1 March 2004). The NHS Health and Advisory Service specifies five indicators of good mental health in children: the capacity to make and sustain mutually satisfying personal relationships; the progression of psychological development; an ability to play and learn at levels appropriate to age and intellect; the development of a moral sense of 'right' and 'wrong'; psychological distress and maladaptive behaviour as expected for the child's age and circumstances.

In October 2002, Government announced a review of policies and services that affect the lives of people with mental health problems and learning disabilities in Northern Ireland (chaired by Professor David Bamford). This review will be complete by mid 2005 and includes a review of child and adolescent mental health services.

In Northern Ireland over 20% of children (under 18 years of age) suffer significant mental health problems (CMO, 99) and comprise the commonest cause of severe disability in childhood. One impact of the conflict on children's lives is that they have experienced, on average, twice as many negative life events and reported much higher stress scores than in the UK (Smyth 1998; see Chapter 6). Rates are disproportionately higher for children with learning disabilities and socio-economic disadvantage in urban and rural areas. Children in Northern Ireland are recorded as enduring higher levels of abuse and suicide (DHSSPS, 1999b). There is a growing problem of substance abuse (see Chapter 6) and medication is recorded as being administered to 7% of 11 to 15 year olds for sleeping difficulties and to 6% for 'nervousness' (HPA, 2001). Despite the evidence of the risk and

reality of mental health problems, including the cumulative adverse impact on psychosocial development, child and adolescent mental health has been neglected and under-resourced by policy makers and legislators.

Only approximately 20% of children with significant mental health problems or disorders receive specialist mental health services. Many go unrecognised. In primary care while only 2% of children attended surgeries for perceived mental health problems they were found to be present in 23% of cases. In paediatric outpatient departments 5 to 10% attended for mental ill health reasons but the diagnosed figure was 28%. There is also evidence that childhood mental illness is often defined as conduct disordered behaviour (see Chapter 6) and thus goes unrecorded and untreated. For those children who are referred it is estimated that between 60 and 70% not receive appropriate early intervention. The cost of inaction impacts disproportionately on the most vulnerable and marginalised. The Eastern Board, for example, has for three years experienced increasing referrals of looked after children and other vulnerable children, 58% of whom were assessed as high risk of self harm and in need of a risk management plan. Of the 3% assessed as in need of urgent admission only a few access an emergency bed (YPC Outpatient Project Team, 2003). A health professional interviewed for this research commented:

*"In some of the most deprived and fragmented sections of our society, rising levels of emotional and psychological stress among children and young people, manifesting as anxiety, depression, deliberate self-harm and escalating suicide rates, are collateral damage following years of civil strife".*

Despite clinical expertise and a management commitment to community-based out-patient services, clinics for children with Attention Deficit Hyperactivity Disorder (ADHD) have been reduced through an unforeseen increase in referrals and under-resourcing of appropriately qualified staff. A health professional commented that there are currently no new patients being seen and the waiting list is two years. In some trusts community paediatricians are taking the weight of the rapid increase in ADHD referrals.

Mental health professionals interviewed for this research commented:

*"Some of the most vulnerable young people in our society, children who have been exposed to indescribable levels of trauma and abuse, are having clinical decisions made based on resource availability rather than need. We have worked with them for years but due to the present crisis in the service we can no longer keep them safe. They may end up on the street or another suicide. There's been a lot of talk and promises, but no-one is really listening. No-one is doing anything".*

*"The burgeoning of bottle-necks in service provision is a consequence of the regional deficit in planning, co-ordination and accountability. It thwarts innovation and stifles commitment within CAMHS. It is a pattern echoed across Northern Ireland and is symptomatic of a fundamental misunderstanding of the nature of the tiered system upon which the service is predicated".*

*"Staff are leaving after years of working with these youngsters because they cannot watch them hurt by a system that promised to get them help and provide them with a safe place and is no longer doing that".*

*"It is like fire fighting with a cup of water".*

Obstacles to accurate assessment and diagnosis are compounded by 16 to 18 year olds falling into the gaps within child and adolescent health services which, in some areas, end at 16 years while adult services start at 18 years. Many children aged between 14 and 17 years are inappropriately placed on adult psychiatric wards and managed by staff with minimal or no training in paediatrics or child and adolescent mental health. In 2001-02 130 children were admitted to adult units across Northern Ireland, five times the proportionate figure for England and Wales (O'Rawe, 2003). Yet contemporary practice recognises crucial physiological and psychological differences for treatment between children and adults. There are also serious implications for child protection.

Although children under 18 years represent 25% of Northern Ireland's population the proportion of expenditure on child and adolescent mental health services is less than 5% of the mental health budget. In the context of competing demands on public services and priorities, children are most likely to benefit from early intervention and preventive provision. It is well established that mental ill-health in children can be avoided through preventive and early interventions in children's lives. For convincing outcomes to be achieved interventions need to be sustained long term. Sure Start programmes offer a unique opportunity to progress preventive work in child mental health problems. They can also provide sound research evidence of the effectiveness of early intervention initiatives.

‘Probably the most important role in prevention for Sure Start programmes is that they are designed to identify the most vulnerable, such as teenage mothers, unsupported lone parents, mothers with mental illness, babies born prematurely and/or of low birth-weight, children with antisocial behaviour problems, and families where there is domestic violence and/or child maltreatment’ (Surestart website, 2004).

Such programmes are focused on relationship building, are embedded within communities, offer a flexible and adaptive approach and support the engagement of hard-to-reach families in intervention. They also operate early intervention through a multi-agency approach, integrating with mainstream services (Kurtz, 2004).

The present situation in Northern Ireland regarding child and adolescent mental health services is of critical concern reflecting a serious deficit in provision and breaching baseline levels as established in international standards on the health and well-being. Within voluntary and involuntary admission and treatment regimes, the rights and requirements established in international standards are not met. As in other jurisdictions, child and adolescent mental health services require a mandate in legislation. The Mental Health (NI) Order (1986) fails to recognise that the needs of children differ from those of adults. Given the Committee’s expression of concern over the high rates of mental health problems experienced by UK youth in general and the Northern Ireland evidence in particular, major investment in fully reviewed and expanded mental health services for children is imperative. This review and provision must meet anti-discrimination requirements (Section 75 NI Act 1998 and CRC. Art 2) concerning age, class, gender, sexuality, ethnicity and disability. It is a matter of priority that a just and principled framework for the reform of regional mental health and learning disability law and policy regarding children, based on international standards and existing best practice, including a legal framework for assessment and treatment of children with mental health problems, is introduced.

### **Key Issues**

- Assuring comprehensive and resourced regional provision for child and adolescent mental health including a service framework, a thorough needs assessment, coherent strategic planning and framework of accountability.
- Identifying, through audit and consultation, best practice at all levels of existing service provision as part of the development of regional provision.
- Keeping pace with demand for specialised services (e.g. Autistic Spectrum Disorder services).
- The development of effective multi-agency initiatives based on prevention and early intervention and planned to sustain long-term care and support.
- Establishing formally-contracted, dedicated day-care facilities for children and young people across Northern Ireland as part of an integrated programme of community-based services for children with mental health problems.
- The expansion and resourcing of in-patient provision.
- Training, recruitment and retention of appropriately qualified staff.
- Section 75 impact assessment on new provision to guarantee equality of access.
- The end of admission of children and young people to adult psychiatric facilities.
- The delivery of mental health care through appropriately trained and PECS checked staff at all levels.
- The establishment of an anti-discriminatory framework for the identification of need and the delivery of services.
- Addressing the issue of gaps in provision for 16 and 17 year olds through auditing existing provision focusing particularly on mental ill health and learning disabilities.

## **MENTAL HEALTH, CARE AND CUSTODY**



*Highest attainable standard of health (mental health services that are culturally acceptable, medically appropriate, provided in a safe environment) (Arts. 23 & 24) Survival and development (Art. 6) Views of the child (Art. 12) Protection of privacy (Art. 16) Access to appropriate information (Art. 17) Psychological recovery (Art. 39) Disabilities, special needs provision and community integration (Art. 23); Deprivation of liberty (Art. 37).*

## **Context**

While alternative care (see Chapter 2), including secure accommodation, and detention in custodial settings (see Chapter 6), are distinct issues in policy and legislation both concern very vulnerable children. Further, as the discussion of children in custody shows (see Chapter 6), the progression of looked-after children into the criminal justice system is a matter of increasing concern throughout the children's sector, in social services and youth justice. It is a concern echoed in child and adolescent mental health services. Looked-after children have significantly higher rates of physical, emotional and developmental illness when compared to the child population in general. Approximately two-thirds of children and young people in state care suffer from mental health problems, a rate equivalent to those in residential settings. (Mental Health Foundation website, 2004) A series of reports in the UK has called for a significant review of children's mental health services and the Mental Health Foundation records that 25% of looked after young people endure major depressive disorders. Yet their access to services is hindered by: poor communication between health and social care; inadequate health assessments; multiple placements; staff shortages, particularly qualified staff; and lack of appropriate training for staff and foster carers.

Mental health professionals were concerned that adequate legislative frameworks and administrative protocols were not in operation for children detained under mental health legislation. These concerns included: consultation with, and participation of, children in their assessment and treatment; lack of consistent approach to advocacy; weak safeguards regarding privacy and confidentiality; failure to ensure adequate legal representation for detained children; appropriateness of education provision; unacceptable delays in accessing specialist services for serious cases.

As with the adult prison population, there is now a body of research supported by the observations of professionals interviewed for this research that children in conflict with the law who are sentenced to custody often suffer mental ill health. Such children are rarely diagnosed as mentally ill but as personality, conduct or behaviour disordered. In particular, repeat offenders often display a tendency towards more serious mental ill health including depression, anxiety and attachment disorder. A professional working in the criminal justice system commented: "*retributive responses to offenders have continued in some jurisdictions with the result that young people who may have been helped have been viewed as simply requiring additional punishment*". It is not clear from the available data to what extent young men in custody at Hydebank Wood YOC receive appropriate mental health-care. As Chapter 7 notes, the Visiting Committee has expressed concerns regarding the standard of health care and the continued use of isolation and seclusion within 'punishment cells' as part of the management of often disturbed and distressed young men and children. It also discusses the lack of a gender-specific regime for girl children and young women also held at Hydebank Wood.

Whatever the setting in which children are detained, whether in secure accommodation or custody, there is significant concern regarding the use of physical restraint. With reference to care a professional worker commented, "*the existing combination of vague guidance, lack of regional training and accreditation and uncertain techniques does not provide sufficient safeguards*". There is no specific legislation that clearly establishes when restraint can be used on children. Different rules apply in different settings whether residential care or custody. As Hart (2004: 10) states, "A method of restraint thought not to be inhuman or degrading when used on an adult could still breach the rights of a child".

The best interests principle is absent from mental health legislation regarding the detention of children in a mental health context (see Chapter 1). The paramount consideration must be the acknowledgement and promotion of existing obligations under international standards and domestic law. This should be consistent with the concluding observations made by the Committee in 2002. It is clear that there is a compelling need to evaluate, monitor and address the mental health needs of children on the basis of anti-discriminatory policies and practices. This is particularly the case for the expanding constituency of children looked-after by the state, for those in conflict with the law and for those who experience coexisting learning difficulties. Compliance is necessary with international standards regarding the auditing of regional variation in policies and procedures on

the use of restraint and seclusion for managing children with mental ill health. It is also vital to establish training standards and guidance for the assessment of staff competencies based on international standards and best practice.

### **Key issues**

- Review of mental health assessment procedures and the provision of early intervention for looked after children, including those who are adopted.
- The incorporation of the best interests principle (Art. 3 CRC) into mental health legislation.
- Provision for the participation of the child within the legal and policy framework for compulsory assessment and treatment including age-appropriate review and advocacy.
- The treatment of children in separate accommodation to adults and compliance with child protection guidelines.
- Training on international children's rights standards for all staff involved in the care and custody of children with particular emphasis on physical and mental health (see Chapter 1).
- Ensuring the informed consent of the child to treatment and confidentiality on all matters
- Provision of appropriate and independent legal representation for children detained under mental health legislation (see Chapter 1).
- To make mandatory the framing of and individualised education plan within the context of the care plan.
- Establishing a reliable mechanism for speedy referral to specialist child and adolescent health services when severe mental disorder is suspected.
- The urgent provision of adequate guidance and training on the use of restraint on children in health, care and custody settings.
- Provision of disaggregated data, particularly by region, on the services and programmes provided for identifying and meeting mental health care needs of all children in care and custody.

## **DISABILITY AND HEALTH**

*Non-Discrimination (Art. 2) Survival and development (Art. 6) Disability rights (Art. 23) Health and Health Care (24).*

### **Context**

The life expectancy of people with learning disabilities has increased markedly over the last 60 years but people with learning disabilities still have higher mortality rates than in the general population (Review of Mental Health and Learning Disability Northern Ireland, 2004: 7.4). They also have a heightened risk of health problems (ibid. : 7.6). A submission to this research from a non-governmental disability rights group confirmed that children and young people with a learning disability are more likely to have weight problems – problems with obesity as well as low weight. They are also more prone to certain medical conditions than the rest of the population, including hypertension, skin disorders, spinal problems, epilepsy, respiratory problems, physical disabilities, visual and hearing impairments and dental problems (Submission to the research). The Equal Lives Review also noted that mental health problems may also be more prevalent among people with learning disabilities (Review of Mental Health and Learning Disability Northern Ireland, 2004:7.17).

In research for Barnardos, Monteith et al. described children and their families' experiences of health and social services provision in Northern Ireland (Monteith et al., 2002). Children talked about their visits to, or stays in, hospital, and their experiences of health professionals. For example, a child talked about a nurse who had hurt him: "one nurse hurt me ... she put my medicine, she put my fingers up my throat ... she just said take the

medicine ... mummy had to tell her off ... she said she was sorry, not to me, to my mum ...” (Monteith et al., 2002).

Another child talked about having to travel to Belfast for treatment as her local hospital “doesn’t even know what cystic fibrosis means – anything that is wrong with me they don’t even have a clue”. An issue raised in Monteith’s study was that of mobility aids, including wheelchairs, hoists, seats for the bath/shower, and walking aids. One teenage girl said that “kids like to be modern. Lots of kids ask me where I got mine [walking aids] and ask their mums and dads, can I have some too? I wish someone would start up a company and make sticks and calipers that are modern” (Monteith et al., 2002). Parents also commented on the need for lighter wheelchairs and greater access to aids and equipment and the report recommended both greater financial assistance for aids and equipment and also the active involvement of young people in their design (ibid.).

Monteith et al.’s research raised issues relating to the importance of the self-esteem of children with disabilities, one child said that he hated going to the hospital because it was “like I’m weak.” Sensitivities regarding personal care needs were also noted as important, particularly as children became adolescent.

A health professional in a focus group for this research described the lack of resources to ensure the effective participation of children with severe disabilities: “Some of the children with complex needs, adolescents in the mid-Ulster direction - didn’t have any stimulation, even from the Department of Education. A boy of 16 with difficulty communicating had nothing - this was not seen as an essential service”.

A submission from an NGO to this research argued for investment in specialist healthcare and therapy services for children and young people with a learning disability; and equality of access to health promotion initiatives by children and young people with a learning disability. The Equal report on Learning Disability noted that “despite increased emphasis on health promotion issues in government and health service policies there is little evidence of specific targeting of people with a learning disability within Northern Ireland. This contrasts with the position in England where specific guidance and policy has been produced” (Review of Mental Health and Learning Disability Northern Ireland, 2004: 7.15). The report also recommended “specific health promotion initiatives and intervention that focuses on improving the health status of children with a learning disability in key areas such as nutrition, obesity, exercise and dental health” (ibid.: 7.33). The report also notes the social isolation faced by parents of children with a learning disability and challenging behaviours (ibid.: 7.26) (see Chapter 2).

### **Key issues**

- Greater incidence of health problems for children with physical and learning disabilities;
- Inequalities in healthcare for children with physical and learning disabilities;
- Need for greater support for parents;
- Need for more funding of physical aids and equipment;
- Need for greater participation of children and young people with disabilities in making decisions about their own health care;
- Need for government strategies on health to specifically target children and young people with learning disabilities.

## **ETHNICITY AND HEALTH**

*Non-discrimination (Art. 2) Preservation of Identity (Art. 8) Freedom of thought, conscience and religion (Art. 14) Access to appropriate information (Art. 17) Rights of Refugee children (Art. 22) Health and health services (Art. 24) Rights of Children of minorities or indigenous populations Art. 30). Committee on the Elimination of Racial Discrimination.*

### **Context**

With respect to children from ethnic minorities in general, the CRC requires Government and health professionals alike; (a) to look at resource allocation and organisation of services - to ensure that its principles and standards are promoted in participation with children and families and in collaboration with partners in education and social services: (b) To guarantee equality of access to services, and: (c) for all professionals to advocate for the social, economic and political changes to secure them access to the best possible health.

Ethnicity is a major determinant of longevity and well being (Rawaf and Bahl, 1998). Yet issues of ethnicity in relation to the provision of regional health and social services for all age groups, but especially children, are rarely addressed except in the most peripheral terms (NICEM, 2004). The lack of ethnic monitoring at a regional level has meant that the extent and implications of the growing province-wide cultural diversity are neither well documented, evaluated nor provided for in a regional sub-population where children aged under one to four years comprise the highest numbers of people from ethnic minority backgrounds and young people comprise more than one third of the population (Save the Children and NICEM, 2004). The Committee on the Rights of the Child specifically highlighted current inadequacies in anti-discrimination provisions regarding children of ethnic minority background, recommending the use of monitoring to inform the development of comprehensive and targeted strategies (UN, 2002).

Preventable diseases and avoidable mortality affect a high proportion of people from all Black and Minority Ethnic (BME) communities across the UK (Skellington, 1996: especially chapters 4-6). The Committee on the Elimination of Racial Discrimination in its Concluding Observations on the UK's 16<sup>th</sup> and 17<sup>th</sup> periodic reports, drew specific attention to the discrimination experienced by Black and Minority Ethnic communities in the area of health, which is reflected in their limited access to health services and higher mortality and morbidity rates (CERD, /C/63/CO/11, para 22-23). This includes a higher than national average incidence of disability in ethnic minority communities in Great Britain. In Northern Ireland, there is no existing data on the prevalence of disability in BME communities. In light of the increased prevalence of obesity amongst some BME communities, a major research initiative is targeting adolescents in England, to investigate the basis for the significantly higher morbidity and mortality from diabetes and heart disease amongst the UK's Black and Asian communities (BBC News, 10<sup>th</sup> March 2003). BME communities are also over-represented in the mental health care system (NICEM, Dec 2003 and NICEM, 2002) and in Great Britain there is mounting pressure to create a national mental health network for minority ethnic communities, to provide regions with expertise and culturally affirmative training (BBC news, 15<sup>th</sup> Sept 2003).

The 2001 Census provided the first official regional information base on the size and composition of Northern Ireland's Black and minority ethnic communities although low participation rates have however raised significant concerns regarding the accuracy of the data. The Northern Ireland Commission for Ethnic Minorities (NICEM) in 1997 estimated the BME population around 20,000 i.e. approx 1.3% of the population (published in Youth Council for NI, 2001). Although less marked than in the rest of the UK, the regional diversity of the BME population in Northern Ireland is increasing and the population is younger than among the white ethnic majority. BME communities are not of themselves homogenous. Awareness of cultural diversity (CRC Art. 30) and developing the competence to deal with it are essential both in addressing specific health problems and inequalities.

There is currently no available regional data on the health needs of children and young people from ethnic minority communities. Participants at a focus group of health professionals conducted for this research agreed with the statement of one worker that:

*"Ethnic minority children are being listened to even less. We haven't got a global picture yet in Northern Ireland of what the overall needs of children from ethnic minority groups are".*

It is known however that household income, unemployment and poverty are crucial issues in those areas of Northern Ireland where most BME children live. An NGO representative involved with the Portuguese community confirmed that: *"The major health issue would be psychological issues and mental health problems arising from racism, prejudice, poor housing, poor working conditions etc."*

Workers with the Traveller community commented that the high child mortality rate for Traveller children is affected by poverty and the living conditions on site as well as by the absence of safe areas for children to play. They said that because Traveller sites are often located at the fringe of a busy road, children are immediately put in danger of being knocked down. There is also danger lurking on the site in which they live and play from the scrap metal which occupies traveller living quarters. The lack of physical space within a caravan can place children in danger given the small amount of room available to cook on stoves. Low levels of literacy also

mean that Travellers who receive prescriptions may not be able to read the instructions as to how and when drugs should be administered.

Poverty and material circumstances are also identified as important factors in the ill health of BME children throughout the UK. Action to tackle poverty and poor family housing in inner city wards would, it is predicted, have a positive impact on the health of these children. The NI Public Health Strategy acknowledges that inequalities in health outcomes are greatest amongst those with highest levels of deprivation. One target for this has been the Traveller community, whose basic health and social care needs have been long neglected. With a history of social exclusion and high morbidity and mortality rates across the age groups, the obligation to guarantee equality rights to the Traveller community is undisputed:

“There are about 1,200 Travellers in Northern Ireland and the Irish Traveller community is classified in law as a racial group. It is generally accepted that Travellers are amongst the most disadvantaged members of society. Many families are living in conditions which contribute to poor health and low educational achievement. Travellers’ life expectancy is considerably below that of the settled community. Historically, there has been an unwillingness among the settled population to accept their nomadic lifestyle and other aspects of their culture; and this has been associated with discrimination and harassment against them” (OFMDFM, 1999).

The PSI working group found that “alarmingly, the mortality rate of Traveller children up to the age of 10 has been found to be 10 times that for the population as a whole. Overall, the life expectancy of Travellers is around 20 per cent lower than the general population. Only 10 per cent of the Traveller population are over 40 years of age and only 1 per cent are aged over 65” (OFMDFM, 2001).

A worker with the Traveller community commented on the double discrimination which Traveller children with physical disabilities face being stigmatised as a Traveller child and because of their disability.

### **Asylum Seekers and Refugees**

Research on asylum seekers and refugees in the Republic of Ireland found malnutrition among pregnant women, diet-related ill health in babies and weight loss among children (Fanning et al., 2001). A health professional working with asylum seekers in Northern Ireland noted that:

“the Health Service that exists here in Northern Ireland (and the UK) is very different to that existing in any of the home countries of the young people. Given many of the young people have travelled extensive distances to arrive here, often in unacceptable conditions with little or no food, water and basic provisions, a primary duty is to arrange medical aid and a thorough medical assessment”.

He continued:

“My own experience with young people seeking asylum has demonstrated a variety of complex physical health needs, from persecution, sexual exploitation, prostitution and sexual abuse, and experiences of severe trauma which have resulted in the need to access mental health and therapeutic services. It might be a help to run a voluntary befriending service to help vulnerable young people through the trauma of asylum seeking”.

The challenge of institutional racism within health and social services is very real (Connolly and Keenan , 2000, 2001a, and 2002). A recent study demonstrated that a significant proportion of ethnic minority adults are not receiving the services they need, including a number who continue to be excluded access to primary care (NICEM, 2004).

### **Racism**

The adverse effect on mental and physical health, of the long-standing isolation and marginalisation experienced by many ethnic minority communities, is reinforced by the escalating occurrence of racist incidents. A recent study of the experiences of BME young people in NI, suggests an underestimate of the scale and impact of racial violence and harassment, with incidents frequently recurrent and recorded against children as young as two years old (NICEM, 2004). The increased incidence of psychiatric outcomes for individuals subject to racial harassment and race hate crimes is similar to that resulting from other violent crimes (Rogers and Pilgrim, 2003) however, victims are more likely to experience additional, deeply rooted concerns about an attack on an

immutable element of their identity. This introduces a group aspect to the trauma, with peers of victims traumatised vicariously, an experience very familiar in NI over recent 'troubled' decades.

Within the UK, NI has the most extensive equality duty (under the Northern Ireland Act 1998, section 75) and with the implementation of the Race Directive this extends to social protection including social security and healthcare. The complementary nature of the TSN policy and the s75 duty, invite Trusts to consider a co-ordinated approach to their implementation, both in terms of reporting mechanisms and framework for implementation. This should not only focus Trust resources but should enhance Trusts' commitment to mainstreaming equality and strengthen the capacity of the local framework to combat social need and to promote social inclusion, in line with national and EU wide policy objectives. In NI, the introduction of statutory quality care standards will lay the foundation for a system of entitlement provision (soon to arrive in NI as the HPSS Quality, Improvement and Regulation Order). The system of clinical and social governance that the legislation aims to introduce supports the need to incorporate cultural and linguistic competence within the regional health strategy.

In an increasingly culturally diverse society, safeguards must be in place to ensure that ethnicity does not influence either the assessment of need or the quality of services provided. The challenge is not to treat everyone the same (formal equality) but rather to ensure that greater attention is paid to identifying the particular needs of those who are marginalised and powerless (substantive equality or equality of effect). In the *Climbie* case for instance, concerns were raised within the Black community at an early stage about the child's safety by an unregistered child minder. However, misplaced cultural assumptions and fear of being accused of racism were acknowledged as having bearing on the way that Victoria Climbié's case was dealt with by the professionals involved. Such tragedies raise critical issues that may have far reaching implications for how we safeguard children belonging to BME communities

Ethnic monitoring and evaluation are fundamental to service provision. To comply with S. 75 of the Northern Ireland Act 1998, collecting data on ethnic group from all patients treated under the NHS should be routine. In the context of competing demands on public priorities, ethnic minorities are one of society's most vulnerable groups. Yet there has been no attempt to define or analyse whether the apportionment of resources for members of ethnic minorities does reflect a realistic balance of comparative need - and the lack of regional data on the demand for services by members of ethnic minorities province-wide, may undermine the magnitude of the corresponding gap in provision.

Issues of equality in accessing services clearly arise in face of the particular difficulties experienced by BME communities. In particular, BME children in rural areas have less access to support and traditionally suffer from greater exclusion within these communities (Countryside Agency in Child Right, Dec 2000, 172: 17-18). For instance, during the PSI working group investigation of the status of NI Travellers it emerged that as a distinct community they may have been disadvantaged by the Sure-Start initiative's criteria, and this led to the recommendation that the DHSSPS should conduct an Equality Impact Assessment (EQIA) on the Initiative. Young people from BME communities locally are reluctant to spontaneously access provisions and services outside their communities (NICEM, 2004).

An NGO representative working with the Portuguese community noted that when children are ill, the language barrier and medical jargon used to diagnose illness may lead to unwillingness to seek medical advice. Children who become ill are often taken to the hospital accident and emergency department rather than to their local GP. A worker with the Traveller community explained that Travellers' nomadic lifestyle can make it hard to build relationships with any particular GP. This means that any medical advice is likely to come from elders already living in the community who have no formal education or training. They stated that with no immediate medical treatment, common illness can become life threatening. This situation is further exacerbated by the poverty levels in Traveller communities and their distrust of modern medical ways of treating and curing illness.

Results of a recent health needs assessment on adults from smaller BME communities in NI, provide a number of useful insights: (a) there is evidence that all BME groups to a greater or lesser degree continue to be underserved by health and social services; (b) language remains a major barrier to access and appropriate use of health services; (c) lack of access to primary care is the single greatest problem confronting BME individuals within the health care system (Bayne-Smyth, 1996) (this results primarily from cultural, linguistic and institutional barriers and in its most extreme form, entails people being turned away by front line staff) and (d) cultural factors play a far more significant role in the recognition of mental disorders than they do for physical illness. Overall, many of the health issues raised by adults from BME communities were not dissimilar to those concerning the 'general population' however, whereas in Great Britain, BME communities are already recognised as having higher rates of ill-health than the majority ethnic community, there are no prevalence rates

for NI. There is currently no information on patterns of hospital attendance between different ethnic groups for children or adults, including gender differences. Monitoring the use of NI hospital and community services by ethnic group is essential to define and address the service gaps and to determine whether regional and local service usage reflects the trends already reported in other parts of the UK.

The use of relatives, including children to interpret, remains common, and some providers call on family members including the client's own children to interpret, without making an effort to find trained interpreters. Such substitutions could lead not only to errors and misunderstandings but also to strained family dynamics (e.g. role reversal between parents and children). Trusts have in theory, signed up to ensuring that patients whose first language is not English receive the necessary information and are able to communicate appropriately with health care staff. They have also affirmed that the use of children as interpreters is inappropriate (HPSS, 2003). A health professional working with immigration and asylum applicants explained the importance of effective interpretation services:

"In Northern Ireland we do not have the access to the volume of interpreters that may be available in other parts of the UK and Ireland. However, my experience has been that the interpreters tend to build personal relationships with young people seeking asylum, often adopting a genuine interest in the well-being of these vulnerable young people. In obtaining reliable interpreters the services of NICEM is essential, as often the contacts social services may have are engaged in employment in other fields and are not always available during working hours".

An NGO representative stated that:

"Language barriers block the information to families especially where there is maybe a young children with an infectious illness this is a problem.... The information has been translated but the issue is when the health visitor visits the home... they challenge her about the baby, 'how good? How bad?' So language can be problematic ... that's why the health visitor needs to bring an interpreter when visiting the family".

This representative argued that while there are sufficient interpreters (particularly through the NGO sector) it is important that the issue is addressed through government departments: "we are still pushing them [Government Departments] to centralise as it would be worthwhile to employ a central group of full time interpreters".

### **Key Issues**

- Link between ethnicity, longevity and well-being;
- Discrimination experienced by BEM communities in relation to health care;
- No available regional data on the health needs of children and young people from ethnic minority communities;
- Link between poor health and poverty among BEM communities;
- Poor health and low life expectancy of Traveller children;
- Health issues relating to asylum seekers;
- Barriers to access to health care for BEM communities;
- Lack of cultural awareness or training of health professionals;
- Need for improvements in provision of interpretation services.

## **YOUNG LGBT HEALTH**

*Non-discrimination (Art. 2) Access to appropriate information (Art. 17) Right to privacy (Art. 16 and ECHR Art. 8) Right to health and health care (Art. 24).*

## Context

International human rights standards stress non-discrimination and the Committee has commented on the need for greater protection for the rights for young lesbian, gay, bisexual and transgendered (LGBT) people (UN, 2002). However, as Loudes notes “it is important to remember that up until a decade ago the World Health Organisation classified homosexuality as a mental health disease” (Loudes, 2003: 22). There is, therefore, much work to be done in improving the rights of children and young people in this area. Loudes study of the attitudes and experiences of young lesbian, gay, bisexual and transgendered people in Northern Ireland found that “whilst a few young LGBT people were very open and confident in their GPs and had positive experiences, several of them recounted that their GPs were judgmental about their sexual orientation” (ibid.: 22). One young woman’s doctor had allegedly told her that “Gay people go to hell” and “outed” her to her family (ibid.: 22). Loudes noted a prevalence of mental health problems among young LBG people “because of the violence, social disapproval, isolation and discrimination they experience...” (ibid.: 23). One young person commented that having to hide one’s sexual orientation “leads to lies and guilt and stress” (ibid.: 23). The *Shout* report also highlighted that young LGBT people are five times more likely to be medicated for depression, 29% of those involved in this research had attempted suicide and 50% of young people who identified themselves as being transgendered reported having self harmed (Carolan and Redmond, 2003). A small scale study (unpublished) by Foyle Friend studied the experiences of young people who had been attracted to others of the same sex while at school. The study found experience of social isolation, attempted suicide and psychiatric illness (cited in OFMDFM 2004:11). Research by the Rainbow project found that gay men were more vulnerable to mental health problems and more likely to commit suicide. Both studies identified the need for specialised counselling services (ibid.)

A review for ODMDFM in 2004 of research on LGBT issues in Northern Ireland concluded that a number of issues required urgent research including, suicide, mental health strategy, substance and alcohol abuse, lesbian health needs and gay people with disabilities.

Loudes argues that health service providers send out an ambiguous message to LGBT people for example, in that while they offer non-judgmental advice on sexual health to young LGBT people in GUM clinics, on the other they refuse to take blood from gay men. “Consequently, young LGBT people feel that they are either invisible or stigmatized by health professionals” (ibid.:22). The Terence Higgins Trust, a charity working on education on HIV and AIDS, has called for greater clarity about the grounds for excluding some people from donating blood (Loudes, 2003: 22)

Confidentiality was another key issue in Loudes research with several young people saying that they had been “outed by health professionals”. This is a breach not only of the professional ethic of confidentiality but also of the right to private life protected by Article 8 of the European Convention on Human Rights and Article 16 CRC.

Young LGBT people and workers interviewed for this research confirmed these findings. At a focus group discussion it was noted that class is an issue facing these young people, many of whom do not have the financial resources to move out of their community/area or even home in order to live their lives as they wish. On confidentiality, one worker said that they had encountered a case where a young man had asked his doctor for advice only to find that when he returned home, the doctor had phoned his parents and the local parish priest informing them of the nature of the conversations that had taken place. It was also noted that doctors tend to assume that young people who go for advice or medical check ups are heterosexual and this puts the young person in an awkward position discouraging them from seeking more advice or information about the issue which promoted them to seek help in the first place. Additionally, it was reported that young lesbians not only lack access to good information regarding sexual health but that there is also a great deal of misinformation regarding general health issues. As one NGO worker told us: “The whole thing about smears as well because to me that’s the actual worrying thing, there has been a message around for a while that if you are a lesbian you don’t need smears if you’re not having penetrative sex, that’s crap, absolutely crap ... the wrong messages are going out for lesbians as well”.

Lack of co-ordination between LGBT groups due to inadequate funding was thought to be a problem. Most organisations dealing with these issues are based in Belfast leaving young people from other areas very isolated. These organisations are also poorly funded and this has a detrimental impact on their ability to reach out to the young people needing their services. Some young people are afraid to travel to Belfast to avail of services. The sectarian geography of Northern Ireland can make finding accommodation for young LGBT people even more difficult. It was agreed among interviewees that there is a lack of support for parents in dealing with the issues.



Difficulties were reported in advertising services for young people. A worker noted that if advertising cards giving information about services are left in schools, youth clubs or church halls they often 'disappear' or are removed because of objections on the basis of homophobia. For example, with regards to circulating information regarding HIV and AIDS to schools and youth clubs (which is a health risk faced by all sexually active young people, irrespective of their sexual orientation), we were told: "When we were doing the red ribbon campaign around schools they didn't put them up they didn't put them out it was to sensitive an issue. And in some centres you'll find that a youth worker will put them up one week and the following week someone comes in and takes them down" (NGO Worker). It was agreed by all professionals and workers in the field of LGBT that there needs to be an awareness of the issues faced by young LGBT people built into youth and social work provision and in teacher training programs. The underlying message was that "Ignorance breeds contempt and fear" (NGO Worker).

### **Key Issues**

- Right to confidentiality;
- Impact of homophobia on health services for young LGBT people;
- Funding needs of groups;
- Training needs for health professional;.
- Need for effective sexual health services and sex and relationships education for young LGBT people.

## **CHILD POVERTY**

*Right to life, survival and development (Art. 6 CRC). Right to life (Art. 2 ECHR and Human Rights Ac;); Right to health (Articles 23 & 24).*

### **Context**

There is considerable evidence to demonstrate that Northern Ireland has higher levels of children living in poverty than any other region of the UK. Research carried out for the Office of First Minister and Deputy First Minister (OFMDFM) found that 38% of children live in households which are in the bottom 30% of household income after housing costs (McLaughlin and Dignan, 2002: 206-7). That these high rates of child poverty include high rates of material deprivation were confirmed by the Poverty and Social Exclusion Survey for Northern Ireland which found 37.4% of children living in households that had equivalised incomes after housing costs below 60% of the median and were lacking in three or more necessities (Hillyard et al., 2003: 27-34).

Although Northern Ireland has been considered to be one of the most deprived parts of the United Kingdom and for many years was an EU Objective 1 region, poverty measurement and poverty alleviation strategies have however been poorly developed until very recently. The UK government statistics on poverty did not include Northern Ireland for the last decade. Since devolution, there has been considerable research activity aimed at closing this information gap. Most of the information on child poverty in Northern Ireland comes from research commissioned by NISRA through OFMDFM's Equality Unit. The most detailed information on child poverty is contained in the Poverty and Social Exclusion Survey for Northern Ireland (PSE NI), published as *Bare Necessities* (Hillyard et al., 2003). The aims of the PSE NI survey were:

1. to provide a baseline, early 21<sup>st</sup> century measurement of poverty and social exclusion which can be updated periodically in the future;
2. to provide data on the extent to which poverty and social exclusion vary across the nine dimensions of equality specified in the Section 75 of the Northern Ireland Act 1988; and
3. to compare poverty levels in Northern Ireland with results of research on low incomes, poverty and social exclusion in Britain and poverty levels in the Republic of Ireland (Hillyard et al, 2003: 13).

The PSE NI included two surveys carried out between June 2002 and January 2003. A random sample of the NI adult population was asked in the first survey to say which material items and social activities they regarded as necessities of life and these responses were used to establish a 'social consensus' of items and activities in Northern Ireland which people should be able to afford and not have to do without. The second survey used the

list of items and activities derived as necessities by more than 50 percent of respondents from the first survey to identify the numbers of households lacking these necessities. The survey evidence on deprivation was then combined with household income to establish a measure of poverty.

The resulting poverty threshold calculated using a “range of sequential statistical procedures to relate the number of necessities lacking in a household to the incomes of households” (Hillyard et al., 2003: 21) was defined for Britain as a household on low income and lacking two or more adult necessities whereas in Northern Ireland the poverty threshold was three or more adult necessities. In terms of severe poverty the survey found that:

- One in five families lacked six or more necessities;
- One in ten lacked 9 or more necessities;
- 7% lacked 12 or more necessities because they couldn't afford them.

Other results were that:

- 28% of children in the survey live in families unable to afford one week's holiday away from home;
- 15% are unable to afford to go to the cinema regularly;
- 15% cannot afford computer games;
- 8% do not have the money to buy new clothes when needed;
- 10% of children never get a family day away; and
- 8% cannot afford sports gear.

This study found that 16% of people said they don't have “fresh fruit and vegetables at least once a day” but only 5% said this was because they could not afford it, with 11% said they don't have them because don't want them. However, other qualitative research has shown that people living in poverty say they rarely buy fresh fruit and vegetables because they are too expensive and don't go far enough – “a loaf or a packet of biscuits will feed more for longer” (NIAPN, 2002). A similar point is made by mothers in a study by North and West Belfast Women against Poverty (1999), with one woman commenting that: “People buy all the cheap stuff. You go by what looks good on the plate, not whether there's this vitamin in it or that – as long as it looks alright when it's set down. When you go to the supermarket you buy the cheapest loaf, you don't go for the bread that's supposed to be better for you. And fruit is dearer than biscuits, so you don't end up buying much of it” (North and West Belfast Women against Poverty, 1999).

The impact of poverty on children and young people's expectations and self-esteem came through strongly in interviews for this research. A health professional commented that:

*“Poverty of opportunity is important. When you go and visit young people in community it seems like they're falling into a pattern of having children early, don't see ahead to educate themselves of getting outside of the home. It's about their own self-esteem. They just feel they might as well get pregnant as do anything else”* (Health Professional).

While the PSE NI survey includes a considerable amount of information on child material and social deprivation, this information was gathered entirely from adult members of their households, not from the children themselves.

To some extent, the higher levels of children living in poverty may be explained due to the greater proportion of children in the Northern Ireland population. The 2001 Census reveals that 29.5% of households in England and Wales have children and 11.4% have children aged 0-4. By contrast, 36.5% of households in Northern Ireland have children and 14.4% have children aged 0-4.

Department of Social Development statistics show that 32% of children live in households whose only income derives from benefits (DSD, 2002). This compares with 19% of children in Britain living in families totally dependent on benefits (DWP, 2002).

This third of children totally dependent on benefits are not equally dispersed across the region. In fact, there is a marked concentration of poverty with over half of all children that live in households in receipt of Income Support residing in 16 percent of wards and over three quarters living in just 37 % of wards (McClelland 2003). The level of child poverty in some of those wards, particularly those in the North West periphery of the region, is staggering. One in three wards in the Derry/Londonderry City Council area has a child poverty rate of more than 70 %. The three worst wards for child poverty in Northern Ireland are in Derry City. The Shantallow East ward has 92.4 % of its children

living in poverty, the Brandywell 91.4 % and Creggan South 89.4 %. Two thirds of the thirty wards in the Derry/Londonderry City Council area have a child poverty rate of more than 50 %, only three have a child poverty rate of less than 25 %.

The fourth worst ward for child poverty is the Falls (Belfast). Seven of the 56 wards that have the dubious distinction of being the worst 10% of wards for child poverty are in West Belfast: Falls where 88.3% percent of children live in poverty; Whiterock (83.8%); Upper Springfield (83.3%) Ardoyne (82.6%); Clonard (80.7%) St. Annes (80.4%); and Shankill (74.2%). While Derry/Londonderry and West Belfast are notorious for high levels of poverty, some of the worst 10% of wards in terms of child poverty are in areas that are seen as very prosperous, for example, 72% of children in the Old Warren ward of Lisburn live in poverty (Connolly and Keenan, 2001).

The greatest cause of child poverty is unemployment. High levels of unemployment and underemployment remain a problem in Northern Ireland, despite the official figures suggesting an improvement. The Centre for Economic and Social Inclusion (CESI) calculates a 'slack workforce' figure by parliamentary constituency, where the numbers on government training and work schemes, those underemployed and those not registered as unemployed but nonetheless seeking work are taken into account.

Using International Labour Organisation (ILO) and CESI figures, unemployment rates in parts of Northern Ireland are high to alarming. In West Belfast, for example, the 'claimant count' in February 2003 had unemployment at 9.1 % of the workforce. That same month, the ILO estimated it to be 11.9 %, while the CESI 'slack workforce' figure was 25.4 % unemployed. In the Foyle constituency, the claimant count for the same month is 8.4 %, 11 % unemployed by the ILO definition and the CESI estimate 23.8 % unemployed (Centre for Economic and Social Inclusion, 2003). The CESI figure does seem to be confirmed by anecdotal evidence. For example, a recent recruitment campaign in Derry City, the boundaries of which are co-terminous with those of the Foyle constituency, by Debenhams department store drew 6,000 applicants for some 200 jobs (Derry Journal July 1<sup>st</sup> 2003).

The Labour Force Survey (2003) shows that long term unemployment as a percentage of total unemployed is much worse for NI than any other region of the UK – 43.5% compared to a UK average of 27.5% and 34.2% in the North East of England, which is the next worst.

Larger families are at disproportionate risk of poverty. The DWP estimates that "by 2004 over half of those children in low income will be in large families" (DWP, 2003: 18). Recent research published by the DWP found that "greater hardship was associated with families of three or more children... Couple families with three children were twice as likely to be in hardship compared to families of two children, although the degree of hardship was concentrated at the moderate level. Severe hardship (three or more problems) was substantially greater for families of four or more children" (DWP, 2003: 18). This applied to both lone and two parent families. A study by the Centre for Research in Social Policy, carried out for Save the Children, found that children in families with three or more children were more likely to be in severe and persistent poverty (Adelman et al., 2003). Over a quarter of all families in Northern Ireland have three or more children (NISRA, 2003, Census, 2001), while 43% of all families in low-income households have three or more children; 34 % of these are partnered families, 9% lone parents (Dignan, 2003).

While the fertility rate in NI has dropped considerably in recent years and now stands at 1.9, the region continues to have a higher proportion of children in its population than any other part of the UK, with 36.5% of all households containing dependent children (NISRA, 2003). While there is a greater concentration of larger families in poorer parts of all regions of the UK, there is at least an element of choice for parents in Britain about family size. However, inequality of access across the region to family planning services, particularly emergency contraception, combined with the fact that the 1967 Abortion Act has never been extended to Northern Ireland, results in less choice here over family size.

Part of the Labour Government's 'welfare to work' policy has been targeted at lone parents. In its document *Measuring Child Poverty*, published just before Christmas 2003, the Department of Work and Pensions set a target of getting 70% of lone parents into paid employment by 2010. This target applies also to Northern Ireland. Work carried out in Britain illustrating the difficulties inherent in meeting this target has identified the lack of affordable childcare as the main obstacle to meeting that target (Gregg and Brewer, 2003). Childcare is certainly a huge obstacle in Northern Ireland also. The region never had the benefit of even the relatively small amount of state-funded childcare enjoyed by children in Britain. However, the lack of well-paid work in the region also impacts sharply on lone parents. As a result, even male lone parents are considerably less likely to be in paid employment than their counterparts in England and Wales.

While overall figures for lone parents in paid employment in Northern Ireland are bad, levels of paid employment among lone parents in areas of high unemployment within the region are considerably worse. The 2001 Census revealed that only 9% of female lone parents are in paid employment in West Belfast and just 12.4% in Derry City.

**Table 3.1: Lone Parents in Paid Employment**

| REGION          | MALE LONE PARENTS         |                           | FEMALE LONE PARENTS       |                           |
|-----------------|---------------------------|---------------------------|---------------------------|---------------------------|
|                 | % in full-time employment | % in part-time employment | % in full-time employment | % in part-time employment |
| N. Ireland      | 45.24                     | 6.82                      | 17.49                     | 20.93                     |
| England & Wales | 55.93                     | 6.95                      | 21.43                     | 26.37                     |

*Source: Census 2001, Key Statistics*

Apart from the lack of jobs, the other main obstacle for lone parents who want to be in employment is the lack of childcare. Northern Ireland continues to have one of the lowest provisions of childcare not only within the UK but Europe as a whole (ECNI, 2003). So, in 2002, the number of day nursery places per 1,000 children aged 0-4 was 62.4, compared to 95 in England. Day nurseries, however, play a relatively small part in the range of childcare options used by parents in the region.

Research commissioned by the Equality Commission on the demand for and supply of childcare in Northern Ireland found evidence that affordability and availability were the main problems in relation to childcare for working parents. As a result, relatives and friends play an important role in providing childcare (Gray and Bruegel, 2002). Grandparents were found to be particularly important. Around one in five of the children of working parents, and over one in three of children aged 5-11, are cared for entirely by a relative or friend.

Analysis of the costs of childcare revealed that an important reason for this reliance on informal childcare was cost. The study's authors point to the specific disadvantage faced by lone parents in Northern Ireland as their earnings are about one third lower than the UK average for lone parents.

The research found that the extent to which mothers' employment is supported by formal childcare increases with the mother's earnings. Within the formal childcare arena, childminders are much more likely to be used by lower paid mothers and day nurseries more likely to be used by mothers in professional and managerial occupations. However, it also found that parents who work outside standard office hours have particular difficulty finding childcare.

Lone parents are particularly impacted by this lack of flexible childcare. Women are much more likely than men to have atypical work patterns, such as part-time, short-term or casual employment and working outside normal office hours. 52% of employees in Northern Ireland are atypical workers; 64% are women and 42% are men (ECNI, 2001). In some sectors, this difference is quite marked. For instance, in the hotel and restaurant sector 60% of the female workforce, but only 36% of men were atypical workers. Similarly, in public administration, education and health sectors 72% of the female workforce were atypical employees compared to 52% of males. The childcare difficulties facing these women are compounded by the fact that those in atypical work are more likely to have poorer terms and conditions of employment than those in permanent full-time positions.

The OPCS studies (1989) on disabled children and families in the UK indicated the level of economic and consequent social disadvantage experienced by disabled children and their families. Parker (2000) concludes that 55% of families with a disabled child are living at or on the margins of poverty and households with a disabled child had a greater likelihood of living in poverty than other disadvantaged social groups such as lone parents or families with disabled adults (Parker et al., 2000). It is also worth noting that the British Medical Association notes that poverty and disadvantage can *cause* disability and SEN (BMA, 1999).

There are high rates of disability and long-term illness in NI; the 2001 Census revealed that 41.31% of households have one or more people with a limiting long-term illness or disability. This compares with 34.05% of households in England and Wales. Overall, 21.3% of all persons in Northern Ireland have a disability, higher than the UK generally (18.5%). The age structure of Northern Ireland's population, which is the youngest of all countries in the UK, would lead us to expect a lower rate of disability. People over 60 make up just 17.6% of the population compared to 20.8% in England and 22.7% in Wales. The 2001 Census showed 22,036 children under

sixteen with a disability. The high level of households with disabled people in Northern Ireland combined with an acknowledged paucity of services for people with disabilities impacts greatly on child poverty. The lack of services means that much of the care and support for disabled people comes from other family members, who therefore cannot take paid employment.

Households with employees in Northern Ireland earn on average 20% less than those in the rest of the UK (HMSO, 2000). Twenty one percent of average household income is derived from social security benefits, compared to 12 % in the UK generally. As a result of lower wages and greater dependence on benefits, average household income is 22% lower than the UK average. At the same time, providing necessities such as fuel, light and food costs everyone more - 26% of average household income in NI compared to a UK average of 20%. (Connolly and Keenan, 2001). Since these form a far higher proportion of household expenditure in poorer families, the higher cost of fuel, light and food in the region greatly increases the severity of poverty.

Unemployment, low pay, a higher cost of living, slightly larger families and a lack of access by poorer women to the means of limiting their family size, together with even greater levels of inequality than in Britain, all contribute to the high levels of child poverty in Northern Ireland.

- Children born to poorer families in Northern Ireland are more likely to be smaller and to die at a higher rate than children born to better-off families (O'Reilly and Gaffney, 2001).
- Children living in poverty are 15 times more likely to die as a result of a house fire. They are five times more likely to die in accidents and four times more likely to die before the age of 20 (DHSSPS, 2000).
- Suicide rates among 15-24 year olds are almost three times higher in the lowest income groups than in the other groups combined (General Consumer Council for Northern Ireland, 2002).
- Death rates for Sudden Infant Death Syndrome (SIDS) and unexplained infant deaths are more than twice as high for those families in poorer social classes than for those in social classes I and II (Ballanda and Wilde, 2001).
- The rate of births with a congenital malformation in NI is over twice the level in England and Wales (DHSSPS, 2004).
- In 2002-2003, 88% of children under 2 years in NI had been immunized against measles, mumps and rubella. This compares with 87% in Scotland (in 2002), 82% in England and 78% in Wales ([DHSSPS, 2004). However, the uptake of vaccination and screening services is lower in poorer areas (Browne, 2001; EHSSB, 1995). This may be because families living in deprived areas are more likely to live further away from their GP's surgery and less likely to have a car to get there (O'Reilly and Browne, 2001).
- The incidence of tooth decay is much higher in poorer areas. Again, research suggests that access to dental care is more difficult for families living in poverty (CHIP, 1997).
- In Northern Ireland, the fifth of the population who are most well off have a life expectancy among the best in Europe. For the poorest fifth, life expectancy is closer to that of people in Eastern European countries (General Consumer Council for Northern Ireland, 2002).
- It has been estimated that about 2,000 lives could be saved each year in Northern Ireland if those living in the District Council areas with the highest death rates (the poorest areas) enjoyed the same level of health as those living in the District Council areas with the lowest death rates (the best-off areas) (DHSSPS, 2000).

The following key initiatives are addressed at reducing child poverty:

- Expansion of childcare provision (to encourage parents into employment)
- Children's Fund
- Pre-school education expansion programme
- SureStart
- BookStart
- Fresh fruit in primary schools initiative
- Neighbourhood Renewal Strategy

Funded mainly through New Opportunities Fund and Peace II – with all the difficulties associated with short-term funding, many of the schemes set up are now in crisis because Peace II ended. Most aim to be eventually self-sustaining through Family Tax Credit. The expansion of childcare provision is a key requirement if Northern Ireland is to have any chance of improving levels of employment among lone parents. Indeed, the DWP target of getting 70% of lone parents into paid employment by 2010 applies also to Northern Ireland.

There are a number of problems associated with this strategy. Most importantly, the lack of well-paid work in the region impacts sharply on lone parents. The other main obstacle for lone parents who want to be in employment is the lack of childcare. Northern Ireland continues to have among the lowest provision of childcare not only within the UK but Europe as a whole (ECNI, 2003).

The Executive Programme Fund, which was set up to provide direct support for children and young people in need, made available £32m over 3-4 years; £9m of this made available to community and voluntary sector, the rest to the statutory sector. The Fund seeks to assist in areas such as “child abuse, homelessness, health and well-being, disability and educational outcomes”. However, with ongoing year-on-year ‘cost-savings’ in health and social services Boards and Trusts and given that children ‘in need’ interpreted by Trusts as ‘at risk’, much of the Children’s Fund is going to support the statutory duties of Boards and Trusts rather than to alleviate the effects of poverty on children.

The start of 2004 saw a consultation on a Neighbourhood Renewal Strategy for NI. In it, DSD proposes to resource Neighbourhood Renewal work through a number of different methods including redirecting resources currently spent on tackling disadvantage in towns and villages; bidding for additional money from the government’s annual budget; and, using other external funding sources. In terms of initiatives to tackle child poverty, the emphasis is on raising educational attainment and tackling ‘crime’ and ‘anti-social behaviour’. Potential Neighbourhood Renewal activities are identified under the Strategy’s four strategic priorities of:

- Community Renewal
- Economic Renewal
- Social Renewal
- Physical Renewal

Examples of social renewal activities include:

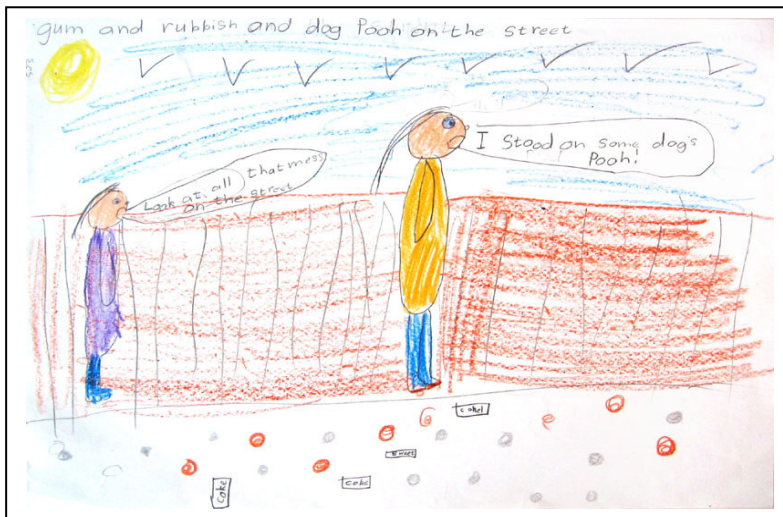
- Helping schools to raise educational standards;
- Making health promotion initiatives more effective, particularly those that deal with issues such as drug and alcohol misuse or teenage pregnancy;
- Making better use of those facilities that are available in Neighbourhood Renewal Areas, for example, using school facilities for community meetings, sports facilities and leisure classes outside of normal school hours;
- Tackling community divisions and tensions, particularly at interfaces; and,
- Reducing the occurrence and fear of anti-social behaviour, vandalism and crime

There is considerable evidence from evaluation of the neighbourhood renewal strategy in England to suggest that it will have no impact on levels of child poverty (ODPM, 2000).

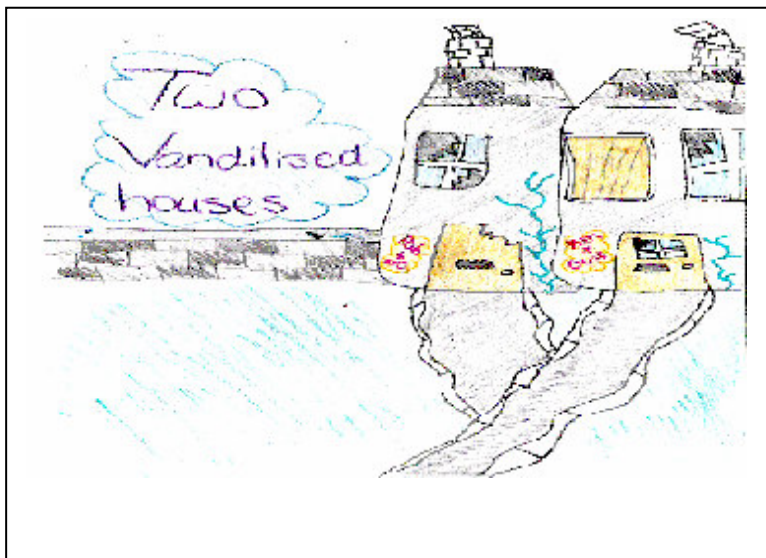
Some interviewees for this research mentioned the potential impact of water charges on child poverty in Northern Ireland. The General Consumer Council - has called on the Government to have an open and transparent debate on the proposed introduction of water charges here (General Consumer Council website). It is crucial that the plans to introduce water charges be child-impact and health-impact assessed (see Chapter 1 regarding the need for children’s rights impact analysis).

## Children's Views on the Impact of Poverty on their area

In the NICCY schools research, however, children and young people voiced many concerns about their area. For example, 309 out of the 582 children and young people who raised issues relating to their area/community (53%) criticised the poor state of their area. These respondents criticised the amount of graffiti, sectarian and otherwise, broken bottles on streets, rubbish, and the lack of bins in their communities. These concerns were most likely to be raised by children from working class areas. As suggested in the following quotes, children and young people were particularly likely to comment on the multiple affects living in poverty can have on their lives. Typical comments included:



"In my area ... there is always glass everywhere you look and last year my sister fell onto glass and cut herself. The oldish people go round drinking on the streets and the little children don't feel safe. Rubbish is thrown about everywhere. They need more bins and the police need to waken up a bit - they don't do anything" (Girl, aged 11).



"My area is stinkin'. It's full of rubbish. The neighbours are drug dealers, drug takers, scumbags or joy riders and they are not very clean to be honest. In my area you won't go one day without seeing a stolen car and being asked if you want to buy drugs. There is an awful lot of anti-social behaviour and loads of fights. Neighbours fighting over something stupid and being left in hospital. There is graffiti, underage drinking and loads of fights and a lot of burnt out cars. Tell Tony Blair we want more cash now!" (Boy, aged 15).

In addition to voicing concerns about the poor state of their area, 126 children and young people (or one in five respondents who raised issues connected with their area/community) expressed apprehension about feeling safe in their area. Once again issues connected with safety tended to be more pronounced among children living in working, as opposed to middle class areas. Safety issues were most commonly raised alongside fears of crime and anti-social behaviour, including drinking on the streets and drugs in the area. In the schools data, these concerns were more likely to be expressed by boys (41%) than girls (33%) and gained increasing importance as children grew older. These children and young people commented:

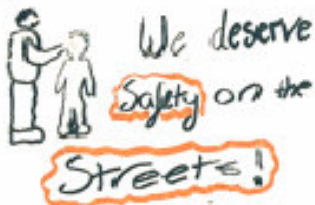
# DRUGS

We should not have to worry about being offered drugs or worry about how to refuse them.








"The streets should be made safer. It annoys me because you have to be in early at the weekend due to gangs being intoxicated and doing stupid things so if you make the streets safer, then you and your parents will have no worries about anything harming to you, or getting into trouble. It is all over the news that more people - young adults - are being attacked and stabbed due to alcohol. Drugs are being sold on your street corners and you can't walk anywhere without people doing drugs and abusing aerosols etc. As a kid you would want the best for your kid and that wouldn't be on the agenda" (Boy, aged 14 years)

# Bullies



"Where I live there is a lot of underage drinking. There are some places you feel you cannot go because of these drunken people. Even on the main road in the public toilets you can see young people drinking and the police just drive past and ignore them" (Boy, aged 15 years).

## Dislikes of our community

-  The dislike of Sectorialism as this may offend people
-  Rubbish all over streets.
-  People breaking windows just for the fun of it.
-  Jay riding in cars maybe even taking people lives.
-  People running about giving people beatings and maybe even killing them.



## **Key issues**

- Link between poverty and poor health;
- Link between poverty and children and young people's self-esteem;
- Link between poverty, poor sexual health and higher rates of teenage pregnancy;
- Rural poverty and isolation;
- Link between unemployment and poverty;
- Need for flexible child-care especially for lone parents;
- Material from school children re lack of services/environmental problems;
- Need to child-impact assess and health-impact assess plans to introduce water charges.

## **HOMELESSNESS**

*The right to life, survival and development includes the right to decent housing (Art. 6 CRC). Charter of Rights (Council of Europe) and ICESCR contain rights to housing.*

### **Context**

Research demonstrates that family and relationship breakdown is one of the most important contributory factors to homelessness, particularly among young people (PRECiS No 145 & McCrum, 2001: 4). This was confirmed by interviews with professionals, NGO representatives and young people at risk of homelessness. Interviewees working with homeless young people explained the circumstances which could lead to that situation:

"... for many young people homelessness comes about as a result of growing up, finding their feet, establishing their independence, leaving home and striking out on their own - for some young people things don't go as expected or to plan, for some young people there's not the back-up or support of family or support of family and for some young people the whole process is too daunting and for one reason or another things go wrong" (NGO written submission).

Circumstances which can lead to homelessness include differences between the young person and their parents, the arrival of a new partner/step parent, lack of opportunities for young people in terms of employment etc and parents being unhappy for the young person to remain at home and/or the young person becoming involved in some form of activity that the parent is not happy with, for example drinking, drugs and sexual activity (NGO submission confirmed by focus group discussion with NGO Workers).

The impact of homelessness on children and young people goes way beyond the simple absence of appropriate housing: it affects their education, job prospects, social life, relationships and self esteem. Being homeless or living in poor housing can adversely affect children and young people's mental health (Shelter, Aug 2000: 1; McCrum, 2001:9). The negative effects of homelessness on children can have long term consequences for their lives as adults, placing an individual at risk for life (McCrum, 2001: 9) Women and girls who have a mental illness and are homeless suffer 'double disadvantage', first because of their gender and their vulnerability to violence and sexual harassment and threats and second because of their mental health problems (Shelter, Aug 2000: 1).

Unpublished research carried out by Queens University/Simon Community with young people at risk of homelessness and living in hostel accommodation noted that the young people felt that homelessness made the following impacts on their lives:

- Often no relationship with GP – many residents have to register with a new GP when they come to stay at the project.
- Often receive anti-depressants on a first 5-minute visit without any past history being known.
- Records too slow to cross Trust boundaries.
- Stigma of homelessness – residents feel that GPs do not treat them seriously.
- Inability to talk openly and honestly with GPs.
- GPs often unwilling to talk to staff who are acting as advocates for residents
- Residents are mainly smokers.
- Alcohol issues – not taken seriously by GPs.
- Poor diet due to money issues.
- Subject to colds, flu, and contagious illnesses.
- Poor nutrition/diet.
- Poor personal hygiene.
- Apathy.
- Depression – again treated by medication.
- Self harm – not taken seriously by services.
- Sexual health issues – STDs.
- Little interest in learning to cook.
- Little interest in healthy eating.
- Insufficient funds to purchase good food and fruit.
- Take away food.
- Quick cook or microwave food.
- Not enough money to purchase winter clothes.
- Not enough money to purchase footwear.

Research in England and Wales found that levels of substance use among young homeless people is considerably higher than that of the general population. Drug use may contribute to and exacerbate their homeless situation therefore, “strong links need to be made between drug services and homeless agencies” (Home Office, 2003:190). However, young people at risk of homelessness warned that assumptions should not be made about them simply because they were homeless, complaining that they were unfairly ‘labelled’ by adults and by other young people because of their homeless status:

*“Other kids our age like they can slag us all they like, saying ‘You live in a hostel’ but they would not be able to have, I can guarantee you that after two nights of living away from the house they’d be balling their eyes out, do you know what I mean? They think they’re all hard, they don’t know what it’s like. £40 a week we have to live on, imagine them, £40 a week” (Young person at risk of homelessness).*

The Committee included homeless children in its list of vulnerable groups to which the state should pay special attention (UN, 2002: para 15). The Committee was concerned at the incidence of poor housing and homelessness (ibid.: para 43) while welcoming the introduction of new legislation in England and Wales (ibid.: B). Professionals and NGO representatives interviewed for this research criticised legislation in Northern Ireland as falling short of the England and Wales model. The Housing (Northern Ireland) Order 2003 is the key piece of legislation governing housing in Northern Ireland. It places a statutory duty on the Northern Ireland Housing Executive to provide temporary and/or permanent accommodation for certain groups of homeless people. Pregnant women and people with dependent children are assessed as having priority need for accommodation (Art. 5 of the Homelessness Provisions of Part II). Young people (aged 16-21) who are at risk of financial or sexual exploitation also have a priority need (Art. 5 Homelessness Provisions of Part II). In England and Wales *all* homeless 16 and 17 year olds are considered to be in priority need (Homeless Act 2002). Interviewees working with homeless young people in Northern Ireland argued that our children’s rights are being breached by this difference in treatment, stating that the legislation in Northern Ireland leaves children and young people open to potential harm. The point was made strongly that *all* homeless young people are vulnerable and that legislation must protect them accordingly.

Under the Children (Northern Ireland) Order, Health and Social Services Boards and Trusts also have a duty to provide accommodation for 16 to 18 year olds whose welfare is likely to be “seriously prejudiced” without accommodation. Health and Social Services Boards also have a duty under the Children (Leaving Care) Act (NI) 2002 to provide advice and assistance to 16 – 21 year olds who have been in care. Research by Pinkerton and McCrea (1999) found that at least one quarter of young people who have been in the care system become

homeless within six months of leaving care. An NGO submission argued therefore that "further work and resources should be targeted on these young people, to inform them of their housing options and equip them with the tools to live independently, thus preventing homelessness" (NGO submission). While children leaving care are a priority group, one young interviewee noted that young people without social services involvement also find it difficult to access accommodation:

"If you're part of the Leaving Aftercare Team or something like that then you're grand 'cos you've got your social workers helping you but if you haven't got anyone, then you're stuffed" (Young person at risk of homelessness).

"There are still a lot of young people turned away and told you're single, and not a priority need ... Young people rarely get priority need" (Housing Support Professional).

When a person or family applies to the NIHE for housing four tests must be met: homelessness; priority need; intentionally (i.e. the person should not have intentionally made themselves homeless) and acceptable behaviour. The latter (a new clause implemented from April 2004) allows the NIHE to take into account the unacceptable behaviour of an applicant, *or a member of their household*, which would make them unsuitable to be a tenant of the NIHE. NGO interviewees commented negatively on this fourth test which they felt would contribute to increased homelessness and was also unfair to family members including other children:

"Siblings can be penalised for the other's behaviour. Where does that family go? We are getting cases through where people are excluded on the grounds of their children's behaviour: 12 year olds - children with special needs. What is anti-social behaviour? There may be underlying reasons for it. Children may be attending the local school - it is hard to get them into another school" (Housing Worker).

Workers also commented that young people aged 16-18 rarely get priority need status and teenagers at risk of homelessness confirmed that it was difficult for them to accrue points under the NIHE system:

"The most points you get in here like 30 points, that's it, that's the lot like you get from the day you move in [to the hostel] to the day you leave after two years. And that's not enough points to get a house in Derry" (Young person at risk of homelessness).

The extent of homelessness is difficult to establish because Government only systematically collects statistics on those homeless people who have applied to local authorities for help. Young people who, for example, are sleeping on the floor of a friend or relative because they have nowhere else to go would not be included unless they had applied to the NIHE for assistance. Yet the impact of living in this fashion should not be underestimated. A teenage interviewee in Derry/Londonderry explained that sleeping on someone else's sofa on a long-term basis is "fucking crap" and told how at weekends when his host was having guests he had to leave and find somewhere else to stay.

NIHE figures show that in 2003/04 the Executive assessed 17,150 households presenting as homeless. At 31st March 2004, 5287 households registered as homeless on the Housing Executive's waiting list. There were 237 single males aged 16-18 presenting as homeless in 2003-2004 and 328 single females of the same age. In 2003-2004 5,924 families presented as homeless. It is particularly difficult to get an accurate picture of the extent of child homelessness as NIHE statistics refer to families with dependents but do not collect information on the numbers of children involved. NGO interviewees considered that it is important to obtain this information so that the extent of child homelessness is known.

NGO workers agreed that homelessness among 16 and 17 year olds is a key priority which must be tackled head on. They noted the difficulties for young people in getting enough points in the NIHE system to secure accommodation. There was insufficient accessible information for young people on their rights relating to housing. Difficulties in the private rented sector were also noted: conditions here were likely to be worse and more health threatening than in public sector – for example through dampness or faulty wiring - and young people were in danger of signing up to contracts with landlords which they could not meet, therefore risking being evicted. It was noted that housing benefit did not always pay the full amount of the young person's rent and there would be a shortfall to make up. One worker said that "this is the biggest issue for us with the private rented sector. Some people go to loan sharks. They end up being evicted. The Executive find them intentionally homeless." Young people under 25 cannot get single accommodation paid for them in the private

rented sector: only a single room. While this may sometimes be preferable, for some young people it may be inappropriate or lead them to being placed in a vulnerable situation. Difficulties for young people who may have had a breakdown in relationship with their family in getting a guarantor for tenancies was also mentioned by several interviewees.

Interviewees also concurred on a lack of suitable hostel or supported accommodation for under 18's, particularly for girls. Young people needing hostel accommodation were often placed with adults, many of whom had mental health, drug and alcohol problems. Concerns were also raised regarding the lack of PECs (child protection) checking for people running bed and breakfast accommodation: "depending on the caseworker, checks may be done on proprietors but there is no requirement" (Health and Social Services Professional.).

Workers involved in homelessness as well as young people were agreed that the particular circumstances of Northern Ireland, with its sectarian geography, makes placing young people in safe accommodation even more difficult. A worker gave a case example to illustrate the point:

"We had a woman recently who was moving out with nowhere to go and had to present as homeless and ended up in a hostel in East Belfast, in an area that she just wasn't safe in - she was catholic - and was absolutely terrified, living in a homeless hostel. She has since been moved but really was quite a dangerous move for her. But it was all the homeless section had that day. They're doing their best but ... there's so much competition for housing that even being classed as homeless and having a baby is not enough to get somewhere reasonable to live. It's a massive issue" (NGO Worker).

Key strategies for tackling homelessness include the NIHE Homelessness Strategy (2001) and the Supporting People Initiative. New TSN and PSI also aim to tackle homelessness. Again, there is disparity between the situation in Northern Ireland and that pertaining in Great Britain. In England and Wales there is a statutory duty on local authorities to produce a homelessness strategy every 5 years (Homeless Act 2002 section 1(4)). In Scotland there is also a statutory requirement on local authorities to produce and submit to Ministers a strategy for prevention and alleviation of homelessness in their areas (Housing (Scotland) Act 2001 Section 1). There is no statutory requirement on the NIHE to produce a homelessness strategy. The PSI working group on homelessness (legislation subgroup) recommended that a statutory duty to produce a homelessness strategy should be placed on the NIHE (PSI Working Group on Homelessness, 2003: para 3.4).

A research review of homelessness for the Northern Ireland Assembly warned that "of concern ... is the position where capital costs associated with new build provision for supported accommodation will have to enter competition over a 3-5 year period for funding." (Northern Ireland Assembly report: 28). The report went on to state that "additional strategy implementation costs" will be in an annual competition for scarce resources and that as many of these areas of activities are outside the statutory duty of NIHE, (for example information, advice and education), there is a danger that these elements of the homelessness strategy will be marginalised" (NI Assembly, 2002: 28).

In interviews and focus discussions workers and young people were keen to stress that finding someone accommodation is not enough to solve the problems facing young homeless people. Indeed, they saw it as only the start of the journey. Many young homeless people, especially those leaving care, will require support in a range of ways from how to budget, run a home and cook for themselves, through to issues such as health care, relationships, education and drugs and alcohol: "There is no holistic service in Northern Ireland" (NGO Worker). A submission from the Foyer group noted that "what marks foyers out from other solutions to housing need amongst young people is their holistic approach to breaking the no home: no job: no hope cycle experienced by many homeless and marginalised young people. In particular they focus on assisting young people into education, training and/or employment". Interviewees – professionals and young people – were agreed that there should be more emphasis on supporting young people once they are provided with accommodation. The point was made several times that most young people in Northern Ireland are still living with their parents until their early 20s and at 16 and 17 would not be expected to cope by themselves with running a home.

Young people at risk of homelessness expressed concern about aspects of their lives in hostels including the lack of privacy; what they felt to be over-strict rules which would not apply to young people in family homes (such as guests having to leave by a set time); hostel managers passing information about young people from one hostel to another so that if a young person was barred from one hostel they would then find themselves banned from other hostels in the same area; having to leave some hostel accommodation if they found employment or in the case of young women if they had a child. One young person in Derry/Londonderry complained about being

"treated like a wain (child)" (young person at risk of homelessness). Another young person at risk of homelessness described the hostel environment as being like "big brother." The young people felt that they were not given enough accessible information about their rights on moving into supported accommodation. One commented that in signing the contract "you're signing away your rights." Those involved in providing hostel accommodation explained in interviews and focus discussions why it was necessary to invoke some of the rules that existed and to check on a young person's status before admitting them to a hostel, nonetheless they shared the young people's concerns that they were unable to enjoy a 'normal private life' in comparison to other young people.

Education on homelessness was considered important by both young people and workers. Education packs for school children such as that devised by Shelter (Shelter, 2002) were thought to be a good idea both in terms of breaking down young people's prejudice against homeless people and also in the prevention of homelessness. Education on homelessness for those working with young people was also considered important.

### **Immigration & Asylum**

Under the Children (NI) Order 1995 it is the duty of every Board to safeguard and promote the welfare of children within the Board's area who are in need (A specialist working in the asylum field noted that "by the fact that a young person presents seeking asylum with no identified parental figure, family member or appropriate adult, that young person is legally deemed to be a child in need"(Health and Social Services Professional). Art. 21 of the Children (NI) Order 1995 places a duty on Health and Social Services Boards to provide accommodation for vulnerable children. The same professional noted that:

*"Given previous experience and knowledge and the issues faced by young asylum seekers, I have found semi-supported and supervised accommodation is mutually beneficial as it provides safeguards and security for the young person, with familiar faces and a level of support and advice that can ultimately lead to improved independence in an 'unfamiliar' country. It also provides the relevant worker with some feedback in terms of the young person's social, emotional and physical development, from a more thorough perspective".*

This interviewee raised concerns regarding the severe shortage of placements for children seeking asylum under the age of 16. One child had ended up being placed, inappropriately, in a children's home "while it attended to his immediate accommodation needs, the young person witnessed behaviours from some young people who had been placed in the Residential Unit for behavioural difficulties and offending behaviours, he was also subjected to racial taunts by some of the other residents".

### **Young gay and lesbian people**

Research carried out by the National Centre for Social Research found that being lesbian or gay can cause young people to become homeless, although homelessness of young lesbians and gay men could also be entirely unconnected to their sexuality (National Centre for Social Research, 2001:2-3). While young lesbians and gay men face the same problems as all homeless young people, their sexuality could also add to the difficulties experienced. The four main ways in which their experience differed was in terms of the degree of emotional distress; difficulty coming to terms with their sexuality; homophobia perpetuated by staff, service users or other homeless people; and invisibility because of lack of awareness amongst some service providers (ibid.: 4-5). The report recommended monitoring of young gay men and lesbian's situation, sexuality awareness training for staff and a greater understanding of the needs of this group. A focus group for the NICCY research made up of representatives and workers who work alongside gay, lesbian, bisexual and transgendered people noted that the difficulties for young people in accessing accommodation can be exacerbated by the nature of segregated housing in Northern Ireland

### **Traveller children**

The right of Traveller children to safe and healthy accommodation was mentioned by many interviewees who condemned the current situation for Traveller children. A worker stressed that this issue "underpins the realisation of Travellers' other rights" (NGO Worker). Under the Housing Order (NI) 2003, responsibility for serviced sites was transferred from District Councils to the Housing Executive with effect from the 1st December 2003.

The Northern Ireland Housing Executive carried out a needs assessment of Traveller accommodation over an eight month period from January to August 2002. The findings showed 42% of Travellers are living in social housing, 21% in serviced sites and 11% on the road side. When asked about accommodation preference 42% of Travellers expressed a preference for social housing, 14% for Serviced Sites and 38% for Group Housing (NIHE website). An NGO worker described the transfer of responsibility to the Housing Executive as a "success story" however, he considered that there were three obstacles to progress: "financial resources; problems/delays in identifying sites; planning - the traditional blocking mechanism". Overcoming these obstacles was a key concern expressed by a group of children from the travelling community who participated in the NICCY research. All of these children highlighted the need for better site facilities, with some asking for travellers to be giving the option of living in houses.



In May 2004 Government announced plans to 'crack down on' unauthorized camping sites in Northern Ireland. These plans were criticized by the Equality Commission which raised concerns about the introduction of law which criminalises unauthorised camping. "The Commission recognises and understands the issues raised by unauthorised camping sites, but is concerned with the intention to proceed with this law while adequate accommodation for Travellers has not been made available" (Dame Joan Harbinson, Chief Commissioner of the Equality Commission, 2004).

### Homelessness through intimidation

Since the early 1970's thousands of people in Northern Ireland, including children and young people, have been forced from their homes through intimidation, mainly on a sectarian basis but also through inter-community disputes and feuds and paramilitary punishments. Darby and Morris estimated that between 1969 to 1972, between 8,000 and 15,000 families – most of whom were Catholic - were forced to leave their homes (Darby and Morris, 1974). Smyth records that more recent trends have also shown Protestants moving out of certain areas: Belfast, Derry/Londonderry, and parts of Fermanagh and South Down: "Segregation is deepening and internal displacement continues to be a problem for some families, particularly those living on interfaces" (Smyth, 1998: 15). NIHE figures show that in 2003/04 1245 households stated that intimidation was a reason for their homelessness - a fall of 22% on the previous year.

Several NGO workers mentioned the fear that in future young people or families may suffer 'double punishment' whereby they could be intimidated from a community by a paramilitary group and also punished by the state either by being given an Anti-Social Behaviour Order or being refused public housing because of their alleged anti-social behaviour. A worker noted with alarm that an adult had recently been deemed ineligible for public housing because he was on a "paramilitary hit list" (NGO Worker). He feared that this may soon also happen to children.

As well as intimidation on a sectarian basis, children and young people in Northern Ireland are also at risk of homelessness through homophobic attacks and racial attacks on them and their families.

The impact of segregated housing was mentioned by many interviewees who work with homeless young people. Sometimes the only accommodation available for a homeless young person would be “in the wrong area” and even if accommodation was in an area of the same religious demography as the young person it could be in an area that they did not know and were nervous about. One housing worker made the point that sending a young person from North Belfast to East Belfast, for example, would be like sending them “to the other side of the world”.

### **Children with disabilities**

A review of research and policy on services for children with disabilities and their families (Kelly and Monteith, 2003) found that accessing appropriate housing was a problem for these families in Northern Ireland. Monteith et al., (2002) found that in 1990, families of disabled children were less likely to afford their own homes than families without disabled children. They noted there is no public finance available for families who need to move to a new home with more adequate space for their disabled child. Kelly notes that research (McKeever, 2000) shows that the accommodation needs of children with disabilities and their families are complex and change as children get older. Monteith et al. recommend increased disability awareness among those designing new homes (cited in Kelly and Monteith, 2003).

A submission to this research from an NGO stated that “research suggests that families caring for severely disabled children are likely to be living in homes that are unsuitable, with lack of space for those caring for a person with physical disabilities or behaviour disabilities being a key problem”. This NGO which works with children and young people with disabilities and their parents stated that in its experience many parents are faced with having to meet the costs of adapting their home environment from their own financial resources. It recommended an accurate assessment of the housing needs of children and young people with learning disability and their families in Northern Ireland and that design of houses in the private and public sectors should reflect the needs of families who care for children with disabilities.

### **Key Issues**

- Lack of statistics and information on child homelessness;
- Problems for single young people aged 16 and 17 in getting accommodation;
- The definition in the housing legislation of vulnerability - all young homeless people are at risk and legislation must reflect this;
- Shortage of suitable hostel accommodation;
- Unsuitable environment in hostels – young people mixed with adults who may have drug and alcohol problems;
- No female only hostels for under 18’s;
- The ‘4<sup>th</sup> test’ in Housing Legislation regarding anti-social behaviour will create problems for young people and their parents and will simply move the problem of anti-social behaviour on to another community;
- Difficulty for young people in accessing private rented accommodation (eg getting deposit and someone to act as guarantor);
- Shortfall in payments made by NIHE to young people in private rented accommodation;
- House conditions in private rented sector;
- Lack of support e.g. education, emotional support for young people when given the keys to their home;
- Lack of privacy and respect for the rights of young people in hostels including their right to a private and family life;

- Provision of safe and healthy accommodation for Traveller children;
- Provision of suitable housing for young people with disabilities;
- Increased disability awareness among those designing homes;
- Need for increased provision of supported housing;
- Need for education on homelessness for both children, young people and workers.

## EMPLOYMENT AND WELFARE

*CRC Art. 6 (right to life, survival and development); Art. 12 (Participation rights).*

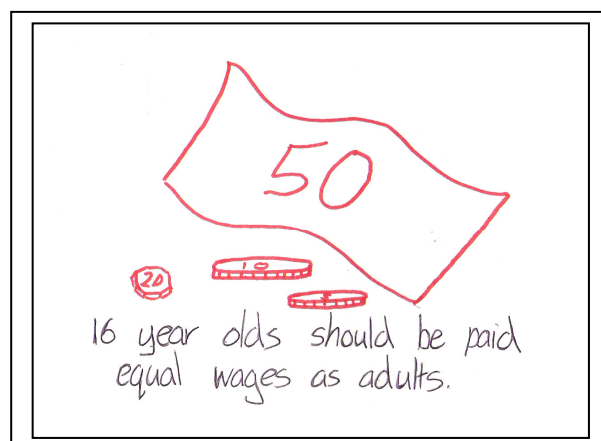
### **Context**

The Committee on the Rights of the Child expressed concern in 2002 that the national minimum wage did not apply to under 18 year olds noting that these young people were at risk of economic exploitation (UN, 2002: para 53). The Committee recommended that the state reconsider its policies regarding the minimum wage. In March 2003 Government announced that from October 04, 16 and 17 year olds would be paid a minimum wage of £3 per hour. The rate for young adults aged 18-21 is £4.10 and for adults £4.85.

However, young people under 19 years of age who are in apprenticeships, for example those on New Deal voluntary programmes, will not be given the protection of the minimum wage.

Dr Paul Dornan of the Child Poverty Action Group welcomed the announcement of the minimum wage for children but said £3 an hour was too low: “It must be increased on a regular basis to make sure that young people continue to get the income protection they deserve” (Cited BBC News Online, 15/03/04). Information for young people on their right to a minimum wage is crucial. British Youth Council research found that none of the 3,000 young people interviewed in a recent study knew how to enforce their right to a minimum wage. Nor did young workers know about their rights to holidays or health and safety protection (Unison website). An advice worker with an NGO in Belfast confirmed that many young people in Northern Ireland would not be aware of their rights in relation to employment law, nor would they always have the confidence to ensure that their rights were not breached. Consequently, children in employment could easily be summarily dismissed from their jobs and they would not make a complaint. The point was also made that there is inadequate regulation of children’s employment, particularly by the education and library boards which have responsibilities in this area (an NGO Worker).

A study for the Children’s Law Centre found that almost 12% (124) of young people surveyed had issues regarding discrimination in employment. The majority of these issues related to the age of legal employment and unequal payment due to age. A 16 year old complained that, “I am not treated fairly in employment as there are people older than me earning more for doing the same job” (CLC, 2004: section 4.9). The same issue arose in the NICCY schools research where young people rejected lower wages as discriminatory on the basis of their age.





The unadjusted youth unemployment rate in Northern Ireland was 8.5% of those aged 18-24 between February and April 2004. This represents an increase of 1% on the figure one year previously (Barometer, 2004).

- Research carried out with young people at risk of homelessness in Northern Ireland found that the following issues were of concern to the young people relating to the welfare benefits system: Benefits – too low to be able to live on - £40 per week.
- Young people who genuinely want to achieve a career and go on a training course are discriminated against as they only receive the £40 per week training element (if they do two days a week at college and on placement three days per week.). However, others at age 16 who choose to go back and resit exams are able to get the £30 enhancement to stay on at school plus the £40 benefit payment. Therefore, those with a clear career path and motivation are £30 per week worse off.
- Young people coming into hostel accommodation tend to leave full time education soon after admission due to circumstances surrounding their leaving home, peer pressure and apathy
- Young people earning £40 per week (and who often have to leave the project at 7.15am to get to training at 9.30am, returning at 6.30pm) have difficulties paying for work clothes, boots etc?
- Young people who decide to take up employment have difficulties paying their rent of £45+ particularly when they normally have to do a 'lying week' and in some small companies get no holiday pay for the first 6 months.

Young people at risk of homelessness interviewed for this research made similar comments, complaining that £40 per week is not enough to live on "who can live on £8 per day for their breakfast, lunch and dinner?" (Young person, at risk of homelessness). Getting paid on first signing on was a problem for some with it taking some weeks to sort out their benefit arrangements. The support of other young people in the same situation was thought to be vital: "in here if you run out of money your mates will provide you." Crisis loans were hard to get and benefits staff could be unsympathetic. One young woman said that when applying for money a staff member had just laughed at her. Others young people at risk of homelessness commented:

"The Dole tell you nothing"

"You can sign on at 16 and get a crisis loan from 16 but they don't tell you that."

An NGO worker involved in providing benefits advice noted that front line benefits staff were often inadequately trained in dealing with queries from 16 and 17 year olds. While some young people came to the advice centre to query the information they had been given, it was thought that others had probably simply gone away not realising that they were in fact entitled to benefits. Improved training for staff was recommended both in terms of the information being given and in dealing appropriately with young people. Chapter 1 also discusses these issues in relation to right to access information and advocacy services.

### **Key issues**

- Discrimination against children in lower minimum wage;
- Need for more effective monitoring of children's employment;
- Inadequate level of welfare benefits for young people;
- Lack of accessible information for young people regarding benefits and employment rights;
- Need for more effective training of frontline benefits staff;
- Need to ensure that benefits rules do not result in young people having to turn down employment in order to stay in hostel accommodation.

## **TRANSPORT AND ENVIRONMENTAL RIGHTS**

*The right to life, survival and development (Art. 6) Right to health (Arts. 23 & 24); Right to participation (Art. 12).*

## Context

Finding ways to encourage children to travel to school using healthy and sustainable travel methods, as well as ensuring their safety while doing so were key issues raised during consultation on Planning for a Health City (Healthy Cities Belfast, 2003). The BMA notes that: "road traffic presents a major risk for children's health and safety and all relevant government departments should facilitate and promote active play in a safe environment, establish traffic free zones, safe walk to school routes, cycling lanes and play streets"( BMA website, 2004. Safety for children on the roads was raised as a key issue by school children and health professionals and NGO workers in this research.

A recent Barnardo's study on child and road safety (a UK study which included interviews with children in Belfast) found that the UK has one of the worst track records for child pedestrian casualties in Europe (Barnardo's, 2004:3). The research found that the risks of being killed or injured are greatest for children living in areas of high deprivation (ibid. :4). Children living in areas of high deprivation are five times more likely to be killed in a road crash than those in wealthier households (ibid.). Road safety concerns meant that children are increasingly prevented from walking, cycling and playing in safety (ibid.). Yet, 94% of children said that they would rather spend more time outside of their homes (ibid.). Among Barnardos's key recommendations are that legislation should be introduced to make 20mph the default speed limit in residential areas and near schools; increased funding for traffic calming; providing safe routes to school; imposing a planning requirement that all new housing developments include children's play space (ibid.:2).

Government has adopted a 10 year Road Safety Strategy for Northern Ireland (a partnership between the police, the Department of the Environment and the DRD). This has contributed to a reduction in deaths. Last year there were 1,435 people killed or injured on NI's roads – an 18% reduction on the five year average between 1996-2000. The number of child victims fell from 250 to 171 (31% reduction) during the same period. The strategy's eventual target is to cut overall figure by 33 per cent, although campaigners bidding to halve number for children (News Letter 7 October, 2004)

According to a survey carried out in April 2004, 22% of children aged between 10 and 13 years of age, 23% of children aged between five and nine, 12 % of children aged between one and four and two per cent of children under one year, continue to travel without wearing seat belts (information presented in press release from health and public safety Government minister Angela Smith, 28/06/04).

Fears about road safety leading to children being effectively house-bound were also raised by NGO workers. While parents' fears are understandable it was felt that children are being denied their right to independence and play (see Chapter 5). However, as one health professional noted, the problem is not necessarily in attitude but relates to actual risk:

"In Derry I was in a home where a young mother had been in the house for days and I was going to suggest taking the baby out for a walk but then noticed there weren't any pavements. We need pavements and cycling lines to enable us to go out safely".

Two key issues emerged in relation to road safety in the NICCY research namely the dangers that children are placed in when they are forced to play at the side of busy roads and secondly, the lack of adequate facilities to ensure that children are able to cross the road safely. The children and young people commented:

"My area has no playing facilities and nothing to do. There are no places where we can play football or just run about and play something else. It is just all roads and nowhere to play. It could be dangerous for young children who want to play and they would go onto the roads and they could get knocked down and get hurt or even killed! All the facilities are too far away from where we live" (Boy, aged 14).

"I live on a road near a roundabout and I think there should be traffic lights there, so that it is safer to cross the road and easier to get our car onto the road in the morning so that I can get to school on time" (Boy, aged 11).

"In my area there is no grass to play on so sometimes we go down to the local park but the road we have to cross is really dangerous and there is no traffic lights to help us cross the road" (Boy, aged 11).

As well as raising issues connected with road safety, concerns were also expressed about public transport. Issues raised included poor public transport, poor roads and slurry on roads, with the latter being raised by children living in rural areas. Over half of all responses were raised by females (55%) and one in seven of all those who raised this issue were aged between 15 and 16 years, perhaps reflecting the point that once children get older they increasingly desire to spend more leisure time away from their own community. The following comments are typical of the main issues raised:



"They should have transport for every town because it is not fair form some towns to have it and not others. So transport should be for everyone" (Girl, aged 15).

"The speed of cars on the road is crucial. The road I live on is really bad. It was dug up and resurfaced last year. People thought it would make the road safer. Yeah right! Cars fly up the road at 100mph, no exaggeration! It's a racing track. It's mostly young boys who do it" (Girl, aged 14).



"I live in the country and there is no transport. There is a bus stop but no bus so if I want to go somewhere I have to get my parents to take me so we need a bus. And there is a village near us, but if you stop in it, you might get beat up because it is a dirty hole and there should be more police in the area because sometimes the people throw eggs at cars and snowballs and they graffiti" (Boy, aged 13).

The need for children to be actively involved in planning decisions for their areas, and for planners to conduct child-impact assessments on any proposed developments was considered crucial. Belfast Healthy Cities provided a positive example from Ballybeen in Belfast where children had been involved in contributing their ideas through building a model, to a project for a development in the area.

### Key issues

- Need to continue reducing number of child road deaths through road safety strategy;
- Need to make local areas safer for children to ensure their right to play and right to health;
- Need to involve children in decision making about planning decisions for their area;
- Need to carry out child-impact assessments on any proposed developments/planning decisions.

## **KEY PRIORITIES**

- Statutory agencies must be encouraged to respond to the evidence based link between poverty and poor health in children, young people and their families.
- The rates of benefit and minimum wage for 16 & 17 year olds must be raised and accessible information must be provided on the range of benefits and entitlements available to them.
- Multi-agency approaches must be developed to guarantee appropriate services to meet the physical and mental health needs of children and young people.
- Child and adolescent centred health care services in which children and young people have the opportunity to fully participate in decisions about their health care must be developed.
- Urgent provision of fully resourced and appropriately staffed mental health services for children in care, secure accommodation and custody throughout Northern Ireland must be put in place.
- The serious lack of adequate accommodation and support for 16 and 17 year olds leaving care or who are otherwise homeless must be addressed.
- Regionally based, accessible and comprehensive sexual health services for young people including age appropriate awareness raising should be promoted.
- Inequalities and discrimination in health care policies and practices for children from ethnic minorities, children with disabilities and GLBT young people should be challenged.
- Community safety strategies and initiatives to accommodate and recognise the physical and mental health needs of children and young people should be developed.