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HEALTH AND WELFARE

5.1 Introduction

This chapter encompasses a wide variety of issues that relate to children's health and welfare, recognising that these concepts are, in many ways, interlinked and overlapping and noting their relationship with other key concepts within the Convention explored elsewhere in this report.

The chapter begins with an overview of the expectations of the Committee in relation to the promotion of health and welfare amongst children and young people, before proceeding with a brief overview of the current situation within NI in this regard. The role of health promotion is then considered, followed by an exploration of key elements of children's physical, sexual and mental health. The issue of substance use amongst children and young people is also explored, as are the particular inequalities in health and access to health services experienced by a number of especially vulnerable groups.

Moving beyond the issue of health, the chapter presents an examination of the issues of poverty and homelessness and the ways in which an experience of either can negatively impact upon children and young people's lives. The chapter concludes with the identification of a number of priority action areas that must be addressed if children's rights to health and welfare are to be effectively progressed.

5.2 A Rights-based Approach to Health and Welfare

Considered holistically, children's rights to health and welfare/wellbeing are central to, and pervade all elements of, the Convention. Rights to protection, education and appropriate care, to name but a few, are all of direct relevance to the health and wellbeing of children and young people. A number of articles are, however, of particular relevance to an evaluation of health and wellbeing: these include the four general principles of the Convention (in particular article 6) and articles 23, 24, 25, 27 and 33.

Article 24 of the Convention places an obligation on States to recognise the right of all children to enjoy the highest attainable standard of health and to access facilities for the treatment of illness and the rehabilitation of health where required. Part 2 of the article places a series of specific obligations on States with regard to pursuing full implementation of this right, including provision of necessary medical assistance and healthcare and investment in primary health care, nutrition and health education. Article 25 places an additional obligation on States to ensure that all children who are placed in medical or other placement types (for the purposes of care, protection or treatment of physical or mental health) receive periodic reviews of both their placement and the treatment received.

Moving beyond the issue of health, article 27 addresses the right of all children to enjoy an adequate standard of living. As previously explored within chapter 4, the provisions contained within this article are closely associated with those in articles 5 and 18 (parental responsibility and state assistance for parents) and article 26 (a child's right to benefit from social security). The remit of article 27 is, however, much wider than simply fiscal or material:

"Article 27 recognizes that the child's development cannot be divorced from his or her conditions of living. By listing the different components of full development – physical, mental, spiritual, moral and social – article 27 makes clear that an adequate standard of living is not just limited to the basics of food, clothing and housing, important though these are" (UNICEF 2007:394).

As highlighted above, article 27 ties in closely with article 6 (the right to life, survival and development) and the unequivocal obligation on States to ensure this right 'to the maximum extent possible'.

Article 23 provides for the specific care of children with disabilities and the additional provisions that they may require to enable them to enjoy 'a full and decent life in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community'. Article 33 outlines the State's responsibility to protect children from the use of illicit substances.

As with all the articles of the Convention, these provisions should be interpreted in light of both the four general principles of the Convention and the other articles contained therein. They should also be considered in light of additional commentary by the Committee and other relevant international rights instruments including:

- General Comment Number 4 on 'Adolescent Health and Development'
- General Comment Number 7 on 'Implementing Child Rights in Early Childhood'
- General Comment Number 9 on 'The Rights of Children with Disabilities'
- Article 12 of the International Covenant on Economic, Social and Cultural Rights.

5.3 Overview of Children's Health and Welfare in Northern Ireland

Children's rights to health and welfare, as outlined above, are (with a few notable exceptions) potentially some of the less contentious rights within NI. Few would disagree that all children should have the right to positive health, adequate healthcare and a standard of living adequate for their survival and development. Yet in spite of this, many children and young people fail to access the support and services they require to make these rights a reality.

Significant efforts have been invested in recent years at a strategic level in relation to the consideration of issues impacting upon children's health and welfare. Pertinent examples include the Bamford Review, the work of the Suicide Taskforce, the Committee of OFMDFM Child Poverty Inquiry, the Speech and Language Therapy Taskforce and the Promoting Social Inclusion (PSI) Working Group on Homelessness.

Whilst the work of these committees and taskforces is to be welcomed, the fact that their findings and recommendations have not yet, in the main, been translated into concrete action is a matter of serious concern.

As highlighted throughout this chapter, it is imperative that the government progresses the findings and recommendations of the various review groups and taskforces that it has established in recent years, if the efforts invested by these groups are not to be in vain. It is imperative that it does so in a coordinated and strategic manner, given the frequently overlapping nature of the issues impacting upon children and young people's health and welfare. It is also imperative that the strategies and action plans introduced to progress deficiencies in these areas be congruent not only with each other but also with the commitments made under the 'healthy' high level outcome of the Ten Year Strategy.

Commitments contained within any future strategies must also be target driven, time-bound and adequately resourced through dedicated and sustained ring-fenced funding. They must also be developed within a clear rights-based framework, with the potential introduction of any new policies or service directions being both child-rights impact assessed and developed in consultation with children and young people where appropriate.

Particular consideration must also be given to addressing the recognised inequalities in health provision across different geographical areas and the particular inequalities in health and welfare experienced by certain groups of children and young people, including disabled children, Traveller children, LGBT children, those living in poverty, those who are homeless and migrant, asylum seeking and refugee children.

The issue of health and social care provision within NI cannot be examined without reference to the fundamental structural changes currently being introduced under RPA. The most significant change introduced under RPA to date, in relation to health and social care, is the merging of 19 Health and Social Services Trusts into 6 Health and Social Care Trusts.[53] This was introduced under direct rule and came into effect on 1 April 2007. Other proposed developments, scheduled to follow in 2008, were placed on hold post restoration of devolution in May 2007.

Revised proposals were issued for consultation in February 2008 and, a Health and Social Care Reform Bill (setting out the legislative framework for the proposed structural changes) was subsequently brought before the Assembly for its first and second readings in June and July 2008. Having been approved in principle by the Assembly, the Bill has now moved to Committee stage.

Key developments confirmed by DHSSPS post consideration of consultation responses include:

- replacing the four existing HSS Boards with a single Health and Social Care Board, with responsibility for commissioning, resource management and performance management and improvement

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[53] The Ambulance Trust remained unchanged. The other 18 HSS Trusts were merged into 5 new HSC Trusts.

- the establishment of a Regional Agency for Public Health and Social Wellbeing, with remit for health protection, improvement and development
- the establishment of one regional Support Services Organisation
- replacing the existing Health and Social Services Councils with a single Patient and Client Council
- the development of five Local Commissioning Groups, covering the same geographical areas as the five main HSC Trusts
- transfer of responsibility for Children's Services Planning from the four HSS Boards to the new regional Health and Social Care Board, though it is noted that proposals to strengthen and build upon the Children's Services Planning process will be considered as part of the legislation required for the establishment of the new Safeguarding Board (DHSSPS 2008).

Both the new service delivery arrangements and the new accountability structures being introduced under RPA offer an unprecedented opportunity to reassess how the health and welfare needs of children and young people in NI are currently being met. The implementation of RPA offers a unique opportunity to integrate a rights-based perspective to service planning and delivery and to develop more effective means of identifying and addressing children and young people's needs. With less individual operating bodies, it also offers a potentially effective mechanism for addressing the current 'postcode lottery' nature of some health and social care provision and ensuring greater consistency across different geographical areas.

5.4 Health Promotion

The Convention on the Rights of the Child places a clear responsibility on State parties to invest in preventative health measures as well as responding to ill health when it occurs. Article 24(2) places an obligation on States to ensure that children and their parents are informed about child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents. It also places a requirement on States to 'develop preventive health care, guidance for parents and family planning education and services'.

The importance of health education and preventative measures has been reiterated by the Committee in its 2008 Concluding Observations on the UK's periodic report, in which it calls upon the government to:

- further promote baby-friendly hospitals and encourage that breastfeeding is included in nursery training
- intensify its efforts to provide adolescents with appropriate reproductive services and health education in schools
- provide children with accurate and objective information on toxic substances (CRC 2008:para 59–63).

Each of these issues is addressed in more depth in subsequent sections of this chapter. It is suffice to note, at this stage, that a number of statutory health promotion initiatives have been introduced in recent years, particularly under the auspices of the Health Promotion Agency

(HPA), but despite these welcome developments, health related behaviours and outcomes would indicate that there remains significant scope for improvement.

5.5 Physical Health

5.5.1 Breastfeeding

The issue of breastfeeding has been raised by the Committee in both its 2002 and 2008 Concluding Observations on the UK State party as a matter requiring further attention if article 24 of the Convention is to be adequately implemented.

Having expressed concern at the *"relatively low rate of breastfeeding"* in 2002, the Committee recommended that all appropriate measures be taken *"to promote breastfeeding and adopt the International Code for Marketing of Breast-milk Substitutes"* (CRC 2002a:para 41/42). Commenting again in 2008, the Committee commended *"the progress made in recent years in the promotion and support of breastfeeding"*, but noted ongoing concern that the International Code on the marketing of breastmilk substitutes has not yet been adequately implemented and that *"aggressive promotion of breastmilk substitutes remains common"* (CRC 2008:para 58). The Committee has called on the government to fully implement the International Code and to *"further promote baby-friendly hospitals and encourage that breastfeeding is included in nursery training"* (CRC 2008:para 59).

The early results of the 2005 Infant Feeding Survey show that there has been a significant increase in breastfeeding rates in NI between 2000 and 2005, with breastfeeding rates on discharge from hospital increasing from 54% to 63% during this time (OFMDFM 2007b). However, as SC/CLC (2008:28) observe *"although over half of new mothers start to breastfeed in Northern Ireland, by six weeks this is down to 25% and by six months to 10%. One of the main reasons is 'lack of social acceptability' – research has shown that a third of the public thought breastfeeding was embarrassing, and half thought it should always be done in private"*.

Furthermore although NI has experienced the greatest increase of any UK region during this five year period, the overall rate in NI remains lower than anywhere else in the UK (Bolling 2006). According to the findings of the survey, *"mothers who had left full-time education at age 16 or younger were the least likely to have breastfed… while those who had left full-time education at 18 or older were the most likely to have breastfed"* (Bolling 2006:7). Lower rates of breastfeeding were also noted amongst teenage mothers (Bolling 2006). The patterns of breastfeeding noted by Bolling are in line with those noted in a recent North Belfast based study which found that mothers who are older, have a partner, are from a higher social class or who were breastfed themselves are more likely to breastfeed their children (Bishop et al 2008).

Although 57% of the 120 mothers who participated in Bishop et al's research had breastfed their child, almost half had only done so for the first 4 weeks. OFMDFM (2007b:46) further notes that *"only 10% of mothers in NI are still feeding their babies at six months in comparison to Scandinavian countries where the breastfeeding rate is closer to 80% at this stage"*. While there have been some notable developments in relation to the promotion of breastfeeding within NI in recent years, including the establishment of breastfeeding support groups and peer support programmes (OFMDFM 2007b), these figures reveal the scope for further development in the field. The current situation falls far short of World Health Organization (WHO) recommendations that children should be exclusively breastfed for the first six months of their lives and highlights the need for further investment in this field if the recognised health benefits of breastfeeding (reduction in certain illnesses and lesser likelihood of juvenile obesity) are to be equally accessible to all children (OFMDFM 2007b).

Bishop et al's (2008:175) research observes that women's tendency to breastfeed may be reduced where *"artificial feeding is perceived as the cultural norm"*. It further notes that mothers who bottle-fed their babies are more likely to be influenced by siblings and friends than by professionals. These observations on the contextual factors influencing mothers' decisions regarding breastfeeding offer potentially important insights as to how best to target future breastfeeding promotion:

"Breastfeeding promotion should target the young before negative attitudes have been formed and should encourage breastfeeding not only through education in schools but also by promoting positive images of breastfeeding and increasing the public profile of breastfeeding mothers and babies" (Bishop et al 2008:177).

"Future interventions to promote breastfeeding in Northern Ireland could adopt a social approach, encouraging positive norms for existing and potential mothers, fathers, families, employers and the public in general" (Bishop et al 2008:177).

If it is to fulfil its obligations under the UNCRC, the government must build on existing developments in relation to the promotion of breastfeeding in the early stages of a child's life. The existing breastfeeding strategy must be evaluated and updated to take account of learning and shifting cultural norms over the last 10 years (the existing strategy dates from 1999) and incorporate the recommendations of the Committee in relation to the promotion of breastfeeding and the restriction of marketing substitute products. Findings from recent research, highlighted above, would suggest there is particular benefit to be gained from specifically targeting younger mothers and those from lower social classes, in addition to universal promotion strategies.

5.5.2 Infant and Child Mortality

Article 24 of the Convention requires State parties to take appropriate measures to 'diminish infant and child mortality' and to 'ensure appropriate pre-natal and post-natal healthcare for mothers' in pursuit of full implementation of the child's right to enjoy the highest attainable standard of health. The right to health is thus closely linked with the right to life contained in article 6, which requires the government to ensure, to the maximum extent possible, the survival and development of the child. Commenting on this in General Comment Number 7 on Implementing Child Rights in Early Childhood, the Committee explains:

"States parties are urged to take all possible measures to improve perinatal care for mothers and babies, reduce infant and child mortality, and create conditions that promote the well-being of all young children during this critical phase of their lives. The Committee reminds States parties (and others concerned) that the right to survival and development can only be implemented in a holistic manner, through the enforcement of all the other provisions of the Convention, including rights to health, adequate nutrition, social security, an adequate standard of living, a healthy and safe environment, education and play (arts. 24, 27, 28, 29 and 31), as well as through respect for the responsibilities of parents and the provision of assistance and quality services (arts. 5 and 18)" (CRC 2005b:para 10).

"States parties should ensure that all children have access to the highest attainable standard of health care and nutrition during their early years, in order to reduce infant mortality and enable children to enjoy a healthy start in life (art. 24). States parties have a responsibility to ensure access to clean drinking water, adequate sanitation, appropriate immunization, good nutrition and medical services, which are essential for young children's health, as is a stress-free environment" (CRC 2005b:para 27).

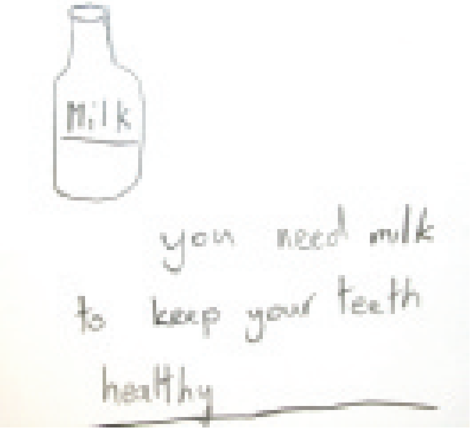
The latest available statistics for infant mortality rates in NI show that there were a total of 121 deaths of children aged less than 1 year in 2006. Nearly three quarters of these children died in the first four weeks of life (NISRA 2007c). Children under the age of 5 made up 1% of all deaths in NI in 2006 (NISRA 2007c). Considering these rates in relation to those of preceding years, DHSSPS (2007a) reports that the infant mortality rate per 1,000 live births in NI has decreased from 5.7 in 2001 to 5.3 in 2006. The Ten Year Strategy contains a commitment to decreasing the infant mortality rate further during the lifespan of the strategy, but no further specifics are provided in either the strategy or the accompanying first action plan.

Although the Committee welcomed the observable decline in infant mortality rates in the UK in its 2002 Concluding Observations, it simultaneously expressed dismay at the persisting inequalities in health observable amongst certain groups of children. Reporting on the variable infant mortality rates amongst different groups of the population, DHSSPS (2007a) reveals that whilst infant mortality rates in rural areas are lower than the NI average (4.9 compared to 5.3 per 1,000 live births), rates in deprived areas are significantly higher (6.5 infant deaths per 1,000 live births). Travellers also continue to experience high infant mortality rates, with mortality rates among Traveller children up to 10 years of age noted to be 10 times that of children from the 'settled' population (ECNI 2007b).

The continued disparity in infant mortality rates remains a matter of concern for the Committee, as noted in its recent 2008 Concluding Observations on the UK (CRC 2008). DHSSPS must urgently address the disproportionately high infant mortality rates amongst Traveller children and those living in areas of high economic deprivation, if it is to ensure all children full enjoyment of their article 6 and 24 rights, without discrimination of any kind.

5.5.3 Oral Health

Reports suggest that children in NI have the poorest level of dental hygiene across the UK (HPA 2007). Oral health is an issue of concern for children and young people in NI not only in terms of the prevalence of dental decay, but also in terms of the patterns of inequality in experiences of oral health and, more recently, increasing difficulties in accessing appropriate treatment through the National Health Service (NHS).



DHSSPS issued an Oral Health Strategy for consultation in 2004. The final strategy followed in 2007 with two primary aims of improving oral health overall and reducing inequalities in oral health. Commenting specifically on the oral health needs of children, the strategy notes:

"Dental decay (caries) in children is a significant public health problem in Northern Ireland. It is also completely preventable. Compared to the UK average, our 12-year- old children have more than double the level of decay for this age group. A 2002 survey showed that by the time they begin primary school most children in Northern Ireland will have experienced dental decay. Many of these children will suffer pain, will miss days at school and will require costly dental treatment. Parents will have to take time off work so that their children can be treated and some children will require a general anaesthetic so that their decayed teeth can be removed. In 2003 almost 8,000 Northern Ireland children attended hospital to have dental treatment under a general anaesthetic. This is the highest per capita rate of general anaesthetics for dental reasons in Europe. It is also the most expensive way to treat dental disease. Even excluding these hospital treatments, fixing the decayed teeth of our children cost over £25 million pounds in the same period" (DHSSPS 2007l:9).

The strategy notes four key reasons why, on a population level, NI compares so unfavourably with other countries in terms of oral health. These are the unhealthy diet of the population (NI spends the largest amount on sugary foods and drinks in the UK), the fact that NI is the most deprived country in the UK, the fact that the public water supplies are not fluoridated and lower levels of personal dental hygiene (DHSSPS 2007l).

As with many other aspects of health, oral 'ill' health is experienced disproportionately by those living in socially deprived areas. The Oral Health Strategy reveals that children living in the 20% most deprived wards in NI are nearly twice as likely to have experienced dental decay as children from the 20% most affluent wards (DHSSPS 2007l). The 2006 report on monitoring poverty and social exclusion in NI further reveals that children whose parents are in receipt of means-tested benefit have a higher average number of missing, decayed or filled teeth than other children (Kenway et al 2006).

Despite the fact that dental decay is more prevalent among children and young people from deprived areas, the rate of dental registration in deprived areas in 2007 was 13% lower than NI generally (DHSSPS 2007a). SC/CLC (2008) note the particular difficulties that ethnic minority groups have in registering with dentists.

The Oral Health Strategy identifies public water fluoridation and school based initiatives as effective means of improving oral health amongst children, noting several examples of the latter currently in operation within NI. Recommendations set forth in the strategy include making preventing dental decay in children, particularly among those from disadvantaged backgrounds, a key health objective for all Boards and Trusts and ensuring all schools are free from vending machines selling sugary snacks and have a healthy breaks and meals policy (DHSSPS 2007l).

The challenges outlined here in relation to the promotion of positive oral health appear to have been compounded, in recent years, by difficulties accessing appropriate dental care. When asked to comment on whether they felt the health needs of their children were being adequately met by the government, many parents/carers who participated in this review made reference to the difficulties they faced when attempting to access dental treatment for their children:

"Accessing a dentist for your child can be difficult; often there is a requirement that to register your child you must be a patient there as well. With more dentists now private some parents choose not to remain on the dentist list however this doesn't mean that they don't want there children to be able to receive regular check ups and care through the NHS."

All children and young people are entitled to free dental treatment under the NHS, however, with the increasing privatisation of dentist surgeries, many parents report finding it difficult to access dentists on the NHS for their children, which in turn can result in them having to pay for treatment. This presents a further barrier to parents, particularly those on low incomes, accessing the dental services their children require:

> *"I am also worried about dental treatment. Our dentist has found a loophole that allows him to charge for children. I'm sure other dentists will follow this example."*

> *"Over three-quarters of the dentists in our city are now private and a large portion of these have children private also, goes against free healthcare for all which we are paying A LOT of tax to pay for."*

While the recognition of the problem by government and the development of a strategy to address this is a welcome first step, it is imperative that the recommendations set in the 2007 Oral Health Strategy, both those that are universal and those that seek to target the existing inequalities in oral health, be urgently implemented and adequately resourced if the existing inequalities and deficiencies in oral health are to be addressed.

5.5.4 Obesity

The Chief Medical Officer's 2007 annual report reveals that one in four girls and one in six boys in primary one are overweight or obese (DHSSPS 2007c). The 2005 Health and Wellbeing Survey presents similarly alarming statistics, with one measurement scale revealing that 1 in 10 children in NI is obese, with over 1 in 4 obese or overweight and another measurement scale reporting 18% of children aged 2 to 15 to be obese and more than one third to be obese or overweight (NISRA 2007d). Focusing in on the early years of children's lives, it has been projected that, without significant intervention, over 1 in 4 (27%) 4.5 to 5.5 year olds will be overweight or obese by 2010 (DHSSPS 2007d).

A cross-departmental taskforce was established by the Ministerial Group on Public Health (MGPH) in August 2004 to *"examine options for preventing the rise in levels of obesity of children and young people and to make recommendations to the Ministerial Group on priorities for action"* (Investing for Health Team 2006:1). This 'Fit Futures' Taskforce reported to the MGPH in March 2006, whose response followed in January 2007 with a Fit Futures Implementation Plan that they issued for consultation. The introduction to the MGPH response to the taskforce report acknowledges both the scale and implications of increasing levels of obesity amongst children in NI:

> *"On the basis of the research and analysis commissioned by the Fit Futures taskforce and published in its report to MGPH in March 2006, it is now clear for all to see that obesity, poor nutrition and increasingly sedentary lifestyles are very real problems facing the children of Northern Ireland. According to the 2005 Health and Social Well-Being survey, around one in ten of our children are now obese and well over a quarter are either overweight or obese. Analysis of the child health system has also*

found that levels of obesity are increasing year on year. These findings have major public health implications. Obesity significantly increases the risk of developing Coronary Heart Disease, Stroke, Cancer and type 2 diabetes. In addition, people from disadvantaged backgrounds, who already suffer poorer health, are at increased risk of developing obesity and related chronic health problems. Obesity, poor nutrition and sedentary lifestyles can also have a negative impact on the mental health of our young people and on children's capacity to learn and develop" (DHSSPS 2007d:1).

The Fit Futures Implementation Plan seeks to realise the vision of the Taskforce that *"in the Fit Future, children and young people, of all ages and from all sectors of society will be motivated and supported to access a range of readily available, quality enjoyable opportunities to be active and eat healthily"*. The principal measure of success is noted to be achievement of the Public Service Agreement target of stopping the rise in obesity in children and young people by 2010 (DHSSPS 2007d:3). While many of the recommendations contained within the draft implementation plan are being progressed in its absence, the fact that no final plan has yet been published over 18 months after the end of the consultation is a matter of serious concern.

There were a number of different issues raised by participants in this review in relation to why increasing rates of obesity are observable amongst children and young people in NI. These include: lack of exercise, the cost of providing a healthy diet, the impact of marketing of sedentary activities and unhealthy foods on children's preferences and choices and, relatedly, inadequate education around healthy lifestyles:

"I spend my time trying to talk about health and wellbeing but am up against rampant consumerism e.g. playstation computer, junk food culture and my children think my healthy eating and outdoor play ideas are pretty rubbish" (parent).

"In this day and age there is far too much computer, DVD, videos, IT technology that young people are becoming couch potatoes eating all the wrong foods. Fast foods everything is so handy bought and little exercise as they are sitting all day glued to a screen of some kind or another" (parent).

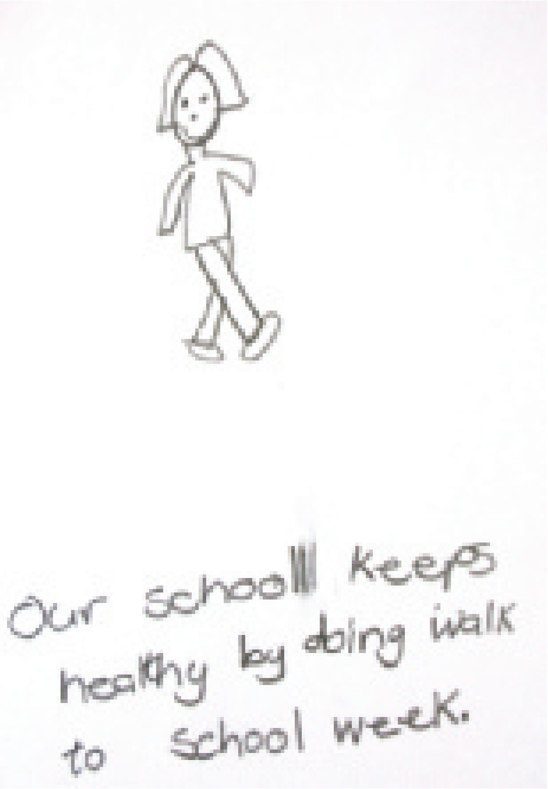
"Increasing numbers of obese children – associated with poor dietary and exercise habits. This issue whilst acknowledged continues to grow, with ongoing impact on children and young people's lives and longer term consequences for chronic disease management" (professional).

"I think everyone should stay well and healthy – why wouldn't we? Some people just don't realise that they don't do enough exercise or eat the right food until it's too late" (young person).

"There should be more classes for children on how to stay healthy and what to eat because that's why so many children are obese because they don't know" (parent).

"Fresh food/fruit/veg is becoming too expensive – people eat too much processed food. Too many fast food outlets encourage children to eat unhealthily" (parent).

These concerns mirror those raised in other reports. The Chief Medical Officer's 2007 annual report, for example, suggests that increasing levels of child obesity are due, in part, to the fact that many children today *"are not as physically active as they should be"* (DHSSPS 2007c), while the HPA (2007a) recognises the importance of a balanced diet through childhood in the fight against obesity. The Committee on the Rights of the Child notes concern *"about the influence exerted on adolescents health behaviour by the marketing of unhealthy products and lifestyles"* (CRC 2003a:para 25).



While initiatives such as the Healthy Schools Pilot and Sure Start Healthy Start Vouchers and tools such as the 'How Healthy is Your School?'

toolkit (HPA 2008) are to be welcomed, it is imperative that such discrete initiatives be mainstreamed with adequate and sustained funding and integrated within a definitive target-driven, time-bound and adequately resourced strategy and implementation plan. It is also imperative that the government recognise the relationship between articles 17, 24 and 27 in their drive to reduce childhood obesity, noting the importance of the provision of appropriate information to children and young people, and those responsible for their care, and the relationship between an adequate standard of living and the promotion of good health.

5.6 Sexual Health

"It is widely accepted that the sexual health of the population of Northern Ireland is relatively poor. This is evident in the high numbers of teenage births, as well as increases in HIV/AIDS and other sexually transmitted infections (STIs). The sexual health of young people in particular has been a key concern for health promotion in recent years and is now a priority issue for Government" (North and West Belfast Health Action Zone 2008:7).

5.6.1 Sexual Activity

A number of recent surveys have explored patterns of sexual behaviour amongst young people in NI, offering much needed insights into what has traditionally been an under-researched area. A Love for Life (2005) survey of 10,745 14 and 15 year olds from across NI, for example, found that the most common age at which first sexual intercourse was reported was 14. The 2007 Young Persons' Behaviour and Attitude Survey similarly reports that 81% of young people who reported having had sexual intercourse said they had first done so between the ages of 13 and 15 (NISRA 2008a). These findings are in line with those of other local research which places the age of initial sexual activity between 14 and 15 years (Schubotz et al 2004; North and West Belfast Health Action Zone 2007).

Fourteen per cent of the 14 year olds and 22% of the 15 year olds who took part in the Love for Life survey reported having had sexual intercourse on at least one occasion. Less than half of these young people said they had had just one sexual partner; while 17% of 14 year olds and 12% of 15 year olds reported having had 5 or more partners. Just over one fifth of those who reported having had sexual intercourse, said they were currently sexually active (ie had sexual intercourse in the last month). The authors note a relationship between lower ages of initial sexual activity, higher numbers of partners and current engagement in sexual activity (Love for Life 2005).

Data gathered via the 2007 YLT survey presents a similar picture in terms of the sexual behaviour of young people in NI with 23% of participants, all of whom were 16, reporting that they have had sexual intercourse (4% once, 10% a few times and 9% many times) (ARK 2007). Data from a 2006 survey of the sexual health services needs of young people in North and West Belfast reports notably higher rates of engagement in sexual activity with over half of respondents stating they had experienced 'heavy petting', 'oral sex' and 'sexual intercourse' by age 15, however, these rates may be skewed by the fact that most of the 279 respondents were users of sexual health education and service projects (North and West Belfast Health Action Zone 2007).

The findings of these, and other, surveys indicate that a significant minority of young people are engaging in sexual intercourse and other forms of sexual activity in their early to mid teens. These young people face a number of health related risks, including unplanned pregnancy and sexually transmitted infections (STIs).

5.6.2 Sexually Transmitted Infections

While the diagnostic rates of the majority of STIs remain lower in NI than elsewhere in the UK, the most recent statistics issued by the Communicable Disease Surveillance Centre (2007) reveal an overall increase of 18% in the number of new STI diagnoses between 2000 and 2006, with notably higher rates observable amongst 20–24 year olds. Furthermore, according to the Family Planning Association (FPA) (2007b), NI has the highest rate of increase in Human Immunodeficiency Virus (HIV) infection in the UK. Twelve of the 63 new cases of HIV diagnosed in NI in 2005 were young people aged under 24 (YCNI 2007) and though the number of diagnoses of HIV fell slightly during 2006, the numbers recorded were still nearly double the comparable figure for 2003 (Communicable Disease Surveillance Centre 2007).

These patterns of increasing cases of STIs are particularly concerning in light of research findings that indicate that around one third of young people in NI did not use condoms (or indeed any other form of contraception) when first engaging in sexual intercourse (Schubotz et al 2004; North and West Belfast Health Action Zone 2007). Comparative figures for LGBT youth reveal that only 44% of gay and bisexual young men and 31% of lesbian or bisexual young women surveyed used contraception when they first had sex (North and West Belfast Health Action Zone 2007).

Noting the recent increase in the diagnosis of STIs amongst young people (reported to be 118 per 100,000 for under 16 year olds and 681 per 100,000 for 16 to 19 year olds in 2004/05), the Ten Year Strategy identifies a decrease in diagnostic rates among those aged 19 and under as a key indicator of success. However, as with infant mortality rates, no specific targets have been set in either the strategy or the accompanying first action plan.

5.6.3 Teenage Pregnancies

Concern around the high rates of teenage pregnancies across the UK was raised by the Committee in both its 2002 and 2008 Concluding Observations on the UK. While the NI teenage birth rate has reduced from 17 per 1,000 females in 2001 to 16.1 per 1,000 in 2006, there are still a relatively high number of teenage births. Rates of teenage pregnancy are particularly high in socially/economically deprived areas, with teenage pregnancy rates of 28.9 per 1,000 females in 'deprived areas' compared to a rate of 12.4 in 'non-deprived areas' (DHSSPS 2007a).

In their 2007 report to the Committee, the NI Government emphasise the work they have done in this field under the Teenage Pregnancy and Parenthood Strategy, including *"the publication of local directories of resources, further development of community based teenage personal development programmes, courses on parent/child communication and training for staff working with young people"*. They further note the target set under the strategy to reduce the rate of births to teenage mothers under 17 years by 40% by the end of 2007, concluding that *"considerable progress has been made towards achieving this target in reducing the rate of births to under 17 year olds from 4.1 per 1000 in 2002 to 3.1 in 2005"* (OFMDFM 2007b:46/47).

While many of the initiatives introduced under the strategy and the reduction in teenage birth rates recorded above are to be welcomed, not all of the targets established under the strategy have been fully met. The failure to introduce a subsequent strategy, post conclusion of this one in 2007, is particularly concerning in light of this.

5.6.4 A Holistic Approach to Sexual Health

Though the management of unwanted pregnancy and STIs are critical elements of sexual health, it is important to note that the promotion of positive sexual health goes much wider than that. As WHO observes:

"Sexual health is a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled" (WHO 2002 cited in NICCY 2008a:2).

The fact that over half of all clients to the Brook Clinic in 2005/06 were under 18 (28% under 16 years, 28% aged 16–18 years) suggests that young people are wanting to avail of advice and assistance on sexual health matters, when on offer (Brook 2006). It is therefore imperative that young people are assured access to appropriate information and services to allow them to make informed choices about their sexual health, as is their right under articles 17 and 24 of the Convention.[54] Commenting on the obligations contained with these articles, General Comment Number 4 on 'Adolescent Health and Development' states:

"Adolescents have the right to access adequate information essential for their health and development and for their ability to participate meaningfully in society. It is the obligation of States Parties to ensure that all adolescent girls and boys, both in and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their

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[54] Article 24 of the UNCRC places an explicit responsibility on States parties for the provision of family planning education and services. Article 17 places a further obligation on states to ensure that children and young people have access to information aimed at the promotion of health.

health and development and practise healthy behaviours. This should include information on the use and abuse, of tobacco, alcohol and other substances, safe and respectful social and sexual behaviours, diet and physical activity" (CRC 2003a:para 26).

"In light of articles 3,17 and 24 of the convention, state parties should provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases…[they should]… develop effective prevention programmes, including measure aimed at changing cultural views about adolescents need for contraception and STD prevention and addressing cultural and other taboos surrounding adolescent sexuality" (CRC 2003a:para 28–30).

The production of a draft sexual health promotion strategy and action plan, circulated for consultation by DHSSPS in 2003, represented a welcome development in terms of governmental recognition of the necessity of a comprehensive response to sexual health and its role in relation to this. However, although a summary of consultation responses was issued in 2004, no subsequent strategy has yet been published four years later. This is in spite of the fact that the first action plan for the Ten Year Strategy for children and young people also committed to the production of a sexual health promotion strategy and action plan, by May 2007 (OFMDFM 2007a). The continued failure of the government to produce these outcomes, despite stated commitments to do so, remains a matter of serious concern, as does its failure to evaluate and progress the Teenage Pregnancy and Parenthood Strategy which came to an end last year.

5.6.5 Sex Education in Schools

In the absence of a comprehensive strategic approach to the promotion of sexual health within NI, the primary source of many young people's knowledge of sex and sexual health remains that provided within the school environment. The findings of a number of recent research reports, that the sex education currently provided in schools in NI is not relevant to, or meeting the needs of, many children and young people, are particularly concerning in this regard (Fleming et al n.d.; McNamee 2006; McAlister et al 2007; North and West Health Action Zone 2007, 2008).

Particular issues raised within these studies include the factual/biological nature of sex education, the moral/religious perspective incorporated in sex education, a bias towards heterosexuality and consequent failure to adequately address the issue of homosexuality within Relationships and Sexuality Education (RSE). As McNamee et al (2008:34) observe:

"The heterosexism that exists in our society is perpetuated through the education system… Even though the teaching of Relationships and Sexuality Education in schools in Northern Ireland is now a statutory requirement, most schools in Northern Ireland are not prepared to deal with issues they see as morally problematic, such as

abortion, sexual feelings, and homosexuality… Positive teaching on homosexuality is rarely provided in schools, and teachers often ignore homophobic name-calling."

This failure to address homosexuality in RSE is particularly critical in light of the fact that young people generally become aware of their sexuality in their early teenage years (Breitenbach 2004; McNamee 2006; Quiery 2007). RSE should be taught in a manner that does not discriminate against LGBT students and seeks to dispel the myths and prejudices that contribute to homophobic bullying, social isolation and mental health issues. As Fleming et al (n.d.:18) conclude:

"LGBT young people want homosexuality to be covered consistently in RSE in all post-primary schools to enable all young people to understand and accept those of different sexuality."

Young people who raised the issue of sexual health in this review were also generally critical of the sex education they received in schools:

"Well when I was at school like, all they'd say to you is, this is a penis, this is a vagina and this is how it works blah blah blah. They don't tell you anything else like. I think they're just telling you the stuff that they think your parents want you to hear."

"I actually think you learn more about sex on the street, you know what I mean like. What people would be saying like."

A parent who raised the issue of sexual health in this review observed that schools need to be more imaginative in the way they teach the subject to both pupils and their parents, citing a community based programme as an example of good practice:

"[Need] imaginative drug and sex education for parents and children. My daughter has just benefited from an excellent community programme called "Love Academy" which is streets ahead of what she receives in school."

Although guidelines for the provision of RSE within schools were produced in 2001, the development of an RSE policy is still not a mandatory requirement on schools. The quality of, and approach to, the provision of RSE consequently varies significantly between schools, with pupils receiving variable levels and types of information regarding sexuality and sexual health.

This inequity in sexual health education in schools is borne out by the results of a mapping exercise of RSE provision undertaken by North and West Belfast Health Action Zone (2008) that found that one fifth of the post-primary schools and two fifths of the primary schools who responded were not familiar with either the Council for Curriculum, Examinations and Assessment (CCEA) or DE guidance on RSE. Over half (56%) of the 34 schools that participated did not have a written RSE policy, despite the fact that this is recommended in the CCEA Guidelines/DE Circular.

The majority of schools that participated in this research indicated that RSE was delivered by teachers (closely followed by the school nurse) yet only 15% said their staff had attended any relevant training during the last 12 months. Just over one third of schools utilised external agencies in the delivery of RSE. Pupils received an average of 4.69 hours of RSE per year, but only a minority of schools said they addressed sensitive issues of sexual orientation (37.5%), abortion (31%) and contraception (28%) within this. The authors also note limited provision for disability, LGBT and Travellers' groups, with no programmes on offer specifically for black and minority ethnic (BME) groups (North and West Belfast Health Action Zone 2008).

Summarising the findings of the mapping exercise, the authors conclude that while schools are generally aware of their obligations for RSE delivery, there is a lack of consistency in terms of allocation of responsibility for delivery, access to training and programme structure and content. The authors further note that *"the level of parental involvement in RSE provision in schools is a cause for concern, given the vital role that parental involvement can play in enhancing and complementing RSE provision"* (North and West Belfast Health Action Zone 2008:21). Minimal levels of pupil involvement in the design of RSE were also noted, though increasing levels were noted in post-primary schools.

Reflecting on their findings, the authors set forth a number of recommendations. These include DE ensuring RSE policy in schools is afforded mandatory status, all schools appointing a specific RSE coordinator, greater involvement of external organisations and a particular focus on ensuring the needs of all s75 groups are met (North and West Belfast Health Action Zone 2008). Complementary recommendations set forth by Schubotz et al (2004), on the basis of their survey of the sexual behaviours of young people, include incorporation of the traditionally neglected emotional aspects of sexuality within RSE and more extensive and in-depth training for staff.

Continued deficiencies in the delivery of RSE in schools are having a negative impact on the ability of young people to make informed choices about their sexual behaviour and sexual health. This is especially true for LGBT young people. The fact that the quality of sexual education received by young people in NI varies according to the school they attend, or indeed the approach of an individual teacher, is in clear conflict with a rights-based approach to the provision of sexual education. It is imperative that DE introduce a mandatory requirement for the production and dissemination of a comprehensive RSE policy in each school that is non-discriminatory in content and complies with children and young people's article 13 right to seek, receive and impart information. Attention must also be paid to reconciling the differing codes of ethics currently governing education and health professionals delivering sex education within schools and to ensuring that appropriate standards are agreed and consistently applied across both disciplines.

5.6.6 Access to Sexual Health Services

There are a total of four statutory Genito Urinary Medicine (GUM) clinics providing sexual health services for the whole population of NI, including young people. Combined, these clinics are open for fewer than 40 hours per week. While some operate on an open access basis, others operate an appointments based system available only in restricted hours, primarily during the school day. This can result in significant access issues for young people, especially those engaged in full time education. As one young person who participated in this review observed:

"Well there is a family clinic down there in the town. It gives you out free condoms and it talks to you about all that there stuff. But it's only open on a Wednesday at like 8 o'clock."

Current government guidelines state that the maximum waiting times for access to a GUM clinic should be 48 hours, but inadequate provision across NI means this cannot be adhered to. The clinic at the Causeway hospital, for example, is only open for three hours over two sessions on a Tuesday and Thursday; it is therefore impossible for this clinic to meet stipulated waiting times if a (young) person presents on certain days of the week.

Young people living in rural areas of NI face particular difficulties when attempting to access sexual health services. Young people living in Fermanagh, for example, must travel at least 60 miles in order to access a GUM clinic. This is a major constraint in accessing sexual health services, particularly for young people who are reliant on public transport (NICCY 2008a).

Though some other organisations also offer sexual health services, young people seeking to access these can be faced with picket lines and potential harassment from protestors, which again acts as a barrier to accessing services. As McMahon and Keenan (2008:116) observe:

"The Brook clinic is the only non-statutory sector agency offering sexual health and advice services to young people under 19 years old. In the course of gathering information for this review Brook staff raised a number of concerns in relation to young people's rights to access their services. The first is that in order to enter the clinic in Belfast City Centre, young people have to "run the gauntlet" of pickets…Brook is concerned that this may serve to dissuade some young people from seeking the support of the clinic and is distressing for those that do as some protestors display photographs of aborted foetuses and have buckets of plastic foetuses, covered in red paint."

Given both the potential ramifications of a failure to access appropriate advice and assistance and the embarrassment that many young people initially experience in accessing sexual health services, it is imperative that additional barriers such as these should be removed, if young people are to be facilitated to access preventative sexual health services:

"I went to the GUM clinic and I am telling you it is one of the most embarrassing things like. It really is like. But you see once you go like, you're grand, because everyone in that waiting room is either waiting to see if they've got cancer or whatever. The reason you're going is

to get a check up, you know what I mean, so you're ok."

Though access to sexual health information and services is generally poor for young people across NI, particular young people are more disadvantaged in this regard than others, most notably LGBT youth, young people with disabilities and looked after young people.

A 2006 report by the University of Ulster and the FPA, investigating the sexual health and wellbeing of people with learning disabilities in NI found the situation to be far from ideal. The report observes a lack of information for both young people and their parents/carers, concluding that professionals and front line staff need clear guidance and training to enable them to advise and support [young] people with learning difficulties in accessing both information and sexual health services (Simpson et al 2006).

The sexual health of looked after children is particularly complex; for some young people in care, school is the only place where they receive information on sexual health. Foster carers and those working with looked after children must be equipped to give accurate information and guidance to young people on sexual health. Foster carers who participated in research on this subject suggested that *"a program covering sex education and appropriate relationships would be particularly valuable in assisting them"* (Fleming et al 2005:44). The young people however, preferred to talk to their social worker about sex and contraception as to talk to the foster carer was *"likely to cause embarrassment"* (Fleming et al 2005:45).

Training and guidance need to be given to staff in residential settings, social workers and foster carers to help them provide information and support on sexual health to the young people in their care.

LGBT youth attempting to access sexual health services are faced with the additional barrier of *"the homophobic atmosphere and heterosexual bias that exist in Northern Ireland [that] cause difficulties for young LGBT people coming to terms with their own sexuality"* (FPA 2007a:2). As professionals who participated in this review observed, they are often faced with a lack of acceptance and/or understanding, inadequate or misinformation and the challenge of refuting assumptions of heterosexuality:

"All medical professionals assume that young people who go for advice or medical check ups are heterosexual and this puts a young person in an awkward position of having to out themselves (with fear of discrimination) and actively discourages them from seeking more advice or information about the issue."

"Information left in some local libraries and in schools or youth clubs are often not displayed or disappear."

"Young people not only lack access to good information regarding sexual health but that there is also a great deal of misinformation regarding general health issues. Information provided to young women in particular is misleading – for example in the area of cervical smears some GPs still provide the message that woman who do not have penetrative sex do not

need a smear test. In the absence of information from other sources young lesbian and bisexual woman are dangerously withheld information."

One professional participant in this review felt that these difficulties were more acute for lesbian and bisexual young women:

"Whilst there is a gay and bisexual men's organisations funded by health boards and the DHSSPS to cater specifically for the needs of this group, there is no group specifically set up to meet the sexual needs of lesbian bisexual young women."

As North and West Health Action Zone (2007:37) conclude, *"what emerges as a very clear finding is that young same-sex attracted people remain stigmatised and disadvantaged with regard to the sexual health information and services they feel they can avail of".*

5.6.7 Mandatory Reporting

Under Section 5(1) of the Criminal Law Act (1967), it is a criminal offence for a person to fail to disclose information relating to a 'relevant offence' (one for which the maximum penalty is five years or more) to the police. This includes underage sexual activity and, as such, places a legal requirement on people (including doctors, teachers and other professionals) to report any knowledge of any such activity.

NI is unique in this regard, as the only UK jurisdiction with legislation creating a criminal offence of failure to disclose an arrestable offence to the police. However as Wallace and Bunting (2007) observe, this differential is little more than a technicality with reporting systems in NI largely comparable to those in the rest of the UK.

The crux of the debate around the issue of mandatory reporting centres around the tension between confidentiality as a necessary precursor to the provision of sexual health services and confidentiality as an impediment to effective child protection. To expand, some professionals fear that young people will not access sexual health advice if there is a risk that their confidentiality will be breached and they will be referred to the police or social services. The related fear is that young people will engage in premature sexual activity in the absence of a safe place to discuss the implications of this and/or that they will face greater risk of unplanned pregnancy or STIs due to a lack of contraceptive advice. Conversely, others fear that maintaining this confidentiality will mean that potential cases of abuse go unreported.

Though the reporting of child protection concerns is a valid and very important concern, it is imperative that the practicalities of its operation do not prevent young people accessing the sexual health services they require. As highlighted above, there are significant numbers of young people engaging in consensual sexual activity before the age of legal consent; it is imperative that mandatory reporting requirements do not prevent these young people from accessing necessary support and services for fear of their confidentiality being breached.

Research, undertaken by Wallace and Bunting (2007) on behalf of the NSPCC has explored the issue of mandatory reporting within NI. Considering both the national and international context of the current legislative position, the authors conclude:

"Although the evidence base is limited and it is extremely difficult to isolate the direct impact mandatory reporting legislation has, the available information suggests that mandatory reporting is unlikely to lead to improvements in the protection of children and young people. Based on the available evidence, it would seem that a voluntary system of reporting strengthened by interagency protocols and guidance and accompanied by professional training and awareness raising would be the preferred option in Northern Ireland. This would not only be in keeping with recent Northern Ireland and UK developments but would provide a more flexible environment in which to explore the balance between protection and confidentiality" (Wallace and Bunting 2007:6).

The authors specifically recommend repealing Section 5(1) of the Criminal Law (NI) Act 1967 as it relates to child protection interfaces, strengthening information sharing protocols and clarifying reporting processes for different professional groups (on the basis of open debate on how best to balance confidentiality and protection in order to most effectively meet the needs of children and young people), continued education and training for professionals and increased public awareness raising on the issue of child protection (Wallace and Bunting 2007).

The issue of mandatory reporting, and related issues, have been subject to much consideration and review in the last few years. Following initial consultation in 2006, draft legislation, the draft Sexual Offences (NI) Order 2007, was issued for consultation between November 2007 and February 2008. Summarising the representations received as part of this process, the Northern Ireland Office (NIO) noted general support for reconsidering the issue of mandatory reporting:

"Respondents considered it imperative that young people, including those under 13, were able to access confidential services to enable them to protect their sexual health… One faith based respondent organisation called for the retention of the duty to report under section 5 of the Criminal Law Act 1967 as a guarantor of reporting of alleged or actual abuse to the police. All other respondents, who commented on this issue, called for its repeal or disapplication to consensual activity between young people under 18. Concern was expressed that to retain the duty to report in such circumstances may compel a police investigation of matters that would not be prosecuted by reason of guidance to prosecutors" (NIO 2008a:16).

As a consequence of the views expressed in the consultation and by the Assembly, the NIO introduced an amendment to the draft Order *"to remove the application of section 5 from offences committed against young people by children or young persons"*. However, because of concerns expressed by the DHSSPS that the provision should remain in place to underpin and reinforce the arrangements for reporting possible incidents of child sexual abuse, *"the* *provision will not be commenced until new safeguarding legislation is enacted, planned for 2009"* (NIO 2008a:18/19).

The Sexual Offences (Northern Ireland) Order 2008 was enacted on 9 July 2008. Though Part 1 and Articles 80 and 82 of the Order came into effect one week later, the other provisions of the Order have yet to come into operation.

Article 79 of the Order, not yet in operation, specifically addresses the issue of mandatory reporting, amending Section 5(1) of the 1967 Criminal Law Act (NI) to exclude offences covered under Article 20 of the Sexual Offences Order (sexual offences against children committed by children or young persons) from mandatory reporting requirements. When brought into operation, this will mean that a professional (or any other person) with knowledge of sexual activity between an underage young person (now 15 or under, in light of the new age of consent) and another person aged under 18 will no longer be under a legal requirement to report this to the PSNI.

As the memorandum to the draft order explains, Article 20 seeks to explicitly differentiate between the severity of/penalty for someone aged 17 or under and someone aged 18 or above having sex with a young person aged under 16:

"The purpose of this Article is to provide a lower penalty where the offender is aged under 18. In practice (although there is no provision about this in the Order) decisions on whether persons under 18 should be charged with child sex offences will be made by the Public Prosecution Service in accordance with the principles set out in the Code for Prosecutors. In deciding whether it is in the public interest to prosecute these offences, where there is enough evidence to provide a realistic prospect of conviction, prosecutors may take into consideration factors such as the ages of the parties; the emotional maturity of the parties; whether they entered into a sexual relationship willingly; any coercion or corruption by a person; and the relationship between the parties and whether there was any existence of a duty of care or breach of trust" (NIO 2008b:para 7.47).

The Order also differentiates between offences against children aged 12 or under and those aged 13 to 15 years, providing for *"the non-consensual offences of rape and assault to be used in cases involving children under 13 without any issue of consent being raised (i.e. if someone has sexual intercourse with a child under 13 the offence is automatically rape. It also provides that a child under 13 does not, under any circumstances, have any capacity to consent to any form of sexual activity"* (NIO 2008b:para 7.10).

While the increased protection afforded children under the new legislation is a very welcome development in terms of their protection from exploitation and abuse there remains an ongoing tension around the boundaries of confidentiality that must be resolved in a manner that both protects and empowers young people seeking sexual health advice or services. It is imperative that this, and the other issues surrounding sexual health outlined above, be urgently redressed if young people are to be able to access their right to health education, health provision and health provision and the government is to address the Committee's most recent call *"intensify its efforts in order to provide adolescents with appropriate reproductive services, including reproductive health education in the school"* (CRC 2008:para 61).

5.7 Mental Health

"Mental health and wellbeing underpins all health and wellbeing and, as such, is a resource that needs to be protected and promoted… Mental health is seen to be more than the absence of mental illness. It is a positive sense of wellbeing whereby individuals recognise their abilities, are able to cope with the normal stresses of life, work productively and fruitfully and make a contribution to their communities… Everyone has mental health needs, not just those who have been diagnosed as having a mental disorder. No group is immune to mental disorders, but the risk is higher among the poor, homeless, unemployed, people with low education, victims of violence, migrants and refugees, indigenous populations, children and adolescents, abused women and the neglected elderly" (HPA 2006:6).

Reporting to the Committee on the Rights of the Child in 2008, all four UK Commissioners identified the mental health of children and adolescents as an area of ongoing concern. Mental ill health, and high rates of suicide and self harm amongst children and young people were also identified as one of the key areas of children's rights that is currently being ignored or underplayed by professional participants in this review:

"Mental health is a huge issue" (professional).

"Children with mental health problems are ignored" (professional).

"[A key rights concern is]…alarming rates of suicide among young people [and the] ongoing placement of young people in adult psychiatric wards" (professional).

The Committee on the Rights of the Child has expressed serious concern at the extent of mental ill health amongst children and young people in the UK in both its 2002 and 2008 Concluding Observations on the UK. In 2002 it called upon the government to take all necessary measures to strengthen its mental health and counselling services and ensure these are both appropriate for, and accessible to, young people. Reiterating this call in 2008, the Committee noted concern as to both the levels of mental ill health amongst children and young people in the UK and the inadequate level of appropriate services available to them, a particular issue of concern being the treatment of children in adult psychiatric wards. The Committee raised specific concerns in relation to the mental health experiences of children in NI, noting *"that in Northern Ireland – due to the legacy of the conflict – the situation of children is particularly delicate"* (CRC 2008:para 56).

As recognised by the Committee, research has shown that people in NI are at greater risk of mental ill health than their counterparts in Scotland or England due to higher exposure to factors such as poverty and community conflict (HPA 2006). According to the Bamford

Review, mental health needs are approximately 25% higher in NI than in England, with more than 20% of young people estimated to suffer 'significant mental health problems' by their eighteenth birthday (Bamford 2006a). The 2003–2008 Promoting Mental Health Strategy similarly notes that between 10% and 20% of teenagers will suffer depression at some time (Investing for Health 2003). Bamford (2006a:5) concludes:

"At the lowest estimated prevalence rates of 10% approximately 45,000 children and young people aged 5–15 will have a moderate to severe mental health disorder and require intervention from specialist CAMH Services in NI. Lowest estimates suggest that 0.075% (340) will require inpatient services."

The limited information available on the extent of mental ill health amongst children and young people in NI presents a serious barrier to effective service planning and provision. As the Bamford Review observes, *"one of the core difficulties facing CAMH professionals, service planners and commissioners in Northern Ireland is the limited availability of information about the nature and extent of mental health needs among young people in Northern Ireland. As such the rates of many problems and disorders have to be extrapolated from international studies"*. As the Review concludes, *"it is vital, to ensure that services are planned and delivered effectively, that up-to-date information on need becomes available"* (Bamford 2006b:2).

The prevalence of mental health problems, though generally high amongst children and young people, have been shown to be particularly high amongst disadvantaged or marginalised groups of youth, including those living in areas particularly impacted by the conflict (Muldoon et al 2005), looked after children, LGBT youth, children with disabilities, those in conflict with the law, those living in poverty or areas of economic disadvantage, those who are homeless and asylum seeking or other ethnic minority children. Mental ill health has also been noted to be particularly prevalent amongst those who have been bullied (Dyer and Teggart 2007). The likelihood of mental ill health is also heightened for children who have been denied the opportunity to develop appropriate attachments in early childhood or where these relationships have been disrupted through separation, death or family break up. Children who have suffered abuse and/or neglect are also at particularly high risk of developing mental health problems (Investing for Health 2003).

5.7.1 Bullying and Mental Health

There has been increasing recognition in recent years of the impact of bullying[55] on young people's emotional wellbeing and mental health. As Dyer and Teggart (2007:353) observe:

"Bullying experiences have been shown to evoke a number of emotional states including anger, frustration, sadness, anxiety and guilt...They have also been associated with more enduring difficulties such as low self-esteem, insomnia, anxiety disorders, depression, attention deficit

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[55] The issue of bullying is explored further in chapter 6, section 6.9.

and hyperactivity disorder, somatisation, physical health problems, antisocial behaviour, self-harm, suicidal ideation, and attempted suicide…Being a 'victim' of bullying is [also] a direct antecedent to the development of emotional problems and poor social relationships…the predominant psychological difficulty associated with being a 'victim' of bullying was depression."

Research on the relationship between bullying and mental health is still, however, in its infancy in NI despite bullying manifesting as a prevalent problem with clear links to mental health difficulties and despite high numbers of 'bullies' and 'victims' coming into contact with Child and Adolescent Mental Health Services (CAMHS). Dyer and Teggart (2007) in a small scale study of 12–17 year old CAMH service users in NI, noted that bullying (in a school or community setting) appeared to be a more significant problem for CAMHS users than the general population, with almost two thirds of the CAMHS users identifying bullying as a moderately/very important reason for their attendance at the service. CAMH service users also reported clear links between their bullying experiences and their mental health difficulties. Given the scale of bullying across NI, and the new mediums for bullying offered by technological advances, this is an area that requires further investigation and investment.

5.7.2 LGBT Youth and Mental Health

McNamee's (2006) research into the mental health needs of young same-sex attracted men in NI highlights the extent and severity of mental ill health amongst this group. Her 2006 study with 190 same-sex attracted young men revealed that:

- 32.4% of respondents had a potential psychiatric disorder
- 34.4% had been diagnosed with a mental illness at some time of their lives
- 37.9% had received professional help – this was in relation to their same-sex attraction in almost two thirds of cases
- 27.1% had attempted suicide
- 71.3% had thought about taking their own life – four fifths attributed this to their same-sex attraction
- 30.7% had self harmed – two thirds attributed this to their same-sex attraction.

McNamee observes that though it was a combination of different factors that contributed to mental ill health, suicidal thoughts, suicidal attempts and self harm, homonegative experiences (bullying, homophobia, isolation) in school or the local community played a crucial role, as did a fear of society's attitudes to people of a non-heterosexual orientation and, in some instances, negative beliefs about their own sexual orientation:

"The young men spoke of different factors which affected their mental health. There factors were: difficulties accepting their sexuality, a shortage of people that understood what they [were] going through and homophobia in school, at home and in society. Loneliness and isolation were subjects that also took great prominence in interviews…Another common topic was the attitudes of family members to non-heterosexual orientations" (McNamee 2006:6).

Considering the potential numbers of young people affected by this, McNamee et al (2008) report that a 2002 non-probability sample of over 1,000 young people aged 14–25 in NI found that 10.9% of males and 12.9% of females reported having been attracted to another person of the same sex at least once. Relatedly, 10.9% of males and 3.6% of females reported having experience of homosexual sex. These findings are not dissimilar to the 2005 YLT survey that found that 8.8% of 16 year old respondents said they had been attracted to someone of the same sex as themselves at least once. These young people were significantly more likely than their peers who identified as only being attracted to people of the opposite sex, to report experiences of being bullied within school and to find the support provided to be inadequate. The authors also note that these young people do not necessarily have to be openly 'out' to experience bullying, but that they may be bullied purely on the basis that they are perceived to be gay (ARK 2005). Same/both-sex attracted young people were also more likely to have poor mental health and to *"experience higher levels of social pressure to engage in behaviours that may be adverse to their general and mental health, such as drinking alcohol, taking illegal drugs, losing weight or engaging in sexual intercourse when they do not really want to"* (McNamee et al 2008:42).

McNamee (2006) concludes that the needs of young same-sex attracted men are currently not being met and that a multi-faceted response is required to this, including improved RSE in schools, greater access to individual counselling and support groups and challenging of ongoing heterosexist and homophobic societal attitudes.

5.7.3 Disabled Children and Young People and Mental Health

Young people with learning disabilities are significantly more at risk of developing mental health difficulties than their non-disabled peers, with prevalence rates of around 40% commonly reported. Young people with learning disabilities living in State care are particularly vulnerable in this regard, given the higher rates of mental ill health also observed amongst those in care,[56] but little attention has been paid to the mental health experiences and needs of this particularly vulnerable group to date (Taggart et al 2007). A recent study by Taggart et al (2007:411) found that more females than males with learning disabilities were residing in State care. These individuals, aged between 9 and 16 years, had entered care for a 'variety of complex and interwoven reasons' including

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[56] Looked after children's experiences of mental ill health are explored in chapter 4, section 4.18.

those relating to parental child-rearing practices/strategies and those relating to the behaviours of the child, which the authors note *"may contribute to the high prevalence of potential mental health problems in this population"*. The study found that over three quarters of the young people with learning disabilities within the study had potential mental health problems and/or the presence of a psychiatric disorder. Though the small scale nature of the study and use of third party informants require caution in the generalisation of its findings, they clearly illustrate the need for further research within this field.

Bamford (2006a) reports that children with physical disabilities are also at higher risk of developing mental health problems, with rates of psychiatric disorder in 5–15 year olds with epilepsy as high as 37%.

A 2005 report by the National Deaf Children's Society (NDCS) has explored the mental health needs of deaf children and young people in NI. While observing that fewer individuals have presented with mental health problems than would be expected, the report highlights the particular vulnerability of deaf children to mental ill health, given the potential frustration and isolation experienced by this group and the challenges they experience in living in a hearing oriented society:

"Although deafness in itself does not predispose anyone to mental health problems, there are a number of issues relating to the management of a child's deafness, which may place that child under considerable stress, resulting in the need for mental health management…Deaf children, particularly those from hearing families, may be exposed to an excess of risk factors that can affect all children and lead to adjustment disorders in adolescence. These factors include academic failure, low self-esteem, rejecting relationships, inconsistent discipline, failure of age-appropriate development, and abuse (sexual, physical and emotional). Most of these are secondary to negative attitudes to deafness and, above all, to failure to develop age-appropriate communication" (NDCS 2005:7).

The authors note the need for accessible mental health services (both preventative and responsive) to be developed for this particularly vulnerable, and frequently isolated, group of children and young people.

5.7.4 Statutory Responses to Child and Adolescent Mental Health

The importance of positive mental health amongst children and young people, and the impact mental ill health can have on both their current development and their future functioning in adult life, have traditionally been under-developed and under-resourced within NI. As the Bamford Review (2006a:2) observes, *"mental health services for children in NI have received too little attention for too long and have suffered from a lack of coherent planning and investment"*. Gilliland et al (2005), however, note that the issue has started receiving increasing recognition in recent years. Indeed HPA (2006:5) concluded two years ago that *"the policy environment that supports mental health in Northern Ireland has never been more favourable"*. Particular statutory developments that have contributed to this changing landscape include the Ten Year Strategy for children and young people, Investing for Health Promoting Mental Health Strategy for 2003–2008, the work of the Bamford Review and the work of the Suicide Prevention Taskforce established by DHSSPS in 2005.

The Bamford Review of Mental Health and Learning Disability

The Bamford Review was established by DHSSPS in 2002 to *"carry out an independent review of the effectiveness of current policy and service provision relating to mental health and learning disability, and of the Mental Health (Northern Ireland) Order 1986"* (Bamford 2006a:81). Within this, the Review was tasked with considering how best to provide services to people with specific mental health needs or learning disabilities and promote their social inclusion and how best to promote positive mental health across all sectors of society.[57]

Though this Review was not youth specific, child and adolescent mental health was one of the 10 identified categories for which an Expert Working Committee was specifically established. The findings of this aspect of the Review are presented in a 2006 document entitled 'A Vision of a Comprehensive Child and Adolescent Mental Health Service'. The legislative developments required to realise the Committee's recommendations are presented in a subsequent document, released in August 2007 and entitled 'A Comprehensive Legislative Framework'. Key shortcomings in the current system, identified by the Bamford Review include:

- inadequate information about the nature and extent of mental health needs amongst children and young people in NI
- inadequate expenditure on CAMHS services – less than 5% of the total mental health budget, despite the fact that under 18 year olds constitute 25% of the total population
- absence of a comprehensive strategic plan for service delivery and development
- unequal distribution of services across NI
- inadequate specialist services for eating disorders, ASD, looked after children etc
- long waiting lists (Bamford 2006b).

The Review concludes that *"despite many examples of good practice the overall quality, consistency and accessibility of services is so inadequate that urgent strategic action is needed to tackle these shortages"* (Bamford 2006a:i). The Review further observes that the current *"inequalities and inadequacies in CAMHS provision in NI could amount to violations of the European Convention on Human Rights"*, highlighting the *"fundamental need for a coherent, comprehensive regional CAMHS framework linked to an effective cross-region network of statutory and voluntary bodies promoting material well-being in children and young people"*. The report concludes: *"NI CAMHS does not need a structural review – it needs a structure"* (Bamford 2006b:2/3).

Many of the criticisms contained within Bamford have also been raised in a number of different local research studies, including that of Davren (2007), Niwa (2007) and Teggart and Linden (2006). Participants in this review were also highly critical of the existing state of mental health services for children and young people in NI:

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[57] www.rmhldni.gov.uk/index/aboutus.htm [accessed October 2008].

"Mental health for young people is not at all adequate with vulnerable children not properly protected even when child is suicidal" (parent).

"You need to put in place properly resourced adolescent mental health services" (parent).

"If everything is going smoothly then it's ok. But if you face a problem such as mental health issues, abuse, criminal accusations for young people, then parents are left high and dry to sort out for themselves. Less able parents have great difficulty in this regard" (parent).

"Concerns about teenage suicide should not be addressed by platitudes but by ensuring proper access to psychiatric care where it is needed" (parent).

"I work with children and adolescents in terms of mental health, and mental health is really over looked in terms of accessing services" (professional).

"There is a gap in services, or a lack of mental health services provisions for adolescents. They fall between children's and adult services" (professional).

"I think the fundamental difficulty with mental health is in the mental health legislation. What is used with children is the actual adult mental health legislation…if children under eighteen are detained for treatment or detained for assessment that will follow them through their life.…If we are talking about children under 18 that maybe are going through trauma or going through emotional difficulties, really is that appropriate legislation that we are using for those children? For children you know you can lose a criminal record but you can't lose a detention in a hospital setting – which is fundamentally wrong" (professional).

Particular concern was raised around the lack of information and support available to children and young people and/or their families when mental health concerns arise:

"Not enough info on mental health accessible to young people" (young person).

"People with mental illness don't have access to information" (young person).

Particular concerns were also raised about the lack of child/adolescent specific services and the consequent inappropriate placing of young people in adult oriented facilities/services or facilities outside of their local area or even outside of NI:

"Young people with mental health problems are being admitted to adult units. Issues like this that doesn't seem to be getting addressed because there aren't the resources to do it. They do what they can but it's not enough" (parent).

"The support that is set up is usually concentrated around urban areas; however rural areas suffer from the problem of suicide just as much" (professional).

"Children are having to go to England and Wales away from their families to access special therapeutic services, really we should be looking at something here" (professional).

The inadequacy of existing child and adolescent mental health services has also been identified as an issue of serious concern within the Ten Year Strategy, which reports 1,224 young people waiting for their first CAMHS outpatient appointment as of 31 March 2005. The strategy further reports 66% of young people to be waiting over 3 months for their first appointment, 31% to be waiting over 6 months and 14% to be waiting over 1 year (OFMDFM 2006c). The strategy commits to decreasing the numbers of young people on a waiting list and to reducing waiting times for those who are, setting a target in the first action plan of ensuring no young person should be waiting more than 6 months from point of referral by a GP to receipt of their first outpatient appointment (OFMDFM 2007a; 2006). In the absence of any published evaluation of the success of the first action plan, it is not possible to determine the degree to which this target has been met.

The Bamford Review team's 2006 report on CAMHS sets forth 51 recommendations that, if implemented in a structured and comprehensive manner offer an opportunity to reform and modernise the provision of CAMH services within NI and ensure that all children and young people can access *"the services they need, deserve and have the right to expect"* (Bamford 2006b:9). Key elements of these recommendations include:

General:
- development of a structured cross-departmental implementation process
- extension of CAMH services to all young people under 18 years of age
- dedicated budget for CAMH services
- ensuring CAMH services are delivered in developmentally appropriate settings
- commissioning of research into the mental health needs of children in NI
- ongoing mapping of service provision across NI
- development of a flexible four-tier model of service delivery, ranging from universal services at Tier one to specialist services for children with serious mental health problems at Tier four
- training and support of relevant professionals
- engagement of service users in shaping and monitoring of services.

Health promotion:
- development of mental health promotion and prevention in school settings
- development of infant mental health and early intervention services
- expansion of parenting support
- development of suicide prevention strategy
- development of post-abuse intervention services and services for children who display sexually harmful behaviour
- further investigation into specific mental health needs of LGBT youth.

Services for those with mental ill health:
- improved interface between CAMH and adult mental health services
- development of out of hours services
- development of more specialist mental health services for children, especially those from particularly vulnerable groups or those with complex needs
- prevention and treatment strategies for alcohol and substance misuse

- development of specialist community based teams for young people
- development of a regional forensic CAMH service
- voluntary or statutory partnerships, with longer term funding arrangements guaranteed (Bamford 2006b).

While the authors of these recommendations *"recognise the resource implications of implementing these recommendations"*, they have *"urge[d] government to begin this process as quickly as possible, so that children and young people can benefit from a range and level of mental health services, which will appropriately meet their needs"* (Bamford 2006a:Foreword). They have also urged the government to ensure that any proposals progressed in relation to the improvement of CAMH services in NI *"take account of all the rights contained in the UNCRC"* (Bamford 2006a:Introduction).

The government released its response to Bamford – 'Delivering the Bamford Vision' for consultation in June 2008. Key elements of the proposal, of relevance to CAMHS, include:

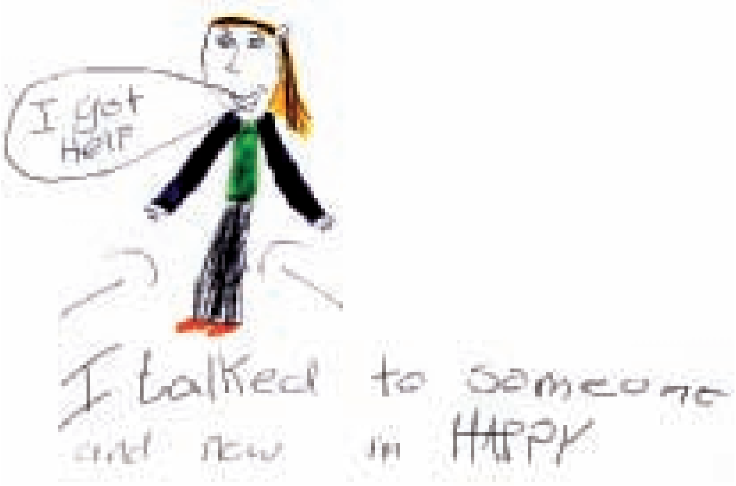
General:
- greater service user involvement in planning, delivery and monitoring of services
- greater say for service users in relation to their care and treatment and the development of clear care pathways
- development of a new service framework for mental health by December 2008
- review of existing information services and production of information base of relevant services by March 2009
- additional advocacy services and consideration of a statutory right to advocacy within planned legislative reform
- replacement of the 1986 Order by 2011 and enactment of new mental capacity legislation by 2014
- establishment of monitoring bodies, with the Health and Social Care Task force and the Bamford Monitoring Group to be established by March and September 2009 respectively.

Child/youth specific:
- development of services in line with four tier model recommended by Bamford
- mainstreaming of funding for an NI wide Crisis Assessment and Intervention Service
- a new 18 bed regional adolescent mental health in-patient unit, to replace existing facilities that have a maximum capacity of 12, and the replacement of the current 15 bed children's psychiatric unit (for under 14s) in line with this adolescent facility – 33 mental health beds will be provided for under 18s by 2010
- development of specialist eating disorder services (Northern Ireland Executive 2008).

At the time of writing, the consultation period had just come to an end. No further information on progress is therefore available as yet. It is, however, important to note that while the provisions outlined above are to be welcomed, the lack of clarity given the timeframes for implementation of several key aspects is a cause for concern, as is the caveat included in the introduction that *"while this document sets out the long term vision over the next 10–15 years for improving services for people with a mental health problem or a learning* *disability, the speed of change will depend to a large extent on the availability of additional resources"* (Northern Ireland Executive 2008:1). Furthermore, concern has also been expressed that many aspects of 'Delivering the Bamford Vision' may be seen to constitute little more than a repackaging of existing strategies and initiatives, thereby bringing into question what real difference they will make to children and young people's lives (NICCY 2008c).

It is imperative that in progressing the delivery of Bamford, the government avails of the opportunity to implement real and significant change, taking account of the Committee's recent call to:

- Ensure *"additional resources and improved capacities are employed to meet the needs of children with mental health problems throughout the country, with particular attention to those at greater risk, including children deprived of parental care, children affected by the conflict, those living in poverty and those in conflict with the law"* (CRC 2008:para 57)
- *"Strengthen mental health and counselling services ensuring they are accessible and sensitive to adolescents in all jurisdictions"* (CRC 2008:para 63).



Promotion of Emotional Wellbeing and Mental Health in Schools

Significant initiatives in relation to the promotion of the emotional wellbeing and mental health of children and young people within the school environment have also been introduced in recent years. Money has been made available, for example, under the CYPFP, for the establishment of independent schools counselling services within post-primary schools. Commenting on this, the NI Government input to the UK State party's 2008 report to the Committee on the Rights of the Child observes that:

"All grant-aided post primary school pupils have access to counselling support which is independent of the school. Under the Children and Young People Funding Package some £1.8 million per annum has been made available to establish this service. Schools' staff will be able to make referrals and pupils will be able to self-refer. All counsellors must have recognised qualifications and appropriate professional supervision" (OFMDFM 2007b:48).

The allocation of this money was a very welcome development given the findings of the Education and Training Inspectorate (ETI) in 2005 that existing school counselling provision played a significant role, but one that was severely hampered by its limited availability, heightened by increased demands for the service in the absence of any additional funding.

It is also particularly pertinent given the escalating complexity of personal problems and issues being experienced by children and young people in NI. As Adamson et al (2006:4) highlight in their report on the NSPCC's Independent Schools Counselling service:

"Research carried out in recent years confirms that children and young people living in Northern Ireland are struggling to cope with a range of issues that include domestic violence…bereavement, sexual abuse…family breakdown…suicide, alcohol and illegal substance abuse…bullying…and sectarian violence and intimidation…Their struggle to cope is further compounded by their reported reluctance (particularly for young males) to access professional support…and the relative dearth of accessible support services that provide a pragmatic response to children and young people…Consequently, children and young people living with these issues carry them with them to school, where for many, their struggle to cope manifests as behaviour problems and contributes to poor engagement and academic achievement."

Noting the existence of such complex problems, the 2005 ETI report concludes:

"All of the ELBs demonstrate a clear need for counselling support and services in schools within their area. At present, access to counselling, when required, is not available to all pupils in all schools. It has now become widely accepted within educational circles that counselling support in schools has resulted in a range of positive outcomes for children and young people. Consequently, sustained access to such positive and beneficial services should be made available, as a matter of priority, for all pupils within schools in Northern Ireland" (ETI 2005:7).

The additional commitment made by the NI Assembly in the 2008 budget to extend the service to the primary and special schools sector is a further welcome development (NSPCC 2008), however, it is imperative that the provision of counselling to these children, as to all children, be both easily accessible and 'fit for purpose'. It is hoped that the current work being undertaken by DE under the auspices of PEHAW (Pupil Emotional Health and Wellbeing), exploring how best to meet the emotional wellbeing and mental health needs of pupils within educational settings will offer significant and useful contributions in this regard, but it is as yet too early to tell.

In progressing the development of counselling services in schools, it is also imperative that views of pupils are both ascertained and fully integrated into service planning in order to ensure that the service provided offers the greatest likelihood of appropriately meeting need. Children and young people who participated in this review, for example, had varied views on the support programmes offered in their schools. Some spoke favourably of the support on offer:

"The Counsellor in the school is there for everything and everyone…comes in once a week, started a while ago."

"Most students don't realise how many helpful options are open to them but they are there if you need them."

"You write a letter and put your name, age and class on and they come to get you. They're not allowed to tell anyone about it unless its abuse or bullying or something."

"We have a mobile number that you can ring or text; the mobile is kept by one of the teachers."

"Counsellors are very good, they listen to you. It really helps you through."

Others spoke less positively about the services on offer, highlighting issues of anonymity, confidentiality, embarrassment or lack of knowledge as factors that would impact upon their willingness to avail of services offered:

"We've no one in school, some counsellors and teachers but I wouldn't feel comfortable talking to them."

"I feel uncomfortable talking to teachers I like the boundary being there."

"They say to come to them but you go and try and talk but half the time they don't listen."

"You don't have confidence in them…they phone your parents."

"We have a school counsellor but you'd be embarrassed to ask to speak to her."

"Want someone you can trust who won't tell."

"It's very important to have people to talk to for protection, like Childline. It should be in a safe private way, so you won't get embarrassed, like the Samaritans."

"Every school should have an independent counsellor, not a teacher. Makes young people feel uncomfortable."

It is important that further work is undertaken to ascertain the views of children and young people in relation to what they desire/require from counselling or other related support services within the school environment and to determine both barriers and incentives to the effective use of such services.

5.7.5 Feeding and Eating Disorders

According to the Bamford Review, the incidence of new cases of anorexia nervosa and bulimia has now increased to 11 per 100,000 and 18 per 100,000 respectively per year. Anorexia nervosa is cited as the third commonest chronic illness of adolescence, but it is also an issue of concern with younger children with over half of parents reporting 1 problem feeding behaviour, and over 20% reporting multiple problems in children aged between 9 months and 7 years old (Bamford 2006a:para 2.30).

There is a clear gap in service provision in relation to the treatment of feeding and eating disorders within NI which anecdotal evidence suggests has resulted in children not receiving the services they require and/or having to go elsewhere in the UK to do so. The Bamford Review (2006a:para 2.30/para 3.42) observes:

"Parents presenting at specialist services often describe difficulties in accessing treatment for their child, suggesting that at best care pathways are far from clear, and at worst that adequate services are not available to some patients… Services for 'eating disordered children' are generally provided by specialist community CAMH teams, using local paediatric wards or regional inpatient units when admission is necessary. Inpatient places in regional units have not always been sufficient to meet demand, resulting in considerable pressure on overstretched outpatient services in managing very ill young people in the community."

The Bamford Review highlights the need for further investment in, and development of, services for feeding and eating disorders within NI. It recommends that *"working relationships between paediatric, medical and psychiatry in-patient services should be developed for continuity of care"* and highlights the need for both *"a particular increase in specialised outpatient services, and more specialist teams within generic settings, both inpatient and outpatient"* and the provision of age appropriate facilities (Bamford 2006a:para 6.36–6.39).

It is imperative that these recommendations be effectively progressed without delay if children with feeding and eating disorders are to have their article 24 right to positive health and appropriate healthcare realised. The establishment of a Regional Eating Disorders Service, noted in the NI Government's input to the CRC report, is a welcome development in this regard, but to date access to this service can only be achieved through referral from a consultant psychiatrist. The stated *"longer term aim [of providing] a specialist inpatient eating disorder unit in Northern Ireland with re-feeding beds and psychiatric facilities"* also noted within OFMDFM's report is also to be welcomed, but as yet no observable progress has been made in relation to this (OFMDFM 2007b:48).

5.7.6 Self Harm

"Suicide and deliberate self harm are closely related phenomena although they differ in important ways" (Bamford 2006a:7).

The term self harm *"covers a wide range of behaviours including habitual self-cutting and poisoning. Northern Ireland has witnessed a substantial increase in self-harm related admissions to hospital in recent years. Self-harm involves differing degrees of risk to life and suicidal intent, and it is often considered to be a coping mechanism, or a means of helping someone deal with their life. There are myths surrounding self-harm. One is that all of those who self-harm are seeking attention. In reality, many go to great lengths to hide their injuries. Another myth is that, in all cases, someone who self-harms is trying to take their own life. While* *it is true that those who self-harm are more at risk of attempting suicide, it is not true that the majority will go on to die in this manner"* (DHSSPS 2006c:para 1.6/1.7).

According to the British Medical Association, the average age of onset of self harm is 12 years (HSSPS Committee 2008:32). The UK National Inquiry into deliberate self harm reports that 1 in 10 teenagers self harm, with more than 24,000 admitted to hospital each year across the UK (cited in Bamford 2006a). NI specific statistics reveal an average of 7,200 self harm related hospital admissions per year; equivalent to a rate of 421 per 100,000 population (North and West Belfast Health Action Zone 2006). Rates are particularly high amongst those living in areas of deprivation, with standardised admission rates to hospitals for self harm in the 20% most deprived areas being almost double the NI average in 2005/06 (DHSPSS 2007a).

As highlighted above, the term self harm covers a wide range of behaviours; these can include:

- cutting
- taking overdoses of tablets or medicines
- punching oneself
- throwing one's body against something
- pulling out hair or eyelashes
- scratching, picking or tearing at one's skin causing sores and scarring
- burning
- inhaling or sniffing harmful substances.[58]

Recent years have seen increasing recognition of both the extent of self harm and the need for an appropriate response to the same. The issue of self harm, though distinct from that of suicide, fell under the remit of the Committee for Health, Social Services and Public Safety's Inquiry into the Prevention of Suicide and Self Harm, that reported in May 2008. Recognising both that the responses to self harm frequently focus more on the behaviours than the underlying causes and the relationship between some cases of self harm and subsequent suicide, the Inquiry expressed great concern *"about the lack of focus on providing psychosocial assessment and follow-up care for those who self harm"*, calling for the existing pilot self harm service in north and west Belfast to be evaluated and extended to all accident and emergency departments across NI (HSSPS Committee 2008:33).

5.7.7 Suicide

Article 6 of the Convention places an onus on States parties to 'ensure to the maximum extent possible' the survival and development of the child. The numbers of children and young people losing their lives to suicide sits in stark contrast to the effective realisation of this right. The Committee has expressed increasing concern about the phenomenon of suicide amongst children and young people in recent years, requesting that all States parties provide data on deaths of children due to suicide in their periodic reports to the Committee (CRC 2005d) and specifically requesting of the UK Government that it undertake studies on the

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[58] www.selfharm.org.uk/information/what/default.aspa [accessed August 2008].

causes and backgrounds of suicides (CRC 2002a).

Commenting on the increasing prevalence of suicide within NI, the Committee for Health, Social Services and Public Safety reflects on the potential contributory factors:

"Suicide itself is not an illness or a condition,… it is an act that can occur as an outworking of various factors…Suicide is a final act which always arises as a consequence of a great complexity of issues. The evidence produced during the course of the Inquiry demonstrated beyond doubt that there is no single reason why someone takes their own life and the risk factors associated with suicide are exceedingly complex and multi-faceted. As well as mental health issues the factors highlighted to the Committee that may be linked to suicide ranged from social pressures, low self esteem, lack of opportunity, limited education and employment opportunities, limited access to mental health support, lack of communication and interpersonal skills, to sectarianism, intimidation or involvement with paramilitaries. Other factors highlighted were the impact of bullying or of being subjected to physical or sexual abuse, the impact of alcohol or drug misuse, long term medical conditions and post natal depression" (HSSPS Committee 2008:7).

As highlighted above, there is no single universally applicable explanation for suicide amongst children and young people, or indeed those of any age. A number of investigations, evaluations and research initiatives have been undertaken in recent years to try and quantify and understand the increasing rates of suicide amongst children and young people in NI.

Tomlinson (2007:438) notes that *"the most recent figures for registered suicides suggest that NI is on a sharply rising curve"*, with a total of 291 suicides recorded in 2006 compared to 138 in 1997. Bamford (2006a) reports that 2–4% of adolescents make attempts at suicide, with rates being higher among those aged over 16.

Both Tomlinson (2007) and Harland (2008) note the particular vulnerability of young males to suicide with Harland noting both that young men are six times more likely to kill themselves than young women and that suicide is now the largest killer of young males in NI. Within this, suicide is particularly prevalent amongst young males living in deprived and urban areas and gay and bisexual males. Harland further notes that *"suicidal young men are eight times more likely than non-suicidal counterparts to be living alone, in care or hostels or without a family structure, and significantly more likely to have a father who is absent"* (Harland 2008:5).

Considering the possible reasons for these increases in suicide, particularly amongst young men, Tomlinson (2007:436) notes *"growing concern in local communities and among healthcare and social care professionals over a suicide ''epidemic'' and a clustering of suicides within certain areas and friendship groups"*. This issue was also raised by the Committee for Health, Public Services and Public Safety, in its 2008 Inquiry into suicide and self harm, when it noted the development of increasing concern around the role of the internet and social networking sites in relation to youth suicide and commented that work in this field needs to be further developed (HSSPS Committee 2008).

Tomlinson (2007) also notes a strong relationship between experience of the NI conflict and suicide, but highlights recent research that suggests that many teachers and health and social care professionals fail to recognise this causal relationship. Young people who participated in NICCY's Message to the Minister campaign in 2006 offered their insights into potential causes of suicide or self harm. Their responses highlighted both structural and individual factors that may impact on a young person's vulnerability to suicide or self harm, noting that more often than not *"it is not any one particular factor that causes young people to self-harm or take their own lives, but rather the culmination of several different contributing factors"* (NICCY 2006c:4). The societal/structural factors they identified as contributing to the alarmingly high rates of suicide and self harm amongst children and young people were:

- difficulties identifying appropriate sources of advice and support
- unacceptable delays in accessing services
- inappropriate placement of adolescents in adult mental health units – *"I was 13 and put in the adult ward in Windsor, Belfast City Hospital...Do you not think putting a 13 year old child in a unit with drug addicts and violent adults is unacceptable? This was an unnecessary and terrifying experience, which did nothing to help me conquer my illness"* (male, age 17)
- inappropriate incarceration of young people with mental health needs
- insufficient needs-focused training and education amongst professionals
- inappropriate responses from professionals approached for help
- continued stigma/negative societal attitudes – *"As a young person who self harms...I won't seek help cos I feel that people will not understand y I do it and they will judge me. I don't want people to think I'm a freak or weird just cos of my way of coping with life's pressures"* (female, age 20)
- under-funding of services resulting in continued insufficient service provision across the fields of education, health and social services.

The individual factors identified were:

- bullying
- the impact of paramilitaries
- an experience of care or custody
- bereavement
- family breakdown
- mental ill health – *"Having a non-tangible illness, such as mental health makes things worse as no-one can see your pain and how much of a struggle it is for an adolescent to go through. Every aspect of my life is and has been affected"* (male, age 20)
- sexual or physical abuse
- drug use
- lack of self worth (NICCY 2006c:4/5).

Children and young people who participated in this review also shared their thoughts on, and experiences of, suicidal feelings and suicide attempts:

"When people are being bullied and no-one listens, you feel like you want to attempt suicide…have no-one to go to if you are feeling like doing this."

"Sometimes things get too much and you feel like committing suicide."

"Some people in our school feel lonely and unhappy because no-one bothers with them… There is a boy in our school and although no-one touches him in a violent way (I don't think) no-one talks to him and people taunt him about the way he is…I know of one person in my class who is not very happy with themselves and has tried to end their life."

While small scale studies like those outlined above offer useful insights into potential causes of suicide and self harm amongst children and young people in NI, there remain significant gaps in our knowledge and understanding of these issues that, in turn, restrict our ability to effectively respond to the issue. Furthermore, as Tomlinson (2007) observes the crude age categories used in published statistics (15–24) years can disguise the extent of suicide amongst under 18s and prevent meaningful social analysis of the issue.

As a result of concern about an increase in the number of suicides, particularly among young people, DHSSPS established a taskforce to develop a suicide prevention strategy in July 2005. The draft strategy was released for public consultation in March 2006, with the final 'Northern Ireland Suicide Prevention Strategy and Action Plan' for 2006–2011 subsequently released in October 2006 (DHSSPS 2006c).

The overall aim of the strategy is that of reducing the suicide rate in NI. Key objectives within this include raising awareness of mental health and wellbeing issues, early identification of, and an effective coordinated response to, mental ill health and further research into the phenomenon. Recognising that particular groups of the population are more vulnerable to suicide, including adolescents, males, those living in economically deprived areas and/or urban areas, the strategy adopts a dual population and targeted approach to reducing suicide within NI. The scope of the strategy is primarily preventative in nature, but its authors recognise that this must be accompanied by properly resourced mental health services, reiterating the recommendations of the Bamford Review in relation to gaps in service provision (DHSSPS 2006c).

The strategy sets overall targets of a 10% reduction in the overall suicide rate by 2008 a further 5% reduction by 2011. It also sets six specific targets for the reduction of suicide amongst children and young people between 2006 and 2011:

Short/medium-term targets (1–3 years):

- to raise awareness of and ensure availability and timely access to appropriate intervention services, including CAMHS and mentoring schemes
- to make suicide awareness and positive mental health and wellbeing training a priority for teachers and youth workers.

Medium-term targets (3 years):

- to promote a culture of help seeking behaviour amongst young people
- to encourage inclusion of coping and life skills, emotional literacy and programmes that promote positive mental health in the school curriculum
- to develop and implement practices, protocols and referral pathways to smooth the transition from youth to adult health and social services.

Medium/long-term targets (3–5 years):

- to promote the inclusion of positive mental health as a key element of the Healthy Schools Programme and to ensure that children and young people are protected from all forms of bullying.

Recognising the particular vulnerability of males, it also sets a further three specific short/medium-term targets for young males:

- to ensure targeted outreach programmes for young males are available in local communities and all HSS Trusts
- to implement a targeted information and awareness campaign for young males
- to enhance the provision of mentoring support for young people at risk of suicide or self harm (DHSSPS 2006c).

A cross-sectoral Suicide Strategy Implementation Body (SSIB) has been established to oversee and drive forward the implementation of the strategy and report annually to the MGPH. The strategy recognises that the successful implementation of its provisions will depend on both effective inter-departmental working and effective coordination with the targets set in other relevant strategies, particularly the Promoting Mental Health Strategy and the Bamford Review. It will also depend on adequate and effective resourcing: OFMDFM reports that £1.9 million was secured for the implementation of the strategy in the first year, with a total of £3 million identified for 2007/08 onwards, but no further detail is available on the outworking of this (OFMDFM 2007b).

While the introduction of this strategy, and the specific consideration given to the needs of children and young people within it, is a welcome development, at the time of writing no evaluation of progress to date has been released.

The Committee for Health, Social Services and Public Safety's Inquiry into the Prevention of Suicide and Self Harm, reporting in May 2008, recognises that the Protect Life Strategy 'represents a major step forward in the efforts to reduce this needless waste of life', noting in particular progress within DE/Department for Employment and Learning (DEL) funded initiatives for both young people in education and training and those 'hard to reach' young people who are not currently engaged in any such activity. The Inquiry also commends the work of community groups and the commitment of churches to addressing the issue of suicide and self harm.

While commending these developments, the Inquiry also highlights a number of areas where the Protect Life Strategy could be strengthened and enhanced. These include:

- redefinition of priority groups to include those living in rural areas
- establishment of a designated suicide prevention directorate to improve coordination and delivery of the strategy – the current SSIB, with more than 40 members, is *"too large and unwieldy to undertake the role of driving forward the strategy"* (HSSPS Committee 2008:18)
- greater ring-fencing of funding over the lifetime of the strategy and a move away from single year funding of community initiatives
- greater commitment and involvement from all government departments
- enhanced partnerships with churches, local authorities and sporting bodies
- additional and improved training for those coming in contact with people at risk of suicide
- exploration of how good practice models from elsewhere could be replicated in NI (HSSPS Committee 2008).

The Inquiry report also notes concern regarding the fact that the robust annual review and evaluation arrangements promised in the strategy are not yet in place 18 months after its introduction and that some elements of the strategy have been implemented without adequate preparation or evaluation, for example the 24/7 suicide prevention telephone helpline (HSSPS Committee 2008).

The findings of the Inquiry report were debated in the Assembly in July 2007 and the motion that the report be approved and that the Executive bring forward a timeframe for implementing its recommendations was agreed with all party support but this has not yet been further progressed.

5.8 Children's Participation in Decisions about their Health

Under articles 12 and 17 of the Convention, children and young people have the right to be consulted about matters pertaining to their health and welfare, with due regard given to their age and maturity, and to be able to access and impart information relating to the same. As the Committee explains in its General Comment on Adolescent Health and Development, State parties should pay due regard to article 12 (alongside the other three general principles) in exercising their obligations in relation to health and development, with particular attention paid to ensuring that adolescents have:

- access to information that is essential for their health and development and that they have opportunities to participate in decisions affecting their health (notably through informed consent and the right of confidentiality), to acquire life skills, to obtain adequate and age-appropriate information and to make appropriate health behaviour choices
- the opportunity to participate actively in planning and programming for their own health and development (CRC 2003a).

As highlighted throughout this chapter, there are a number of issues in relation to the effective dissemination of health related information to children and young people and their access to related services, with particular difficulties noted in relation to the experiences of vulnerable youth, including those living in poverty, those with English as an additional language and those with disabilities. Commenting in its 2008 Concluding Observations on the UK, the Committee raised particular concern about the latter of these groups, noting that *"insufficient action has been taken to ensure the rights enshrined in article 12 to children with disabilities"* (CRC 2008:para 32).

Participants in this review raised dissatisfaction with the degree to which medical, and associated health professionals, were found to actively consult with children and young people in relation to decisions about their care:

"As I become stressed in hospitals or doctors' surgeries my needs tend to be second guessed. This could be seen as trying to minimise my distress or it could be seen as overlooking my needs as I don't really count" (young person).

"Doctors don't explain about the tablets that they give you, they just give you them" (young person).

"Sometimes they talk to me, but often talk to my mum or dad, cause they think I'm too young to understand" (young person).

Some parents and professionals highlighted good practice examples which they felt should be expanded:

"When a child goes into hospital, some hospitals are very good and provide information to the actual child on their hospital stay and any decisions that have to be made. This can be very helpful" (parent).

"The right to make choices about treatments and other options is important for children and young people with cancer. Information about prescriptions, which are currently being piloted in England, could help to facilitate this" (professional).

The age at which young people can consent for medical procedures was also raised as a matter of contention by some young people who participated in this review:

"The age should be lowered for young people to give their consent to having operations; I didn't have a choice at 14."

One young mother who participated in this review attributed the poor treatment she received at childbirth to her youth, noting that the midwife told her that *"I was too young to know pain and so wouldn't give me pain relief. When I told them that my waters had broken, they didn't believe me and didn't even change the sheets on the bed. I had her (the baby) in the toilet nearly".*

The General Medical Council (GMC) has produced guidance for doctors treating children and young people which includes guidance around issues of confidentiality, decision making, access to medical records, child protection, sexual health and complaints. The introduction to the guidance highlights that children's rights should be respected by *"listening to them and taking into account what they have to say about things that affect them. It also means respecting their decisions and confidentiality"* (GMC 2007:5). The issuing of this guidance is a welcome step in involving children and young people in making decisions about their healthcare in a confidential manner that respects their rights and it is hoped that it will result in meaningful change for children and young people seeking advice or treatment.

5.9 Substance Use

Article 33 of the Convention places an onus on State parties to 'take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances'. The levels of incidence of tobacco, alcohol, illegal drugs and/or solvent use observed within NI in recent years, including that by children and young people, calls into question the degree to which the State is successfully delivering on this obligation.

5.9.1 Drug and Alcohol Use

It is difficult to ascertain exact levels of drug and alcohol use amongst children and young people, given the frequently hidden nature and illegality of its use, however a number of reports released in recent years offer helpful insights in this regard:

Drug Use
- 18% of 16 year olds who participated in the 2007 YLT survey reported having taken drugs – 6% said they had taken drugs once; 9% said they had done so a few times and 3% said they had done so many times (ARK 2007)
- 24% of 11–16 year olds in NISRA's Young Persons' Behaviour and Attitude Survey had been offered drugs on at least one occasion; just under half (49%) of these young people had used or tried drugs at some time (NISRA 2008a)
- the four most common drugs used by pupils in the Young Persons' Behaviour and Attitude Survey were cannabis (tried or used by 9%), poppers (6%), ecstasy (3%) and cocaine (3%) (NISRA 2008a)
- 1.6% of P5 to P7 children surveyed by NISRA in 2007 reported having tried drugs. The drugs most commonly tried were cannabis and solvents (NISRA 2007b)
- 15% of pupils in the Young Persons' Behaviour and Attitude Survey had been offered solvents

and 8% had inhaled them on at least one occasion (NISRA 2008a)
- 6% of participants in the YLT survey reported having used solvents (ARK 2007).

Alcohol Use

- 76% of 16 year olds in the YLT survey said they had drunk alcohol – 8% said they had done so once, 31% said they had done so a few times and 37% said they had done so many times (ARK 2007)
- 54% of 11–16 year olds in the Young Persons' Behaviour and Attitude Survey had taken an alcohol drink; 76% of these pupils were aged 13 or under when they first did so (NISRA 2008a)
- 38% of almost 4,000 P5 to P7 children surveyed by NISRA in 2007 reported having taken an alcohol drink on at least 1 occasion, however, 51% of these children reported their last use of alcohol as having been 'a sip' (NISRA 2007b)
- 56% of the P5 to P7 children who had tried alcohol reported being given it by their parents the first time they did so; relatedly, 85% said that their parent or other person looking after them, knew they had tried it (NISRA 2007b)
- 13% of P5 to P7 pupils reported that they were currently using alcohol (NISRA 2007b)
- 13% of P5 to P7 pupils reported having been in trouble as a result of their use of alcohol (NISRA 2007b).

Taken together, the findings of these recent surveys indicate that a significant number of young people, and indeed increasing numbers of children, are engaging in some form of substance use. This is not, however, true for all children and young people; some who participated in this review were strongly opposed to the use of drugs:

The potential consequences of substance use are widely recognised amongst professionals working in the field. These include decreased awareness and control and, relatedly, increased vulnerability to violence or abuse and both physical and mental health implications. Furthermore, for increasing numbers of young people, substance use is escalating to the extent where medical intervention is required, with the numbers of under 18 year olds in treatment for drug and/or alcohol abuse more than trebling (from 271 to 847) between 2005 and 2007 and under 18s accounting for 15% of all persons in treatment in 2007 (DHSSPS 2007m).

While patterns of substance use/misuse are observable across the general youth population, there appear to be a number of groups who are at particular risk of engaging in such behaviour, including those from lower socio-economic groups, those in care and those excluded from mainstream schooling.

A number of studies have shown that young people from lower socio-economic groups are more likely to engage in alcohol, solvent and drug abuse and smoking than young people from wealthier backgrounds (McAleavy and McCrystal 2007; Save the Children 2007). Young people living in residential State care have also been shown to be particularly vulnerable to substance abuse, with higher levels of tobacco and alcohol use noted amongst 14–16 year olds in residential care than their counterparts not in residential care (McCrystal et al 2008).

According to McCrystal et al (2005), young people excluded from school are also more likely to be involved in risk taking behaviours than those attending mainstream school, with the authors noting that *"when compared with the school sample they are two times more likely to have been intoxicated, nearly three times more likely to have abused solvents and more than three times more likely to have tried cannabis"* (McCrystal et al 2005:317). McCrystal et al (2007a) similarly note a higher usage of both licit (tobacco) and illicit drug use amongst pupils attending Emotional and Behavioural Difficulty (EBD) Units in Belfast. The authors recommend that *"potentially higher levels of interventions are required for those attending EBD units and at an earlier stage than young people attending mainstream school"* (McCrystal et al 2007a:62).

The new government strategy for alcohol and drugs (outlined below) recognises a number of different groups of young people who are 'at risk' of alcohol and/or drug misuse: these include looked after children, young homeless, young offenders, school excludees and children of alcohol or drug using parents (DHSSPS 2006d). The NI NGO report to the CRC further notes the increased vulnerability of child victims of sexual exploitation and LGBT youth to drug and/or alcohol misuse (SC/CLC 2008).

Following a review of existing drugs and alcohol strategies, and consultation on a proposed new strategy in early 2006, a 'New Strategic Direction for Alcohol and Drugs 2006–2011' (NSD), was issued by DHSSPS in May 2006. The stated aim of the NSD is that of reducing the level of alcohol and drug related harm in NI (DHSSPS 2006d). The strategy identifies two key population groups as its focus, one of which is 'children, young people and families'. The progression of five key elements (pillars) is identified as central to the effective realisation of the strategy's aim with respect to this group: prevention and early intervention, treatment and support, law and criminal justice, harm reduction and monitoring, evaluation and research.

The NSD identifies seven overarching long-term aims which include:

- provision of treatment and support for substance misuse
- reduction of alcohol and drug related harm to users, their families and the wider community
- increased awareness of drug and alcohol related harm
- promoting opportunities for children and young people *"to develop appropriate skills, attitudes & behaviours to enable them to resist societal pressures to drink alcohol and/or use illicit drugs"*
- reducing the availability of illicit drugs (DHSSPS 2006d:17).

In order to deliver on these aims, the NSD further identifies fourteen key priority areas that will *"form the cornerstone of work over the next five years"* and provide the likely structure for funding (DHSSPS 2006d:27). These include:

- developing a regional commissioning framework
- developing a four tier model of service provision – with a particular focus on young people's services
- promoting good practice in education and prevention
- targeting 'at risk' populations, including young people; particular groups of young people noted to be at risk include looked after children, young homeless, young offenders, school excludees and children of alcohol or drug using parents
- addressing underage drinking
- reducing illicit drug use
- tackling drug and alcohol related anti-social behaviour (DHSSPS 2006d).

Responsibility for the oversight of the NSD lies with a steering group that reports to the MGPH. The work of the steering group is to be supported by four advisory groups, one of which will focus on the specific issues relating to children, young people and their families. The strategy states that all such groups will be operational by October 2006 (DHSSPS 2006d). The strategy contains a commitment to the production and publication of annual reports measuring progress against key indicators and an evaluation of all programmes and activities across the NSD at the end of the first eighteen months of its operation but at the time of writing no comprehensive regional evaluation has been produced.

While the introduction of the NSD is to be welcomed, the lack of available evaluative data prevents comment on its effectiveness to date. It is however clear, from the available research evidence, that there is much to be done. Commenting on the situation across the UK in its 2008 Concluding Observations, the Committee has noted concern, calling upon the State party to continue to address the issue by, amongst other things:

- studying the root causes of these problems in order to provide targeted prevented measures
- strengthening mental health and counselling services
- providing children with accurate and objective information on toxic substances, as well as support to those attempting to abandon their use or dependency (CRC 2008:para 63).

It is hoped that the government will take on board these issues as it further develops and progresses initiatives under the NSD.

5.9.2 Tobacco Use

As with drugs and alcohol, it is difficult to provide any accurate depiction of the numbers of children and young people smoking tobacco, however, the findings of a number of recent studies once again offer helpful insights in this regard:

- 55% of 16 year olds in the YLT survey reported that they had smoked tobacco – 14% said they had done so once, 12% said a few times, while 19% reported that they had done so many times (ARK 2007)

- 24% of pupils in the Young Persons' Behaviour and Attitudes Survey have smoked tobacco; four fifths did so at age 13 or younger. One quarter of young people who reported having smoked tobacco, state they continue to use it on a daily basis (NISRA 2008a)
- 11% of P5 to P7 pupils surveyed by NISRA in 2007 reported that they had tried smoking cigarettes. Of these, 21% reported doing so for the first time at 8 years of age, 16% had been 9 years of age and 20% had been 10 years of age (NISRA 2007b)
- 2% of all P5 to P7 pupils in NISRA's survey said they were currently smoking cigarettes (NISRA 2007b).

A number of initiatives have been introduced in recent years aimed at reducing the incidence of smoking in NI, including that by children and young people. Most significant of these were the introduction of a smoking ban in all public spaces and work places in 2007 and the raising of the minimum age for purchasing tobacco from 16 to 18 years on 1 September 2008. According to DHSSPS' consultation on the latter of these developments, the age increase is intended to send *"a positive message that the Assembly is serious about reducing the number of young smokers"* (DHSSPS 2007b:43). Introducing the change to the law, the Minister for Health stated:

"Tobacco is known to be the leading cause of preventable death in Northern Ireland. The cost to our society is huge and I believe raising the age of sale will help discourage children and young people from taking up this life threatening habit…Of course, I realise that raising the age of sale will not, of itself, solve the problem of children's smoking. Surveys regularly show that the majority of adult smokers adopt the habit in their teens and obtain their cigarettes from a variety of sources. We will therefore continue to explore the scope for further action in this important area." [59]

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[59] www.northernireland.gov.uk/news/news-dhssps/news-dhssps-september-2008.htm [accessed November 2008].

5.10 Inequalities in Health

The Committee on the Rights of the Child has expressed serious concern in relation to the inequalities in health and access to healthcare within the UK in both its 2002 and 2008 Concluding Observations on the State party reports. Commenting most recently, in October 2008, it notes concern that *"despite the State party's efforts to tackle inequalities in health services through, inter alia, substantial investments, inequalities remain a problem"*, calling on the government to address these inequalities through *"a coordinated approach across all government departments and greater coordination between health policies and those aimed at reducing income inequality and poverty"* (CRC 2008:para 54/55).

Some of the inequalities in physical health currently observable within NI have already been noted in section 5.5 of this chapter. The particular difficulties facing specific groups of children and young people in relation to their sexual and mental health have also been previously explored in sections 5.6 and 5.7 respectively. This section offers more in-depth consideration of the inequalities observed by four particular groups: those living in poverty, Traveller children, migrant, asylum seeking and refugee children and children with disabilities. The particular health concerns of LGBT children are explored in sections 5.6.6 and 5.7.2 of this chapter, while those of looked after children are explored in chapter 4.

5.10.1 Children Living in Poverty

There are a myriad of ways in which poverty and deprivation can negatively impact upon children and young people's right to health and wellbeing. Many of these have already been highlighted throughout this chapter, but to briefly recap and expand, statistics comparing the experiences of those living in deprived communities reveal:

- lower rates of breastfeeding (Bishop et al 2008)
- lower rates of immunisation (DHSSPS 2007a)
- higher infant mortality rates – 6.5 infant deaths per 1,000 live births compared to an NI average of 5.3 (DHSSPS 2007a)
- higher incidence of dental decay – children in the 20% most deprived wards are nearly twice as likely to have experienced dental decay as those from the 20% most affluent wards (DHSSPS 2007l)
- higher prevalence of mental health problems amongst children (Muldoon et al 2005)
- higher rates of suicide – the rate for deprived areas in 2005/06 was16.8 per 100,000 population compared to a NI average of 11.4 (DHSPSS 2007a)
- higher rates of self harm – standardised admission rates to hospitals in deprived areas were almost double the NI average in 2005/06 (DHSSPS 2007a)
- higher rates of teenage pregnancy – 28.9 births per 1,000 females in deprived areas in 2005/06 compared to 12.4 in non deprived areas (DHSSPS 2007a).

Considering why such inequalities have remain unaddressed for so long within NI, McAleavy and McCrystal highlight the role of 'the conflict' in *"obscur[ing] not only health problems but the relative causative factors such as poverty and social disadvantage"* (McAleavy and McCrystal 2007:283). Bearing this in mind, the increasing recognition afforded the relationship between poverty and health/wellbeing in government policies and initiatives in recent years (including, for example, the introduction of Healthy Living Centres specifically aimed at improving health within areas of social disadvantage) is to be welcomed. Much more is, however, required if the serious patterns of health disadvantage observable amongst those living in poverty are to be addressed.

This need for further action and investment in relation to the relationship between socio-economic status and health was an issue specifically raised by the Committee in 2008. While noting the efforts made by the State in relation to this since their last report in 2002, the Committee reiterated its 2002 concern that inequalities still exist, calling upon the State to address this, with a particular focus on policies aimed at addressing the greater ill health experienced by children and young people in poverty (CRC 2008).

5.10.2 Traveller Children and Young People

Life expectancy is 20% lower for Travellers than the general population in NI and Traveller children are 10 times more likely to die before the age of 10 years than non-Traveller children (DHSSPS 2006e). The continued inequalities in health and wellbeing experienced by Traveller children and young people were raised as an issue of serious concern by professionals who participated in this review.

The health experiences of Traveller children are observed to be *"closely related to the type and quality of accommodation available to them"* (SIHP 2007b:84).

Traveller children living in unofficial sites or roadside encampments will experience different health issues than those living on serviced sites or public housing (SIHP 2007a). Those living in unofficial sites or roadside encampments can experience a range of physical health problems associated with lack of basic sanitation, electricity and running water, while insecurity and fear of eviction, together with conflict with the PSNI, landowners and local residents can have a negative impact on their mental health. As one professional participant in this review observed:

> *"Children and families that we work with (Irish Travellers) are forced to live in the most disgusting living conditions. We are currently working with 12 families and over 40 children who do not have access to electricity and adequate sanitation."*

Travellers living in settled housing can also experience tensions that negatively impact upon their mental health, associated with overcrowding in housing, intimidation from local residents and a lack of support when separated from their extended families (SIHP 2007a; 2007b).

A conference held on Traveller health in 2004 highlighted a number of other issues that impact upon Traveller children's ability to enjoy the basic rights of health and welfare, including racism amongst healthcare staff, GPs refusing to treat Travellers and difficulties of access to health records (CAWT 2004). The Southern Investing for Health Partnership (SIHP) report also reported inappropriate treatment of Travellers by front line healthcare staff, noting that *"Travellers often felt 'invisible' and 'hurt by the way the receptionist behaved'. There was a feeling that some staff make it clear that Travellers are not welcome or are creating a problem just by their presence"* (SIHP 2007b:87). These findings reiterate those of a 2006 Community Development and Health Network Report and show the continued relevance of their findings that:

"What this research report provides is evidence of the needs of health professionals, and others providing public services to Travellers, for greater cultural competence and greater knowledge of Traveller culture and ethnicity. This includes the need for front-line staff, and their managers to be familiar with relevant legislation and to be provided with opportunities for cultural awareness and anti-racist training" (Ginnety 2006:267).

The particular health inequalities experienced by Traveller children were raised by the four UK Children's Commissioners in their report to the CRC in 2008, in which they note of NI that, in spite of the s75 requirement to collate data on the health services provided to ethnic minority groups, *"no regional statistics are routinely kept in relation to the health needs of ethnic minority and Traveller children and young people"* (UK Children's Commissioners 2008:22).

The NGO report to the Committee offers further comment on the particular nature of the health difficulties experienced by Travellers:

"Recent research about Travellers' perceptions of health and health services by the Royal Hospitals in Belfast found that almost a quarter of those involved believed they suffered poor/ very poor health – 16% of men, 32% of women. They attributed this to: lack of appropriate accommodation and basic amenities, poor health behaviours (eg poor dietary habits, smoking, alcohol and drug misuse, lack of regular exercise, 'self-neglect' with health and health-checks being a low priority), discrimination and racism. Although improved access to health services has created some positive change for Travellers, depression is a major concern – often not talked about within their community, this was closely linked to racism and discrimination, accommodation needs, stress and grief, and lack of employment opportunities" (SC/CLC 2008:27/28).

The health and wellbeing of Traveller children received specific recognition by the Committee in its 2008 Concluding Observations in which, noting the relationship between standard of living and wellbeing, it called upon the State to address the issue of safe and adequate sites for Travellers (CRC 2008). While there have been some positive signs in relation to the political will to address this in recent months, it is imperative that the government urgently addresses the rights of all Traveller children and young people to a safe and appropriate environment in which to grow and develop. It is also imperative that efforts are made to address the inadequate levels of access to healthcare services for Traveller children and young people and, relatedly, the attitudes of healthcare professionals to them when contact is made. The co-commissioning of an All Ireland Traveller Health Study by DHSSPS is a welcome start in relation to this, but it is imperative that the scope of this research be adequately in-depth and that the findings of the study be effectively utilised to inform the development of policy and practice to address the recognised disadvantages and discrimination experienced by this group in relation to their health and wellbeing.

5.10.3 Migrant, Asylum Seeking and Refugee Children

The absence of both research and statistical information on the health experiences of migrant, asylum seeking and refugee children within NI make it difficult to accurately assess their needs but anecdotal evidence would suggest that they are a particularly vulnerable group in terms of enjoyment of their rights to health and wellbeing. A number of recent studies on the health experiences of migrant workers within NI, most of which have been conducted in the Southern Health and Social Service Board (SHSSB), have noted the additional barriers that these adults face in accessing health services, including language difficulties, racism and cultural misunderstanding. While these reports have not been specifically focused on children and young people, the findings hold direct relevance to their experiences. Similarly, while they relate to the experiences of migrant workers, the issues of racism, cultural misunderstanding and language barriers raised in them would be equally applicable to many asylum seeking and refugee children.

ECNI's 2007 Statement on Key Inequalities also observes the inequalities experienced by migrant workers and new residents to NI:

"Migrant workers and new residents experience difficulties in accessing health and social care services. As our economy grows, reflecting a new era for Northern Ireland's prosperity, it is critical that old inequalities are not replaced by new ones. There is an emerging pattern of inequalities experienced by migrant workers and new residents here, in particular unequal access to basic health care" (ECNI 2007b:25).

A mapping exercise and needs assessment of BME groups in the SHSSB has noted the impact that communication barriers can have on migrants' health and wellbeing. The report observes that *"there was a general agreement that language barrier and a lack of readily available information was a major obstacle in accessing services and appropriate, reliable advice"* (SIHP 2007b:117). Research by Animate on the health needs of migrant workers in Craigavon and Sobieraj's report on the experiences of their counterparts in Cookstown reveal the positive impact that the provision of interpretation services can have on access to healthcare services.

The SIHP report further notes the racism experienced by some migrant workers attempting to access healthcare services and support, reporting that racial attitudes of frontline workers are, in some instances, preventing migrant workers from registering with GPs, with some GPs refusing to accept patients of particular nationalities (SIHP 2007b). These findings are in line with those found by Animate (2005) which also noted experiences of discrimination and racism for migrant workers attempting to access services and Sobieraj (2005), whose examination of the experiences of migrant workers in Cookstown presents examples of the severe discrimination and racism experienced by migrant workers. While the findings of these reports relate to adult workers, they have clear implications for the children in the care of these adults.

Though the policy guidance on asylum seekers and refugees' access to health and social services issued by DHSSPS in 2004 recognises the additional efforts required to ensure that asylum seekers and refuges are given equitable access to health and social care services and outlines a commitment to *"providing a culturally competent health and social care service"* the evidence presented above would suggest that this remains more of an aspiration than a reality (DHSSPS 2004:3).

The findings of the studies outlined above reveal the need for further investment in awareness raising and equality training for front line healthcare professionals if current experiences of racism and discrimination are to be addressed. Greater understanding of cultural diversity is also required if the negative impact of *"stereotyping and limited knowledge about cultural diversity" on "the responses of health care professionals to children and families of minority ethnic groups"* is to be addressed (SC/CLC 2008:28). The relative absence of data on the healthcare needs and experiences of migrant, asylum seeking and refugee children is a further clear barrier to the effective realisation of their health and welfare rights and one that must be urgently redressed, as the numbers of such children arriving into NI continue to increase.

5.10.4 Children and Young People with Disabilities

Article 23 of the Convention on the Rights of the Child includes a number of specific provisions for disabled children and young people, in addition to those provided them in the remainder of the Convention. The article stipulates that all disabled children should 'enjoy a full and decent life, in conditions which ensure dignity, promote self reliance and facilitate the child's active participation in the community'. It further recognises the rights of disabled children to special care and assistance designed to ensure they have effective access to their rights to education, training, healthcare and recreation, placing an onus on States parties to deliver this 'free of charge' to both disabled children and those responsible for their care whenever possible. The overriding principle in regard to the provision of such care and assistance is that of 'achieving the fullest possible social integration and individual development' for each disabled child.

Evidence from a wide variety of sources in NI would suggest that disabled children and young people are currently particularly disadvantaged in relation to the enjoyment of their rights to health and welfare.[60] Indeed, children and young people with disabilities were one of the key groups of children identified as most at risk of not having their rights realised by professional participants in this review, with 18% of those who completed questionnaires citing this group as being particularly discriminated against in terms of their rights. The CRC similarly observes in its 2008 Concluding Observations on the UK that *"children with disabilities continue to face barriers in the enjoyment of their rights guaranteed by the Convention, including in the right to access to health services"* (CRC 2008:para 52).

Data Collation

An underlying difficulty seriously impacting upon disabled children's ability to access appropriate care and assistance from the State, as per their UNCRC right, is the absence of comprehensive statistical data as to both the numbers of children and young people with disabilities within NI and the nature of the disability and need. As one professional in this review observed:

> *"Lack of information in relation to statistics of children with disability is a barrier for the planning of effective services for children."*

Although the Children (NI) Order places a requirement on Boards to maintain a register of disabled children in their area, a 2007 report on disabled children with complex needs observed difficulties in the establishment of these registers and lack of consistency across them in terms of definitions and upper age limits applied (KPMG 2008).

A study of the prevalence of disability and activity limitations amongst adults and children living in private households in NI, undertaken by NISRA in 2006/07, does offer an estimate of the percentages of children with disabilities within NI, noting 6% of children (8% of boys and 4% of girls) aged 15 or under to have a disability, and 4% of all under 16s to be living with two or more disabilities. While these figures provide helpful insights into the numbers of children with disabilities in NI, the restriction of the study to those living in private households is likely to only partially reflect the true numbers of those with disabilities. Furthermore, the statistical grouping of 16 to 25 year olds together prevents identification of the numbers of children aged 16 and over with disabilities (NISRA 2007a). Recognising these limitations, McMahon and Keenan (2008) extrapolate the data, applying the 6% prevalence rate from the NISRA study to mid-year population estimates for 2006, and on this basis estimate that there were 25,920 under 18 year olds with a disability in 2006.

The absence of a comprehensive regional register of numbers of children with disabilities is a matter that requires urgent redress if the rights of children with disabilities are to be effectively realised. It is essential that the new Regional Health Board effectively coordinates the collection of data on the numbers of children and young people with disabilities and their needs, through the development of

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[60] The difficulties these children face in accessing their right to education and play and leisure are explored in chapters 6 and 7 respectively. Their increased vulnerability to mental ill health has previously been explored in section 5.7.3.

common definitional parameters and common age bands for the collation of data. Such information is essential if service planning is to become evidence based and services are ever to adequately meet demand. As the Committee observes in its General Comment on Children with Disabilities:

"In order to fulfil their obligations, it is necessary for States parties to set up and develop mechanisms for collecting data which are accurate, standardized and allow disaggregation, and which reflect the actual situation of children with disabilities. The importance of this issue is often overlooked and not viewed as a priority despite the fact that it has an impact not only on the measures that need to be taken in terms of prevention but also on the distribution of very valuable develop resources needed to fund programmes. One of the main challenges in obtaining accurate statistics is the lack of a widely accepted clear definition for disabilities. States parties are encouraged to establish an appropriate definition that guarantees the inclusion of all children with disabilities so that children with disabilities may benefit from the special protection and programmes developed for them. Extra efforts are often needed to collect data on children with disabilities because they are often hidden by their parents or others caring for the child" (CRC 2006b:para 19).

A Regional Strategy

A further underlying difficulty in relation to the effective realisation of disabled children's rights is, as the Committee has recently noted in its 2008 Concluding Observations, the absence of *"a comprehensive national strategy for the inclusion of children with disabilities into society"* (CRC 2008:para 52). The Committee has clearly emphasised the importance of such a strategy in its General Comment on Children with Disabilities in which it states:

"In order to meet the requirements of article 23 it is necessary that States parties develop and effectively implement a comprehensive policy by means of a plan of action which not only aims at the full enjoyment of the rights enshrined in the Convention without discrimination but which also ensures that a child with disability and her or his parents and/or others caring for the child do receive the special care and assistance they are entitled to under the Convention… The Committee urges States parties to make special care and assistance to children with disabilities a matter of high priority and to invest to the maximum extent of available resources in the elimination of discrimination against children with disabilities and towards their maximum inclusion in society" (CRC 2006:para 11–14).

Both parents/carers and professionals working with children with disabilities who took part in this review expressed frustration at the absence of a comprehensive national strategy for disabled children and young people, together with the consequent fragmented nature of services provided to them and the frequent barriers encountered by their families when attempting to access health and other support services.

The NI Government report to the UNCRC notes that *"work on disability is being taken forward* *by the Promoting Social Inclusion Disability Working Group which was established in 2004"* that is examining barriers which exist for disabilities across five subgroups, one of which is 'children, young people and families' (OFMDFM 2007b:22). The report further notes that a strategy is currently being developed, *"aimed at improving the health and well-being of those with a physical or sensory disability [through] increased service provision…improved inter-agency working, replication of models of best practice, more support for parents and siblings and improvements in the transition from child to adult services"* (OFMDFM 2007b:50) but it is not clear what stage this is currently at.

Gaps in Service Provision

As highlighted above, both parents/carers and professionals working with children with disabilities who took part in this review expressed frustration with the fragmented nature of service provision and the frequent barriers encountered by their families when attempting to access health and other support services. Particular issues of concern included inadequate levels of service provision and difficulties accessing that which does exist, a lack of effective inter-agency working in relation to service delivery and a lack of appropriate information and support for children with disabilities and their families.

"Disabled children and young people and their families have more difficulty accessing services as a right, they are often referred from one organisation to another without adequate coordination between agencies to ensure optimum availability of appropriate services and facilities based on a child's need. Provision of services is more financially driven rather than on a needs basis" (professional).

"A lot of children who have learning disabilities have many professionals involved in their life and getting these people to talk around the table is very, very difficult. And so it's about getting these people from the very top right down to the grass roots to come together and talk and learn to communicate" (professional).

"Service provision for disabled children and young people is patchy, there is little child centred coordination of services and parents often find they are given conflicting information from different agencies" (professional).

Parents/carers dissatisfaction with service provision related to both diagnostic and responsive services, with long waiting lists and a lack of follow-up services being commonly cited grievances:

"It has been a battle to discover what is/can be made available to her. She was diagnosed young and yet we are still discovering various facilities and services that she could/should have received."

"Insufficient provision of clinical psychology in WHSSB. On waiting list 9 months – had to go privately. No structured transition physiotherapy or OT services for over 16 year old disabled person."

"According to his statement he should have access to a physiotherapist. We have not seen one in over a year."

Geographical disparities in service provision were also noted as an issue of serious concern:

"Services for children with disabilities are not consistent across Northern Ireland. Some families have found that moving a few miles away into a different area has adversely affected the services and support available to their child'– better co-ordination of services is needed."

"There are pockets of good practice, such as the SHSSB wrap around project, however access is dependent on where a child lives, there is no guarantee of equality of access to high quality child-rights centred services across Northern Ireland."

One young person who participated in this review explained how a late diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) had negatively affected his life:

"Never even told about ADHD until I was older, if caught earlier a lot of stuff wouldn't have happened. Since it's been caught there have been a lot of positives. I have been in and out of hospital - it should have been caught when I was younger."

A significant proportion of parents/carers of disabled children who participated in this review raised concern that the services they had been offered, were not, in their opinion, in the best interests of their child. They cited numerous examples of having to fight to access appropriate services for their children, noting the negative consequences that failure to access such services had upon their children and the wider family:

"The government seem to prioritise other things rather than listen to what disabled people need. My son and others have no appropriate respite for profoundly disabled."

"Unfortunately I have quite a bit of experience of social workers and health visitors, and only I am from a higher social background they would have destroyed my children's welfare and I was able to stand up to them."

"The services have let myself and my child down so many times. I'm never shocked when they ring to say someone can't come to take my child out. Things are getting strained at times."

"My experience of having children with learning difficulties leads me to think that this group are not well provided for and do not get what they need."

"It is impossible to get access to any help, the only help is self help. We try to understand our children's problems and needs and help as best we can. We find obstacles are deliberately placed in our way to stop us from seeking help…It would appear the government doesn't want to pay for appropriate help needed in special needs."

The dissatisfaction expressed by participants in this review in relation to the inadequate levels of service provision for disabled children and young people are in line with both those noted in other recent studies, including those of disabled children with complex needs undertaken by McConkey et al (2007) and KPMG (2008) and that of young people with Asperger Syndrome (AS) undertaken by Jones et al (2007). They are also in line with the findings of the Bamford Review, which concluded that children with learning disabilities *"have not benefited as they should from initiatives to improve children's experiences, or from measures focused on learning disability issues"* (Bamford 2005:35). The Equal Lives report of the Bamford Review makes 13 recommendations in relation to the development of family support and service provision for children with learning disabilities, emphasising the need for cross-departmental working in ensuring their effective delivery.

McConkey et al's (2007) study on disabled children with complex needs identify difficulties in relation to lack of early identification, difficulties accessing the correct diagnosis and long waiting times for service provision, including treatment and provision of practical aids. KPMG's (2008) report, in noting similar difficulties, also highlighted the absence of, and need for, independent advocacy provision for all disabled children with complex needs.

Jones et al's (2007) report on needs and services relating to young people with AS noted similar difficulties in, and frustrations with, the diagnostic process and similar issues in relation to waiting times for services, lack of coordination amongst service providers and a lack of information and support following diagnosis. Parents of children with AS and other forms of ASD, who participated in this review, reiterated these concerns:

> *"The limited services for children and young people with ADHD and ASD has an effect on my son's potential. Ideally there would be better education provision and input from speech therapy and occupational therapy. However constraints on resources mean that services often have to be secured privately."*

> *"Autism is a hidden disability – it has been difficult to get assessments, and in my case we were left on our own to find and fight for services."*

> *"Children with autistic spectrum disorder may find (as my sons have) that they suffer due to the insensitive nature of their disability. In general there is not enough speech and language, occupational therapists for their needs. It (ASD) is treated in a haphazard manner."*

Speech and Language Therapy

A further significant gap in service provision, affecting many children and young people with disabilities (though by no means exclusively so), is that of speech and language therapy (SLT) provision. This was identified by a number of different professionals and parents who participated in this review:

> *"Access to speech and language therapy is completely disastrous for the people we have spoken to. They have had to fight for everything,*

to make any headway in the services. I don't know why this is, but I have certainly met parents whose child may have needed 3 sessions of speech and language therapy a week, and they have only been getting one session once a month or every 5 weeks. And obviously that has more repercussions down the line, because that child is getting even more frustrated because they can't communicate and it manifests itself in behavioural problems" (professional).

"Absence of services – especially speech and language therapy. No complaint with therapists, just not enough of them" (parent).

Both an initial review of SLT provision within NI undertaken by NICCY in 2004/05 and a follow-up review undertaken in 2005/06 found significant gaps in service provision in relation to SLT, noting long waiting times for both assessment and for subsequent receipt of services post assessment. On the basis of information provided by the HSS Trusts, the latter of these reviews noted that:

- 15,547 children and young people were receiving SLT within NI
- 2,055 were waiting assessment for SLT
- a further 3,402 children and young people were still waiting to commence any form of therapy, despite having been assessed to be in need; average waiting times between assessment and receipt of services ranged significantly across NI, from 2.5 weeks in one HSS Trust to 9 months in another, with some children waiting up to 24 months to receive services that they had been assessed as needing (NICCY 2006d).

The follow-up review observed that while waiting times for assessment within community settings had decreased since the initial review, those for receipt of services post assessment had increased. Commenting on the geographical disparities in waiting times and service provision the report concludes that it is still, and possibly more so, the case that where a child or young person lives in NI determines the length of wait for SLT provision (NICCY 2006d).

Following on from repeated recommendations for the establishment of a regional taskforce on SLT (NICCY 2005, NICCY 2006d), one was finally established in 2006. The taskforce reported to the Minister for Health in February 2008 and, at the time of writing, the report was still with the Minister for consideration.

Residential Care for Children with Disabilities

A further issue of serious concern raised by a number of parents in this review was that of inadequate, inappropriate residential facilities for children with disabilities who required them:

"You say that the government has signed up to an agreement called the convention on the rights of the child. The majority of children my son's age can make their own minds up and have choices. My disabled son cannot. A safe and healthy life? Not when the trust has offered my son high risk facilities with adults ranging from 40 years plus in them."

A further related issue of concern is the continued placement of disabled children and young people in residential units when they have been assessed to no longer require this. The relevance of these issues to children in NI was brought to light in the media in January 2007 when reports revealed that a number of children were living in Muckamore Abbey Hospital on a long-term basis, including some who had been assessed to no longer require such residential care. Following intense publicity surrounding this issue, the issue was debated at the NI Assembly, during which time the following motion was passed with support from all parties:

"That this Assembly expresses concern that more than 100 adults and young people with learning disabilities have been forced to remain in Muckamore Abbey Hospital, Antrim — some for periods extending to several years — because appropriate care within the community is not available; demands a full inquiry into the situation to ensure it cannot occur again; recognises the frequently undervalued contribution of staff, families and carers; and calls upon Government to implement urgently the recommendations of the Equal Lives Learning Disability Report of the Bamford Mental Health Review." [61]

The day after the Assembly debate the then Minister for Health announced an action plan aimed at discharging all patients from learning disability hospitals. Particular commitments made within this include:

- an end to the permanent placement of children in learning disability hospitals, to begin immediately, with an end target of no children permanently resident by March 2009
- the fast-tracking of a new community-based eight bedded unit in Belfast for children and adolescents with learning disabilities.[62]

The issue of children inappropriately placed in residential care has also been raised as an issue of concern by the Committee in its General Comment on the rights of children with disabilities in which it urges State parties to *"use the placement in institutions only as a measure of last resort, when it absolutely necessary and in the best interests of the child"* (CRC 2006b:para 47). Where institutional care is required, the Committee clarifies that this should be developed around the rights and needs of the child and provided within small scale age appropriate facilities. At the time of writing no information on the current status of the developments announced by the Minister in January 2007 could be sourced, but it is hoped that these are being, and will be progressed, in line with the Committee's recommendations.

Indeed it is imperative that all future developments in relation to legislation, policy and service delivery take account of the Committee's recommendations, in particular those most recently highlighted in its 2008 Concluding Observations in which it calls on the State party to:

- *"take all necessary measures to ensure that legislation providing protection for persons with disabilities, as well as programmes and services for children with disabilities, are effectively implemented;*

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[61] Northern Ireland Assembly debates: Monday, Private Members' Business: Muckamore Abbey Hospital 29 January 2007.

[62] http://archive.nics.gov.uk/hss/070130g-hss.htm [accessed October 2008].

- *develop early identification programmes;*
- *provide training for professional staff working with children with disabilities, such as medical, paramedical and related personnel, teachers and social workers;*
- *develop a comprehensive national strategy for the inclusion of children with disability in the society;*
- *undertake awareness-raising campaigns on the rights and special needs of children with disabilities, encourage their inclusion in society and prevent discrimination and institutionalization;*
- *consider ratifying the International Convention on the Rights of Persons with Disabilities and its Optional Protocol"* (CRC 2008:para 53).

5.11 Poverty

Article 27 of the UNCRC recognises the right of every child to 'a standard of living adequate for the child's physical, mental, spiritual, moral and social development'. Although, as explored in chapter 4, the onus for the provision of this falls primarily to the parents/guardians of a child, the Convention also clearly places a responsibility on governments to both support parents in the fulfilment of this duty and to step in where parents are unable to adequately fulfil it.

Research evidence has consistently shown that children living in poverty are being denied access to a standard of living adequate for their physical, mental, spiritual, moral and social development. They are also being denied their article 6 right to survive and develop, to the maximum extent possible. In light of this, the Committee on the Rights of the Child has expressed serious concerns at the levels of poverty in NI and the rest of the UK in both its 2002 and 2008 Concluding Observations on the State party's periodic reports.

Commenting in 2002, the Committee drew particular attention to the relationship between poverty and health, general wellbeing and educational attainment, calling on the government to take all necessary measures, to the maximum extent of available resources, to accelerate the elimination of child poverty (CRC 2002a). Commenting again in 2008, the Committee expressed concern that although child poverty had reduced somewhat since 2002 it remained *"a very serious problem"* across the UK and of *"particular concern in Northern Ireland where over 20% of children reportedly live in persistent poverty"* (CRC 2008:para 64). Reiterating its previous call for action, the Committee again emphasised the multiple discriminatory effects of poverty, noting that *"an adequate standard of living is essential for the child's physical, mental, spiritual, moral and social development and that child poverty also affects infant mortality rates, access to health and education as well as everyday quality of life of children"* (CRC 2008:para 65). The Committee also noted particular concern about the life experiences and opportunities of children living in severe poverty.

5.11.1 The Extent of Poverty

The variety of definitions and measurement tools used to measure poverty make it difficult to accurately assess both the numbers of children currently living in poverty and the variance in poverty levels over time. However, while recognising the disparities and inconsistencies associated with the measurement of poverty, it is still possible to gain a general approximation of the numbers of children and young people currently living in poverty across NI and to conclude that no apparent decrease has been observable over recent years. Save the Children (2007) reports:

- 38% of children in NI are going without basic necessities such as healthy food, clothing and a decent home because parents can't afford them
- more than 100,000 children live in income poverty; below the government's official poverty line – this equates to 24% of all children in NI
- 44,000 children (10%) in NI are living in severe poverty
- the geographical distribution of poverty varies across NI, with child poverty rates After Housing Costs (AHC) ranging from 11% to 36% across different district council areas.

The fact that 1 in 4 children in NI are living in poverty, with 1 in 10 living in severe poverty, is a serious indictment on the government's response to the problem to date. As the Committee of OFMDFM itself comments:

"There can be little doubt that having more than 100,000 children living in poverty and 44,000 living in severe poverty is unacceptable in the 21st Century" (OFMDFM Committee 2007:10).

Although the government has made welcome commitments to tackling child poverty – eradicating child poverty across the UK by 2020 – it is generally accepted that the first target set as part of this process (a 25% reduction in child poverty levels by 2005) has not been met. Progress to date also casts serious doubt of the likelihood of the upcoming target for 2010 being met. Commenting on the lack of progress that has been made since these targets were set, the Final Report of OFMDFM's Committee Inquiry into Child Poverty concludes:

"Although levels of child poverty did fall in the late 1990s and in the early part of this decade, there has been no significant decrease in levels of child poverty during the past three years and there are still more than 100,000 children living in relative income in Northern Ireland" (OFMDFM Committee 2008:1).

McLaughlin and Monteith (2006:para 7–11) further conclude that the evidence on child poverty in NI *"shows a society which remains deeply unequal and even punitive in relation to the accident of birth"*.

High rates of unemployment in NI, together with lower rates of pay and higher living costs (particularly, fuel and childcare) can leave families here at greater risk of poverty than their counterparts in the UK (Kenway et al 2006). Within this, particular groups of children are observed to be more at risk than others, particularly those living in families where:

- parent(s) are unemployed
- parent(s) are in receipt of benefits and/or living in rented accommodation or social housing

- there is only one resident parent
- the mother is under 25 years old
- a family member (parent or child) is disabled
- there are four or more children (Herron 2005; McLaughlin and Monteith 2006; Save the Children 2007; NICCY 2008b).

As McLaughlin and Monteith (2006) observe, 71% of children living in workless households, 46% of those living with lone parents, 47% of those living in large families and 36% of those living with a disabled or chronically ill parent are, according to income based measures of poverty, income poor. Using the Poverty and Social Exclusion (PSE) consensual poverty measure, which includes both income and deprivation indicators, these rates increase with more than 4 in 5 children living in workless households, 68% of those living with lone parents, 55% of those living in large families and 59% of those living with an ill or disabled parent deemed to be poor.

Young people living on their own also face a particularly high risk of poverty, in light of the differential benefit and wage levels afforded them and their restricted access to, and receipt of, benefits. To expand, 16 and 17 year olds do not, as a general rule, have an automatic right to receive benefits and those who do access them receive lower rates than their counterparts aged 25 or over.[63] Similarly, the minimum wage level afforded to 16 and 17 year olds is lower than that afforded to adults,[64] with those aged under 16 offered no such protection at all. Young people also face additional restrictions in relation to receipt of housing benefits compared to those aged over 25, only being able to claim rent for a room in a shared house. Young people, living independently, who participated in this review were very clear about the shortfall between their incomings and outgoings which is unsurprising given the fact that they receive notably less, through wages or benefits, than those aged 18 or over, despite facing equivalent living costs.

Difficulties accessing, and the lower rates of benefits received by young people are particularly pertinent in light of the high rates of unemployment observable amongst this group. The Northern Ireland Labour Force Survey reports the unadjusted level of youth unemployment between July and September 2008 to be 12.2%; notably higher than comparable rates for other age groups.[65]

The Committee has explicitly called on the UK Government in its 2002 Concluding Observations *"to review its legislation and policies concerning benefits and social security allowances for 16 to 18 year olds"* but, to date, no remedy has been introduced (CRC 2002a). There is no justification for 16 and 17 year olds to receive lesser benefit levels and a lesser minimum wage than those aged 18 or over, when all face similar living costs, and the continued existence of this differentiation on the basis of age alone sits in conflict with the principles of s75.

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[63] Income support rates post April 2008 pay £47.95 per week for 16–24 year olds and £60.50 per week for over 25s. Previously, 3 different rates had been in existence, with 16 and 17 year olds receiving even less (£34.60 per week) than both 18–24 year olds (£45.50) and over 25s (£57.45) (www.dsdni.gov.uk; Sharma and Hirsh 2007).

[64] £3.53 for 16–18 year olds, £4.77 for 18–21 year olds and £5.73 for those aged 22 or over (www.hmrc.gov.uk/nmw/) [accessed October 2008].

[65] Available from www.detini.gov.uk [accessed November 2008].

5.11.2 The Reality of Poverty

Poverty is often primarily considered in monetary or material terms, but while material deprivation is certainly a key element of poverty, an experience of poverty encompasses much more than this:

"Poverty…is not just about income, but about education, well-being, employment, good housing and a safe and healthy environment" (McGill 2007:1).

"The effect of poverty on children begins even before a child is born as can be seen by low birth weights and higher infant mortality rates. Poverty affects every aspect of a child's life, from opportunities to access play and leisure activities through to low educational achievement and employment prospects" (NICCY 2008b:1).

Poverty is a multi-faceted phenomenon that both results from, and contributes to, a multitude of other factors. The multi-faceted nature of poverty has been highlighted in a number of research papers commissioned by/prepared for the OFMDFM Committee's Child Poverty Inquiry:

"There is no straightforward and generally agreed definition of poverty. Poverty is seen today as a multi-dimensional issue and understood by many as the inability to participate in society – economically, socially and culturally" (OFMDFM Committee 2008:12).

"Children can be said to live in poverty when they live in families which lack the resources to enable their children to participate in the activities and have the living conditions and amenities which are customary, or at least widely encouraged or approved. Poverty in childhood is harmful to current well-being and a threat to well-becoming. Poverty in childhood is associated with many other problems – poor physical and mental health, low educational attainment, poor housing conditions and homelessness, crime, addiction, and in adulthood, early partnering and child-bearing, family breakdown, unemployment and low pay" (OFMDFM Committee 2007:Appendix 5).

As highlighted above, children living in poverty experience multiple levels of disadvantage and discrimination. These are identified time and time again in research that considers the reality of an experience of poverty and include:

- higher infant mortality rates
- greater physical and mental ill health
- lesser access to primary and secondary healthcare
- inadequate nutrition
- unfit housing conditions
- higher rates of both road traffic and domestic accidents
- lack of opportunity for, and places to, play
- lower educational engagement and attainment
- increased likelihood of subsequent unemployment or low paid employment
- increased likelihood of subsequent drug or alcohol abuse or teenage pregnancy
- worry about household finances and a burden of responsibility (Herron 2005; Save the Children 2007; McMahon and Keenan 2008).

Children and young people who participated in this review, whether living in poverty themselves or not, were clear that children living in poverty experienced unfair disadvantage and were not accessing the support and protection they were due:

"Children from poor families do not always have everything to help them stay healthy safe and well."

"The youth from council estates in my area are very under privileged because people don't want to waste money on them because they will just be vandalised."

"Some people in my class live in the inner city and they have nothing to do and are not always safe."

"At school there are two sisters…They wear trousers that are too short and wear the same shoes every year. Other people hate them and say they are smelly but I think it's a sin. It's their mum and dad's fault."

Professionals who participated in this review also identified children living in poverty as one of the key groups whose rights are currently being breached, identifying it as one of the areas where least progress has been made over the last three years:

"Poverty is a key limiting factor to the exercise of broader rights acting as both a cause and as the effect of a denial of equal access to economic and social rights."

"There are far too many children whose rights are constrained due to economic conditions."

"The issue of child poverty is perennial and endemic."

"The fact that there are a substantial percentage living in either poverty severe or persistent poverty and that has implications and not just in terms of material lifestyle but to health and to education to aspiration."

"More work could be done to improve rights under Child Poverty (article 27) where children have a right to a standard of living that is good enough to meet their physical and mental needs. Families need government policies, collaborative working and appropriate support to address poverty."

The implications of poverty on children's lives are considered further in section 5.9.1 of this chapter (health) and chapters 6 (education) and 7 (play and leisure) but it is important to note here both the immediate and longer-term implications of an experience of poverty. As McLaughlin and Monteith (2006:para 7.15) observe:

"The double whammy of child poverty – adverse impact on the opportunities and potential for personal and social development and adverse impact on physical strength and wellbeing – is a significant, enduring, unacceptable source of inequity in our affluent society."

5.11.3 Statutory Responses to Poverty

Recognising that *"growing up in relative poverty undermines children's well-being, social inclusion and self-esteem and reduces opportunities for learning and development"* and that *"growing up in conditions of absolute poverty has even more serious consequences, threatening children's survival and their health, as well as undermining the basic quality of life"* the Committee on the Rights of the Child has called upon governments to employ all means to *"implement systemic strategies to reduce poverty"* (CRC 2005b:para 26).

There have been a number of important developments in recent years in relation to the recognition afforded the issue of child poverty by the State and potential means for addressing this.

The Committee for OFMDFM committed in July 2007 to conduct its first inquiry into child poverty. The terms of reference for the inquiry were agreed in mid October 2007 and 48 written and 35 oral submissions were received over the next month. The Committee produced an interim report in January 2008 to highlight to the Assembly and the Executive some of the key issues that needed to be taken into account before finalising the Programme for Government, Budget and Investment Strategy. Their final report was subsequently produced on 4 June 2008 (OFMDFM Committee 2008).

Prior to this, an anti-poverty and social inclusion strategy entitled 'Lifetime Opportunities' was introduced by the Secretary of State for NI under direct rule in November 2006. Though not child specific this strategy does include a number of targets in relation to child poverty, doing so under the twin pillars of Targeting Social Need and Promoting Social Inclusion. The strategy has two inter-related objectives: to end child poverty and work towards eliminating poverty and social exclusion in NI by 2020.

The strategy defines specific goals and targets across four key stages in life – early years, children and young people, working age adults and older citizens. Early years covers children from 0–4 years inclusive and the stated goal for this group is *"to ensure that every child should have a chance to develop their full potential in infancy regardless of social background"*. The category Children and Young People covers the age range 5–16 years inclusive and the overall goal for this group is to ensure that they *"experience a happy and fulfilling childhood, while equipping them with the education, skills and experience to achieve their potential to be citizens of tomorrow"*, with a specific focus on breaking the link between poverty and educational disadvantage (OFMDFM 2006d:Executive Summary).

While the development of an anti-poverty and social inclusion strategy is a welcome attempt to address child poverty, certain elements of it have been subject to criticism from the children's sector. Specific shortcomings include:

- the setting of the upper age limit for children and young people at 16 years
- targets are too vague/generic and not adequately time/outcome bound

- the absence of a detailed implementation and monitoring plan
- failure to relate the targets and objectives set to those of other relevant strategies
- absence of clear lines of responsibility and accountability.

The setting of the upper age limit for children and young people at 16 years is a matter of grave concern in light of the particular vulnerability of post 16 youth highlighted above. Furthermore the setting of an upper age limit of 16 is out of line with the definition of childhood used in most other government strategies, including the Ten Year Strategy for Children and Young People. It is also out of line with the definition contained within the UNCRC and the remit given to the Children's Commissioner.

Further to these specific weaknesses within the strategy mentioned above, is the fact that the strategy has not yet been approved by the Executive. Commenting on this in its Final Poverty Inquiry Report, the Committee of OFMDFM *"recommend that OFMDFM should move quickly to adopt the Lifetime Opportunities Strategy as the framework for its work to tackle poverty and social exclusion. Critically, this will allow OFMDFM to focus on remedying some of the deficiencies within the Strategy through the development of a properly resourced medium-term action plan, which includes SMART intermediate objectives and targets capable of delivering the Executive's child poverty targets"* (OFMDFM Committee 2008:3).

As highlighted by the Committee, it is imperative that the strategy be both officially adopted and accompanied by an adequately resourced, clearly targeted action plan, which outlines SMART objectives and clear lines of accountability and responsibility for delivering these. As the Committee notes, the provisions of the PfG and related Public Service Agreements will need to be significantly strengthened to ensure that resources and actions are effectively directed by departments towards the elimination of child poverty (OFMDFM Committee 2008). It is also imperative that any targets set for the reduction/eradication of child poverty under the Lifetimes Opportunity strategy be both rights compliant and complementary to those contained within other relevant strategies, including OFMDFM's Ten Year Strategy for Children and Young People. It is equally important that they be recognised across, and committed to by, all government departments in a comprehensive and collaborative effort to bring an end to this clear breach of children's rights.

Effective implementation and resourcing of a revised strategy would enable the government to meet the recommendations contained within the Committee on the Rights of the Child's 2008 Concluding Observations, namely:

- to adopt and adequately implement the legislation aimed at achieving the target of ending child poverty by 2020, including by establishing measurable indicators for their achievement
- to give priority in this legislation and in the follow-up actions to those children and their families in most need of support
- where necessary, to intensify its efforts to provide material assistance and support

programmes for children, particularly with regard to nutrition, clothing and housing (CRC 2008:para 65).

5.12 Homelessness

"Homelessness is one of the most extreme forms of social exclusion and has increased dramatically in Northern Ireland in recent years" (DSD 2007:para 1.1).

Homelessness has traditionally been understood in terms of a narrow definition of 'rooflessness', but the concept of homelessness is now widely accepted to be much broader than this, incorporating, amongst others, those sleeping rough, those in temporary or insecure accommodation, those living in unfit conditions and those living in violence or fear of the same (Beckett 2004).

The legislative definition of homelessness currently in operation within NI is that introduced under the Housing (NI) Order 1988 and amended under the Housing (NI) Order 2003. Although this definition recognises that a person may be homeless for a number of different reasons including violence or threat of violence in the home, eviction or being asked to move on from temporary living arrangements with family or friends, it fails to accord all categories of homelessness equal status and protection under the law. As Beckett (2004:10/11) observes:

"Whilst all households who prove themselves to be 'without accommodation' are, in theory recognised as homeless by the Northern Ireland Housing Executive, not all are practically treated as thus. All homeless households are categorised into one of two distinct subgroups, the 'statutory' and the 'non-statutory' homeless, both of which are accorded different legal status/rights and receive differential treatment…Viewed as 'deserving' of both recognition and assistance, households in the former category are notably more advantaged than those in the latter, qualifying for both receipt of the Executive's full housing duty towards them and inclusion in official counts of homelessness. Entry to this privileged sector is, however, difficult to attain given that the granting of statutory homeless status is dependent upon proving oneself to be not only homeless, but also unintentionally so and in priority need due to…[a set of]…pre-defined criteria."

Children and young people who end up homeless along with other members of their families are more likely to access greater statutory provision than those aged 16 or 17 who register as homeless, independent of their families. To expand, families presenting as homeless will be assessed as in priority need so long as there are dependent children in the family and/or a member of the household is pregnant. Therefore, so long as they can prove they have not become 'intentionally' homeless, the whole family should be accepted as Full Duty Applicants (FDAs), able to avail of the Executive's full housing duty towards them.

Young people presenting independently as homeless are, however, less likely to be deemed as being in priority need as, despite repeated calls to amend this, young people are not deemed to be in priority need by nature of their age alone. A 16 or 17 year old presenting as homeless must prove they are in priority need in the same way as any adult, with only one additional criteria available to them, that of being a young person at risk of sexual or financial exploitation. If they are unable to do so, or have failed to provide adequate proof of their intention, they are, by default, accorded non-statutory homeless status, thereby accessing a lower level of provision and support. The narrow scope of priority need categories in NI with regard to young people may go some way towards explaining why NI has the lowest annual rate of young people aged 16–24 accepted as homeless within the UK (Quilgars et al 2008).

5.12.1 The Extent of Homelessness

The hidden nature of many forms of homelessness makes it difficult to accurately estimate the numbers of children and young people experiencing it at any given time. Statistics tend to only capture those who have presented themselves as homeless to either a statutory or voluntary sector body, but general consensus would suggest that this may only be the tip of the iceberg.

Furthermore there are significant disparities between the numbers of families and individuals presenting as homeless and those accessing full statutory support through receipt of FDA status.[66] For example, although there were more than 19,000 presentations to the NIHE in 2007/08, just over 9,000 of these were awarded FDA status.

The most common household type to present as homeless to the NIHE is that of families with dependent children, who now constitute approximately a third of all presentations each year (DSD 2007). The numbers of families presenting as homeless within NI have increased significantly in recent years, with a 50% increase recorded in the 10 years between 1995/96 and 2005/06. A total of 6,869 families presented as homeless in 2006/07, 80% of whom were headed by a lone parent. Taken together, these 6,869 families included at least 9,300 children presenting as homeless in 1 year. As highlighted above, not all families who present as homeless are accepted as FDA under the legislation; last year only 61% of these families were afforded this status, leaving 39% unable to avail of the full range of statutory support and provision (OFMDFM Committee 2008).

The other main group of children presenting as homeless are 16 or 17 year olds, presenting independently of their families: 465 sixteen or 17 year olds presented as homeless in this way during 2006/07, however, under 40% of these individuals were afforded FDA status. The most common reasons for homelessness recorded amongst 16 or 17 year olds are leaving care and family disruption (OFMDFM Committee 2008).

5.12.2 The Causes and Consequences of Homelessness

There is no simple cause for, explanation of or response to homelessness. A multiplicity of both individual and structural factors can contribute

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[66] The category FDA refers to applicants found to be (a) homeless or threatened with homelessness within the next 28 days; (b) eligible for assistance; (c) in priority need; and (d) unintentionally homeless.

to an onset of homelessness, including the nature of the housing market, redundancy or inability to access work, inadequate income levels, drug/alcohol abuse, family breakdown, domestic violence or abuse and intimidation or other sectarian factors. Those particular combinations of factors contributing to families becoming homeless will likely differ from those contributing to the homelessness of independent young people, with issues like leaving care or changes in family structure featuring more highly amongst the latter. As the PSI Working Group acknowledges *"risk factors may co-exist. For example, children who have spent time in care may be more likely to have no educational qualifications, and therefore to be unemployed and at greater risk of homelessness"* (DSD 2007:para 3.19).

Children and young people's experiences of homelessness can vary as much as the circumstances contributing to the experience but a number of common disadvantages can be observed including:

- nutritional deficiencies
- physical ill health and inadequate access to both primary and secondary healthcare
- developmental delay amongst younger children
- educational disadvantage and exclusion
- stigma and social isolation
- low levels of self confidence, motivation and self esteem
- mental ill health
- increased likelihood of future episodes of homelessness (Beckett 2004; DSD 2007; OFMDFM Committee 2008).

An absence of adequate and appropriate housing options can mean that children and young people can, and frequently do, remain homeless for significant periods of time. Homeless families who participated in this review clearly expressed their frustration around this and the impact this was having on the family:

"My children and I are homeless at the moment and I do not feel the Housing Executive are doing enough to re-house my family. This I feel is greatly affecting my children."

"There's not enough places for Housing Executive to give people on housing list a house as new houses are being bought by developers."

"A lot of landlords doesn't accept anyone who is DHSS so no one who is on the list will get into one of his properties."

"My mum has been trying to get a new house that has 4 bedrooms, enough for us all, but has been waiting ages."

"Have been a year waiting on a house. Some people have been offered a house before me and I have more points."

"When assessment is done you are supposed to be out of here, but there is nowhere to go."

Beckett (2004) notes similar difficulties for homeless youth, many of whom end up inappropriately placed in generic provision, due to a virtual absence of specific youth provision. The housing of vulnerable 16 and 17 year olds in generic adult provision raises serious child protection concerns, while the prolonged housing of both homeless youth and homeless families in temporary shared accommodation and the research evidence as to the detrimental impact of such experiences raises serious questions as to how, and to what extent, the rights and needs of these children are being met.

5.12.3 Statutory Responses to Homelessness

The key development in recent years in relation to the issue of homelessness within NI has been the establishment and work of a PSI group on homelessness, set up by the Department for Social Development (DSD) in 2004 with the remit of ensuring that the risk of homelessness is reduced and that the full range of appropriate services is available to those who find themselves homeless so that they can make the choices required to play a full part in society (DSD 2007). Key recommendations emanating from this group of particular relevance to homeless children and young people include:

- the development of joint protocols between NIHE and social services in relation to homeless youth
- consideration of designation of specialist officers for homeless youth
- provision of outreach workers to support young people post allocation of accommodation
- removal of housing benefit restrictions for under 25s
- investment in preventative work within schools (DSD 2007).

While both the work and outputs of this group are to be welcomed, the current failure to adequately progress many of these recommendations remains a matter of concern. For example, while it is positive that the particular vulnerability of 16 and 17 year olds has been acknowledged in the strategy and accompanied by the recommendation that all homeless 16 and 17 year olds not already falling within the remit of social services and all 18 to 21 year olds who are leaving care or vulnerable to sexual or financial exploitation should be afforded priority need status, thereby bringing the situation in NI more in line with that of the rest of the UK, the changes required to facilitate this have not yet been implemented more than one year on from its approval by the Executive in July 2007.

Furthermore, a notable absence in the strategy and action plan is that of the needs of families experiencing homelessness. The strategy has, as one of its 16 underpinning principles, a commitment to targeting more vulnerable people – 9 groups are specifically mentioned within this, and while young people are included, children living in families who are experiencing homelessness are not. Given the research evidence as to the detrimental impacts of homelessness on children, both in the short and long term, it is imperative that this group also be recognised as a particularly vulnerable group. A comprehensive response to homelessness, amongst both children and young people, will require a multi-faceted, multi-agency approach. As acknowledged in the 2007 'Including the Homeless' strategy, the multi-causal nature of homelessness requires a multi-faceted response that considers, amongst other things, legislative definitions, financial support, social support structures, accommodation options and advice and assistance. As Beckett (2004:342/343) concludes:

"Homeless young people are frequently viewed as a homogeneous group with comparable needs and experiences. This is a grave error that holds serious implications for both the appropriateness and effectiveness of policy and practice responses to the phenomenon of youth homelessness. Homeless young people's lives are complex and multifaceted, in many cases incorporating multiple layers of need… Housing need is but the tip of the iceberg for many homeless youth. Most have a broad range of social, emotional and material needs in addition to their obvious need for housing and most are in some respect (beyond that of being without a home) vulnerable and in need of support… None are immune from society's negative stereotypes and all experience, to some degree, marginalisation and social exclusion… It is imperative that the interconnected nature of all elements of homeless young people's lives and the multifaceted nature of their problems be recognised within agency responses to their homeless experience."

The same can be said of children living in homeless families. In the absence of both adequate preventative measures that minimise the numbers of children and young people exposed to homelessness and adequate responsive services that support and resource them when they are, these children and young people continue to experience serious breaches of their rights. Children experiencing homelessness are not, in any way, enjoying their article 27 right to 'a standard of living adequate for the child's physical, mental, spiritual, moral and social development' nor are many of them receiving the education, health or social care that is also their right.

5.13 Conclusion

Though there have been a number of positive developments in recent years in relation to the promotion and more effective realisation of children's rights to health and welfare, the issues raised in this chapter clearly illustrate that there are many different ways in which these rights must be further progressed both for children and young people generally and those for whom this has been identified to be an issue of particular concern. Section 5.14 highlights a number of priority action areas which, though by no means exhaustive, would offer a positive start in relation to the more effective realisation of every child's right to positive health, adequate healthcare and a standard of living adequate for their care and development.

5.14 Priority Action Areas

- Ensuring that more effective service delivery and accountability structures are embedded into the new arrangements being introduced under the Review of Public Administration.

- Greater investment in health promotion, including more targeted work at those identified at being most of risk of ill health or negative health behaviours.

- Greater investment in tackling the inequalities in physical health experienced by particular groups of children and young people, including living in poverty and those living in inadequate housing.

- Urgent development of a finalised target driven and adequately resourced Implementation Plan for 'Fit Futures'.

- Development of a comprehensive sexual health strategy that fills the gaps left by the cessation of the Teenage Pregnancy Strategy and the failure to progress the draft Sexual Health Promotion Strategy and Action Plan; particular attention should be paid to issues of sex education, access to services and the tensions between confidentiality and child protection concerns.

- Full implementation of the recommendations of the Bamford Review and revision of the government's current response (Delivering the Bamford Vision) to take on board the issues of concern raised during the consultation process.

- Continued investment in the promotion of emotional health and wellbeing in school settings, based on independent evaluation of existing practice and identification of best practice models.

- Research into the health and welfare needs of migrant, asylum seeking and refugee children, the extent and nature of which are, as yet, largely unknown.

- Development of a comprehensive strategy for the delivery of services and support to children with disabilities, which adopts a child centred approach and encompasses all aspects of their health and welfare needs, together with those of their families.

- Urgent investment in tackling regional inequalities in healthcare provision, both in respect of services available and waiting times for accessing these.

- Revision and subsequent adoption of the 'Lifetime Opportunities' strategy introduced under direct rule in 2006. The revision of this strategy should take on board the concerns expressed regarding it and the findings of the Committee for OFMDFM's 2007/08 Inquiry into Child Poverty. The production of a revised strategy must be accompanied by a target-driven adequately resourced action plan.

- The urgent introduction of the legislative changes required to ensure that all 16 or 17 year olds, and 18 to 21 year olds leaving care, are automatically afforded priority need status when presenting as homeless.

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