



Championing Children and Young People in England

**Office of the Children's Commissioner's
response to the Office of the High
Commissioner for Human Rights (OHCHR)
Study on Children's Right to Health**

October 2012

The Office of the Children's Commissioner (OCC) acknowledges that there are many challenges, barriers as well as effective practice in the field of children's right to health. We have chosen to focus on areas relating to the work undertaken by the OCC and this submission does not address all our concerns or acknowledge the many examples of good practice in this field.

Information on what your organisation considers to be the main health challenges relating to children

Unmet health need of young people within the youth justice setting and care system

Research demonstrates high prevalence of disability including neurodevelopmental disorder¹ and unmet emotional wellbeing and mental health needs² for young people within the secure estate.

Approximately 60% of children in the youth justice system have significant speech, language and communication needs.³ It is estimated that around 50% of children in custody have a learning difficulty.⁴ One in 10 boys and one in five girls in Youth Offending Institutions (YOIs) have attention deficit hyperactivity disorder.⁵ Research commissioned by the Youth Justice Board has found that 19% of 13-18 year olds in custody have depression, 11% have anxiety and 11% post-traumatic stress disorder.⁶ A further study found that 85% of 16-20 year olds in custody showed signs of personality disorder⁷ compared with 10-13% in the general population.⁸

In relation to self-harm, 33 children have died in custody since 1990; all but two committed suicide.⁹ Young people in prison are 18 times more likely to kill themselves than others of the same age.¹⁰ In 2007, 89% of girls in custody had self harmed.¹¹

Children who have been in care are between four and five times more likely to attempt suicide in adulthood,¹² have a fivefold increased risk of all childhood mental, emotional and behavioural health problems and a six to sevenfold increased risk of conduct disorders. Around 60% of Looked After Young People have some level of mental health problem¹³.

¹ Office of the Children's Commissioner (2012): The prevalence of Neurodevelopmental Disorder in Children and Young People in the Secure Estate. London: OCC – Forthcoming

² Office of the Children's Commissioner (2011) 'I think I must have been born bad' Emotional Wellbeing and mental health of children and young people in the youth justice system. London: OCC

³ Bryan, K et al. (2007). 'Language and communication difficulties in juvenile offenders', *International Journal of Language and Communication Disorders*, 42, 505-520.

⁴ Department of Health. (2009). *Healthy children, safer communities*. London: Department of Health.

⁵ Fazell, D (2008). 'Mental disorders among adolescents in juvenile detention and correctional facilities: a systematic review and metaregression analysis of 25 surveys', *Journal of American Academy of Child and Adolescent Psychiatry*, 47(9), September 2008, 1018-1019.

⁶ Chiteseban et al. (2006). 'Mental health needs of young offenders in custody and in the community', *British Journal of Psychiatry*, vol 188, 534-540.

⁷ Lader, D. (2000). *Psychiatric morbidity among young offenders in England and Wales*. London: ONS

⁸ National Institute for Mental Health. (2003). *Personality Disorder: no longer a diagnosis for exclusion. Policy implementation guidance for the development of services for people with personality disorder*. London: NIMHE.

⁹ Statistics at www.inquest.org.uk [accessed 14 August 2012].

¹⁰ Fruhwald S et al, 'Suicide in prison', *The Lancet*, vol 366, issue 9493, 8 October 2005.

¹¹ HM Chief Inspector of Prisons for England and Wales. (2008). *Annual Report 2006-2007*. London: HMIP.

¹² http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_128065

¹³ National Institute of Clinical Excellence

The effects of parental alcohol misuse on the lives of children and young people

Our report *Silent Voices*¹⁴ highlights our concern at lack of support for thousands of children affected by parents who drink too much alcohol. The misuse of alcohol by parents negatively affects the lives and harms the wellbeing of more children than does the misuse of illegal drugs. Hundreds of thousands of children are affected yet too often, parental alcohol misuse is not taken as seriously, in spite of alcohol being addictive, widely advertised, far easier to obtain, and legal.

Research already published on the scale of this problem across the UK estimates:

- Nearly 1 in 3 (30%) of children live with at least one parent who is a binge drinker (between 3.3 - 3.5 million children)
- A fifth (22%) live with a hazardous drinker (over 2.5 million children)
- Around 79,000 babies aged under one year in England are living with a parent who is classified as a 'problematic' drinker ('hazardous' or 'harmful'). This is equivalent to 93,500 babies in the UK
- Around 26,000 babies aged under one in England are living with a parent who would be classified as a 'dependent' drinker. This is equivalent to 31,000 across the UK.

Children and young people told the Children's Commissioner:

"My brother who is 10 says he wants to end it all, my mum also says she wants to die. She really needs to talk to someone but there is no one. I am not getting any sleep. I am scared what I will find when I wake up or what might happen whilst I am sleeping."

"I need somewhere safe to go quickly when mum starts drinking and cutting herself but where can I go?"

Health needs of unaccompanied and separated children

We have particular concerns about the correlation between post-migration stresses and psychological distress including high levels of Post Traumatic Stress Disorder (PTSD) and depression. In one study the immigration/asylum process was found to result in higher levels of PTSD while uncertainty regarding asylum status, age disputes and failed claims were significantly related to depression.¹⁵

Despite positive changes to the family removal process we remain concerned about how children who are to be removed with a parent are prepared for 'travel'. Routine immunisations may be interrupted and the child, particularly if UK born, will have no natural immunity against malaria and other life threatening insect born diseases. Travel vaccinations are not available on the NHS but asylum –seeking families exist on 90% of income support levels so there is little chance that they can afford to pay for preventative treatments. The '*Guidelines for malaria Prevention in Travellers from the United Kingdom*'¹⁶ issued by the Health Protection Agency contains no advice for children or adults being removed from the UK to malarial areas although it does advise on 'long term visitors to the UK returning to live in malarious parts of the world'. Other diseases prevalent in countries of destination that are known to kill children in large numbers include Yellow Fever and Meningitis.

¹⁴ Office of the Children's Commissioner (2012) *Silent Voices: Supporting Children and Young People affected by Parental Alcohol Misuse*/ London. OCC

¹⁵ Bronstein, I. and Montgomery, P. (2011) 'Psychological Distress in Refugee Children: A Systematic Review' in *Clinical Child and Family Psychology Review* Volume 14, Number 1 (2011) pp. 44-56 and E. Sanchez-Cao, E., Kramer, T., and Hodes, M. (2012) 'Psychological distress and mental health service contact of unaccompanied asylum-seeking children' in *Child: Care, Health and Development*

¹⁶ Chiodini P, Hill D, Lalloo D, Lea G, Walker E, Whitty C and Bannister B. (2007) *Guidelines for malaria prevention in travellers from the United Kingdom*. London, Health Protection Agency,

UK born children of those subject to removal are at particular risk if their babies are bottle-fed as this relies on a clean water supply which may not exist in the county of return. This sort of risk assessment is not carried out on infants being removed.

Child sexual exploitation: health needs and data sharing

The Office of the Children's Commissioner is conducting an Inquiry into Child Sexual Exploitation in Gangs and Groups. Our interim findings¹⁷ show the health impacts of Child Sexual Exploitation (CSE) include poor mental and emotional health (including self harm and attempted suicide), repeat actual and feared contracting of sexually transmitted infections, repeat actual or feared pregnancy, and other injuries, are not identified consistently.

A number of potentially significant indicators of CSE are captured by health providers, including Primary Care Trusts, at a local level. Health providers are listed as key stakeholders in the identification of children at risk of CSE within national literature. However, restrictions around data sharing in relation to abortion data and Sexually Transmitted Infection (STI) has prevented key CSE indicators from featuring in our data request. Whilst there is clearly a need to protect the confidentiality of the child around these sensitive data areas, this data could provide a valuable insight into CSE and provision should be considered around how this data could be shared in a lawful manner to inform the national OCC Inquiry and also to direct Local Safeguarding Children's Board activity in relation to the potentially most vulnerable children.

The impact of poverty on children's and young people's health

Poverty continues to be associated with the worst outcomes across virtually all domains including long-term health and life expectancy.¹⁸ For children living in lower income families there is a pattern of life limiting physical conditions, including (examples only, not an exhaustive list): type 1 diabetes at higher than the average rate in the population; similarly higher rates of type 2 diabetes in adults at or beyond middle age; chronic cardio-vascular, pulmonary and related conditions, including in formerly heavy-industrial communities, industry-related conditions in older adults of both genders; poor nutrition, low levels of physical activity and high rates of obesity, including in children aged under 11; higher than average levels of depressive illness. Half of all school aged children living in poverty in England – that's 1.2million – miss out on nutritious and healthy meals every day.¹⁹

Lack of direct involvement of children and young people in planning, design, delivery of health and social care

We know that children and young people still report difficulties in having their voices and views heard and taken seriously. YoungMinds surveyed council Health Scrutiny Committee Chairs and found that 79% had not had outlined to them how local young people would be involved in shaping local services.²⁰ Also, the synopses of the 75 Health Watch pathfinders found that only five mention children and young people and none gave details of how children and young people would be involved.²¹

Evidence from LINKs²² evaluations has demonstrated uncertainty about whether engaging with children was part of their official remit. Even those LINKs that engaged with children often set

¹⁷Office of the Children's Commissioner (2012) Accelerated report on the emerging findings of the OCC's Inquiry into Child Sexual Exploitation in Gangs and Groups, with a special focus on children in care. London. OCC.

¹⁸ Office of the Children's Commissioner (2012) Inequalities in Health Outcomes and How they Might be Addressed

¹⁹ The Children's Society (2012) Fair and Square: The future of free school meals. London: TCS

²⁰http://www.youngminds.org.uk/news/news/528_changes_to_nhs_landscape_devalue_young_people_s_participation

²¹ <http://healthandcare.dh.gov.uk/details-pathfinders>

²² Local Involvement Networks

<http://www.bing.com/search?q=local+involment+networks&qs=n&form=QBRE&pq=local+involment+netw orks&sc=0-11&sp=-1&sk=>

different age parameters for their involvement, many of which excluded younger children. In addition, research by the UCL Institute of Child Health has found that the views of under-16s were only sought in 1 of 38 national surveys of patient experience in the NHS between 2001 and 2011. This comprised less than 0.6% of respondents, despite the fact that children represent a substantial service user group.

Examples of good practice undertaken to promote and protect children's right to health, particularly in relation to children in especially difficult circumstances

Improving mental health provision in the secure estate

Significant changes in the secure estate have arisen from our 2011 report *I think I must have been born bad – Mental health and emotional well-being of young people in the youth justice system*²³. These covered management, leadership, and the living environment across the children's secure estate. The OCC has intervened to change practices in several individual institutions. These have included the complete redecoration of one whole Young Offenders' Institution (YOI); recruitment of child and adolescent trained mental health professionals; ending of "no hugging" rules during visits; the cessation of routine strip searches; and a review of both the timing of meals and the quality and quantity of food. The OCC is continuing to work with Government Departments on improving general policy and practice in these areas.

Children and young people achieving a voice relating to health decisions

There are materials in existence that guarantee children and young people a voice within health decisions. Positive developments have included the *You're Welcome* Quality Criteria²⁴ and the principle of *No Decision About Me Without Me* criteria outlined in *Equity and Excellence: Liberating the NHS*,²⁵. We note these positive developments despite the fact that there has not been a national evaluation into the implementation of the developments.

A good practice example on engaging children and young people is in Rotherham Metropolitan Borough Council's *The Principles for Voice & Influence*²⁶ which have been developed by 262 children and young people from 20 voluntary and public sector groups from across Rotherham. They were developed to provide operational guidelines to support adults working with children and young people in Rotherham and adopt the following statement from Article 12, of the United Nations Convention of Rights of the child:

'Children and young people have the right to say what they think should happen, when adults are making decisions that affect them, and to have their opinions taken into account'.

²³ Office of the Children's Commissioner (2012) *I think I must have been born bad – Mental health and emotional well-being of young people in the youth justice system*. London. OCC

²⁴ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073586

²⁵ <http://www.dh.gov.uk/health/2011/07/liberating-the-nhs/>

²⁶ www.idea.gov.uk/idk/aio/18511252

Please indicate what you consider to be the main barriers in implementing children's rights to health

Identification of neurodevelopmental difficulties and access to services

Studies focused across the range of neurodevelopmental disorders consistently highlight unmet needs due to lack of early identification and assessment and poor access to appropriate support and intervention. Access to a timely specialist assessment will necessitate any potential screening tool to be embedded within local pathways and with commitment from local partner provider agencies so as to enable ready transfer of information.

Young people with identified neurodevelopmental difficulties require access to a range of tiered and evidence based interventions but most importantly they require early recognition, assessment and intervention. However, access to specialist services is often limited and the levels of services commissioned across the secure estate are dependent on the accuracy of local needs assessment and their co-dependence on local commissioning arrangements.

The identification of an underlying neurodisability would ensure that services are responsive to specific needs and learning styles in order to make them more accessible and relevant to a young person and at an earlier stage. This is essential in order to develop individual care plans and to allow resources to be used more cost-effectively, rather than attempting to engage young people in universal, generic or group interventions that may not take specific needs into account.²⁷

The principle of imprisonment should only be used as a measure of last resort

Diversion and alternative sentencing could be used more for children with mental health and neurodisability. The arrest, detention or imprisonment should only be used as a measure of last resort and for the shortest appropriate period of time. This could result in their receiving more suitable care or environment to meet their needs.

Early Intervention and whole family focus with the child at the centre

Work we have completed including our work into parental alcohol misuse found that it is essential to identify at an earlier stage those who do not come to the attention of services and to address these children's needs. Whole family approaches continue to be rare and require a sound infrastructure of partnership work.²⁸

Data and information sharing between professionals

Whilst protecting the confidentiality of children we need to consider whether the Joint Strategic Needs Assessment (JSNAs) takes account of prevalence and incidence of neurodisability and how data can be better collected and shared in order to allow for better protection of the potentially most vulnerable children.

Access to and use of complaint processes

Our research²⁹ with children and young people highlights barriers in relation to access and use of complaints processes for children and young people in relation to mental health, sexual health and GP services. One important barrier is the defensive culture within health organisations which does not in any way recognise complaints as a learning opportunity and which at worst, can leave children and young people feeling mocked or viewed as 'troublemakers' when they try to raise concerns.

²⁷ Office of the Children's Commissioner: The prevalence of Neurodevelopmental Disorder in Children and Young People in the Secure Estate. London: OCC – Forthcoming

²⁸ Office of the Children's Commissioner (2012) Silent Voices: Supporting Children and Young People affected by Parental Alcohol Misuse/ London. OCC

²⁹ Office of the Children's Commissioner (2012) It Takes a lot of Courage. Children and Young Peoples Experience of Complaint Processes for Children and young people.

Children and young people told the Children's Commissioner:

"I'd worry that they would give me bad service if I complain."

"They look at you, they make assumptions about you, its the whole stereotype because of your age."

We need complaints processes to be viewed as a valuable part of service user feedback which can help improve service delivery.

For further information contact:

Lisa Davis
Senior Policy Advisor: Equality and Rights
Office of the Children's Commissioner

Email: Lisa.davis@childrenscommissioner.gsi.gov.uk

Tel: 020 7783 8330

October 2012