

SECTION 4

**AGE,
EQUALITY & HUMAN RIGHTS:**

**ACCESS TO HEALTH AND SOCIAL
SERVICES IN
NORTHERN IRELAND**

**Literature Review-
Equality & Human
Rights: Access to Health
and Social Services in
Northern Ireland**

Age, Equality and Human Rights: Access to Health and Social Services in Northern Ireland

PART A: CHILDREN AND YOUNG PEOPLE

Part A provides a review of literature relating children and young people and equity of access to health and social services. A range of issues are explored in this section including access barriers experienced by children and young people who are homeless, bereaved, living in domestic violence situations, or who are in the care of the juvenile justice system. Other issues briefly explored include the impact of the Troubles on children and young people, the effects of poverty on service accessibility, the experience of “looked after children”, mental health, and engaging the views of children and young people in health and social services. Part A concludes by looking at human rights implications and the UN Convention on the Rights of the Child.

Time and resource constraints somewhat limit the scope of the review. However, this section does at least provide an illustration of *some* of the equality and human rights issues which are relevant to children and young people in relation to access and utilisation of health and social services. It is notable that both the DHSSPS Strategy for Children in Need and the wider OFMDFM³⁴ led Children’s Strategy for Northern Ireland may begin to address many of the issues that have been highlighted.

Children, Young People and Homelessness

Research suggests that homelessness can have a profound impact upon children and young people’s access to health and social care (Barnardo’s, 2002; Croft-White & Parry-Crooke, 2004; McCrum, 2001). It is important to note that the definition of homelessness in this respect is more than just “rooflessness” but also extends to children and young people who are in insecure or temporary accommodation (for example, hostels, refuges).

A study conducted on behalf of Crisis³⁵, for example, highlights that young single homeless people with “multiple health needs” are a particularly vulnerable group. Homeless people with multiple

³⁴ Office of the First Minister and Deputy First Minister

³⁵ a national charity for solitary homeless people - www.crisis.org.uk

health needs are defined as those who experience a combination of factors such as, mental ill health, learning disability, substance abuse, self-harming or engagement in risky practices (for example, sex work) (Croft-White & Parry-Crooke, 2004).

A 2002 report published by Barnardo's identifies a number of common features in the lives of many young homeless people including:

- **poor physical health** – young homeless people tend to suffer from a similar range of physical conditions to the general population but they tend to experience these conditions more often and more severely due to restricted access to basic commodities.
- **poor mental health** – in comparison to the general population, mental health problems are eight times as high for people living in hostels and Bed & Breakfast accommodation and 11 times higher for those sleeping rough.
- **risk taking behaviour** – suicide and self harm are major risk factors, there is also a high prevalence of substance misuse and sexual health risk behaviour.
- **vulnerability** – young people who are forced to live on the streets often fear for their safety and are more likely to be the victims rather than the perpetrators of crime.
- **social exclusion** – many young people experiencing homelessness face high levels of social exclusion including restricted job opportunities and the lack of social networks.

In terms of accessing health and social services, the Barnardo's (2002) research highlights that there is a tendency for young homeless people to be more reliant upon acute rather than preventative services. A general distrust of statutory services, and health and social care professionals, along with low self esteem and low confidence often make young homeless people reluctant users of services. An inability to articulate their needs to service providers in conjunction with a lack of adult advocacy support further isolates young homeless people from accessing the appropriate services they require.

A number of additional barriers preventing access to services are highlighted by the Barnardo's (2002) report:

- **a lack of cohesion** among statutory services, and lack of co-ordination between adult and child services, makes service access particularly difficult for young homeless people with multiple needs.
- **inflexible opening hours** which make it difficult for young homeless people to access services during emergencies which occur "out of hours".
- young people who are homeless are more likely to present at **A & E Departments** when health problems have become acute. However, A & E staff often do not have immediate access to their medical records which may in turn lead to an inadequate medical response.
- bureaucratic referral processes, long waiting lists, lack of staff and resources, geographic boundaries and the ad hoc availability of child and adolescent mental health services are barriers to accessing support for **mental health problems**.
- young homeless people often fear that accessing services for **mental health** issues will make it difficult for them to secure accommodation given the stigma attached to mental illness.
- young homeless people who lack an address, or who change address frequently, can experience difficulties in **registering with a GP**. This in turn can lead to other problems such as reduced access to screening and other preventative health services.

It is possible that many of the barriers to service accessibility experienced by young homeless people, as highlighted by the Barnardo's report, also apply in a Northern Ireland context. Recent statistics, for example, illustrate that homelessness amongst young people is a major concern in Northern Ireland. In 2002/03, for example, 55% of females and 34% of males *presenting* to the Northern Ireland Housing Executive (NIHE) as homeless were

aged between 16 and 25³⁶. In 2002/03 over 3,600 people approached the Simon Community for help, of these, 55% were aged 25 and under³⁷.

The Barnardo's (2002) report makes a number of recommendations for improvements in services for young homeless people. It is advisable that the DHSSPS and associated bodies take into consideration these recommendations.

Recommendations: Young Homeless People (Barnardo's, 2002)

- **A holistic approach to services and support for young homeless people is needed which includes areas such as health, housing and community care. At present most provision for young homeless people tends to be limited to the voluntary sector, therefore much greater co-operation is required.**
- **Steps must be taken to improve access to services particularly in relation to negotiating their locality and opening hours.**
- **There must be greater inter-departmental and inter-agency co-operation in order to increase the capacity of services to deal with the varied and multiple needs of young homeless people.**
- **Preventative and primary care services must be more accessible to young homeless people and must provide greater continuity of care.**
- **There must be greater support for young care leavers to prepare them for independent living.**
- **A resource base of good practice examples and support networks must be developed for young homeless people which addresses both homelessness and mental health problems.**

³⁶ Northern Ireland Housing Executive statistics – cited in homelessness and substance misuse report (unpublished)

³⁷ Simon Community Annual Report 2002/03.

- **Young homeless people must be consulted to help develop supportive and accessible service provision.**
- **Services must be culturally sensitive to reach the most vulnerable of the homeless population including asylum seekers and refugees.**
- **A definition of homelessness must be agreed and adopted by all statutory and voluntary agencies in order to make referrals easier and in order to prevent debates regarding whether a young person meets a service's entry requirements.**

Children in Homeless Families

Research commissioned by the Simon Community in association with the NI Housing Executive and the Western Health and Social Services Board, explored the impact of homelessness upon the family unit in the Derry/Londonderry, Limavady, Omagh, Strabane and Fermanagh areas (McCrum, 2001). The research involved interviews with a wide range of professionals from the health, social care, education and housing sectors in addition to homeless parents and children themselves.

Findings from the report provided an overview of the implications of homelessness in a number of areas including physical health, mental health/emotional well-being and child development:

Physical Health

The report highlighted a high incidence of asthma amongst children in temporary accommodation. Poor diets were a common feature with high reliance on fast foods and high sugar drinks. High levels of stress led to physical symptoms such as bedwetting. Many families in temporary accommodation had also been victims of domestic violence and had physical injuries to deal with.

Health visitors noted that in many cases initial health assessments for children under five had been missed because of the temporary accommodation situation. This meant that a number of treatable

medical conditions often went undetected amongst these children (McCrum, 2001:46).

Mental Health and Emotional Well Being

Housing Executive staff believed that living in temporary accommodation for many months was often a contributing factor to emotional distress. Post natal depression was particularly prevalent amongst mothers with young babies living in temporary accommodation. A high dependency on anti-depressants amongst these mothers was also noted. The study reported that accommodation such as that provided by Women's Aid provided good programmes of care and emotional support for women and their families. However, the study indicated that women living in self-contained accommodation, as opposed to refuge accommodation, tended to lack access to such support (McCrum, 2001:47).

Children's Development

The study highlighted that many children in temporary accommodation are at an increased risk of developing mental health difficulties including emotional and developmental delays. Children in shared facilities and/or living away from friends and family appeared to be most affected. Some of hostel services participating in the study suggested that social services should provide greater support to families, especially those in self-contained accommodation, in relation to parenting skills etc (McCrum, 2001:50).

Recommendations emerging from the report highlighted the need for collective action to be taken by the housing, education, health and social services and voluntary sectors. Those recommendations which are of particular relevance to health and social services in relation to addressing the service needs of homeless children and their families are outlined below.

Recommendations: Homeless Children (McCrum, 2001)

- **Any new funding arrangements must ensure that homeless families with children are prioritised.**

- **Children’s Service Plans should examine ways of linking up with temporary accommodation providers. Reactive services are important, however, there is also a need for proactive services and increased co-ordination across a range of services. There is a need to create mechanisms whereby services can follow service users from temporary accommodation to permanent accommodation.**
- **An information pack should be developed for all families in temporary accommodation with locally relevant information on services and support availability.**
- **The role of the dedicated health visitor at Women’s Aid refuges has a positive affect on the health and well-being of both parents and children. The possibility of extending this service, or creating a peripatetic post, for other temporary accommodation locations and hostels should be considered.**

Young Runaways

A study conducted by Raws (2001) on behalf of Extern, presents a comprehensive account of the lives of young people under the age of 16 who runaway³⁸ (or who are forced to leave their homes) in Northern Ireland.

Research suggests that young people “run away” from home for a variety of reasons including (Raws, 2001:12):

- personal problems (such as relationship difficulties with boyfriends or girlfriends).
- school issues (such as pressure at school, problems with peers).
- family conflict (particularly conflict in step families).
- physical abuse, emotional abuse and neglect.

³⁸ Raws (2001:2) uses “running away” as a umbrella phrase which encompasses all the different experiences of being away from home. For example, being thrown out, homeless, roofless, on the streets, absconding, going missing, sofa-surfing. The study is concerned with those who stay away from home at least overnight.

- sectarianism (such as running away through fear of reprisals for “anti-social behaviour”).

Based on a survey of 1,300 young people in Northern Ireland, Raws (2001:9) estimates that just under one in ten young people here will run away or be forced to leave and spend at least one night away from home before their sixteenth birthday. Thus, Raws (2001:14) suggests that running away is a common phenomenon in Northern Ireland with over 3,500 overnight running away incidents per year and over 2,000 young people running away for the first time each year.

One of the primary concerns of the research was to formulate a number of recommendations for developing better informed responses for young runaways. Some of these recommendations are outlined below.

Recommendations: Young Runaways (Raws, 2001)

Preventative Work:

- **Development of local and regional initiatives (including peer education and school based initiatives) to raise awareness of the risks, consequences and alternatives to running away.**
- **Undertake targeted work with groups who seem particularly vulnerable to running away (such as young people having problems at school, victims of bullying, young people who have been suspended). This should include peer education programmes and outreach work which would provide young people with information on the potential dangers of running away.**
- **Target work with those already in substitute care (such as peer educated training).**

Responsive Work:

- **Need for the development of a dedicated runaway response service, especially for young people in crisis situations (that is, those staying in temporary, unsafe or inappropriate accommodation, those sleeping rough, those unable or unwilling to return home).**

- The service must perform three core functions – (i) crisis assessment, (ii) refuge or crisis accommodation and (iii) a gateway to follow on services. This could include a telephone helpline and a drop in facility which would provide advice, information and practical help (such as hot food, clothes, washing and laundry provision).
- Development of agreed protocols for frontline agencies that come into contact with young runaways on a regular basis (for example, police, social services).
- Development of outreach work including the use of streetworkers to identify popular locations for young runaways.
- Provision of follow-on services such as counselling, befriending, advocacy, mediation, family group conferencing and health services (physical and mental).

Policy:

- A strive towards a better understanding of the problems that young people from “reconstituted families” encounter during the transition period of living in different family forms.
- A new onus on listening to the views of the young people in the family – making concerted efforts to consult with them, include them, and offer support and advice during the process of separation and transition to a new family form.
- Improved co-operation between caring agencies including the police, social services, youth service, voluntary sector projects, probation and health services. Such co-operation should manifest itself in the development of joint strategies to respond to young runaways.

Children, Young People and Bereavement

Smith (1999) refers to bereaved children as the “forgotten mourners” in that their responses to bereavement are often overlooked (Barnardo’s, 2002:7). A literature review conducted by Barnardo’s demonstrates that the death of a sibling, for example, can have adverse impacts upon the lives of children and young people, often placing them at an increased risk for significant

psychological problems (Barnardo's, 2002:1). This is particularly the case where the cause of death is traumatic (for example, homicide) (Barnardo's, 2002:1999).

The Child Bereavement Trust reveals that a family's bereavement process can be profoundly affected by the way in which professionals communicate with and support them³⁹. Recent research into children's bereavement services in the UK suggests that the vast majority of bereavement services for children and young people are located in the voluntary sector (Rolls & Payne, 2003). These services tend to be very diverse in terms of service provision, location, funding arrangements and service interventions. Little appears to be known about children's access to or uptake of bereavement services or the effectiveness of such interventions. Furthermore, even less is known about the interactions of gender, ethnicity or class in relation to access and use of services (Rolls & Payne, 2003).

There is very little widely available research regarding children, young people and bereavement in Northern Ireland both in terms of access to and uptake of such services. This is perhaps an area which requires a much greater research focus in order to identify barriers to, and indeed gaps in, service provision in Northern Ireland.

Recommendations: Children, Young People and Bereavement

- **A increased research focus on the needs of bereaved children and young people in Northern Ireland including identification of barriers and gaps in service provision.**

Children, Young People and Domestic Violence

A report by PricewaterhouseCoopers, commissioned by OFMDFM, highlights that a *minimum* of 11,000 children in Northern Ireland are living in a domestic violence situation. The report acknowledges that this figure may only be the "tip of the iceberg" as it excludes children from families where the perpetrator or victim

³⁹ Information extracted from the Child Bereavement Trust Website
www.childbereavement.org.uk/showContent.php?page=144&ParentID=11

has not come into contact with statutory services or situations in which children and families have not disclosed domestic violence (OFMDFM, 2001:7).

The Barnardo's publication, "*Bitter Legacy: the emotional effects of domestic violence on children (2003)*", highlights that in nine cases out of ten children are present in the next or same room as a domestic violence incident. The report suggests that this can have serious psychological effects on children, ranging from bedwetting and disturbed sleep in very young children, to problematic behaviour in older children.

In a Northern Ireland context the OFMDFM report notes that almost half of health professionals and two thirds of the childcare organisations surveyed did not have an agreed and consistent definition of domestic violence. Interviews with health professionals revealed a significant level of misunderstanding and confusion in relation to domestic violence including 'myths' regarding the typical perpetrator and the type of victim (OFMDFM, 2001:3).

The majority of health care providers surveyed (85%) were not aware of any systematic questions to ask victims or perpetrators in order to enable routine screening of domestic violence (OFMDFM, 2001:4). More than half of health care providers had no clear procedures on what to do if they suspected a child was suffering from domestic abuse. Furthermore, the report highlights that although the role of the GP is crucial to identifying domestic violence situations, very little screening awareness and activity was reported amongst GPs (OFMDFM, 2001:4).

In terms data collection and domestic violence incidents, the survey highlighted that the majority of health professionals (65%) do keep a record of all domestic violence incidents. However, a significant number (35%) did not. Barriers to systematic evidence gathering included a desire to respect confidentiality, the lack of time and resources, denial on the part of the victim, and concerns of further violence resulting from disclosure (OFMDFM, 2001:5).

Less than half of health professionals stated that they had received training on how to deal with victims of domestic violence. The majority of health professionals participating in the survey (79%)

stated that they needed more support to assist them in handling cases more effectively (including training in screening, data collection and monitoring) (OFMDFM, 2001:6).

A range of problems were identified by childcare organisations in respect to the day to day provision of services for children involved in domestic violence situations. Key problems included (OFMDFM, 2001:7):

- a lack of resources, both financial and staff, to provide specialist services to children (such as counselling).
- a lack of **specialist advice** available to those working with children, families and perpetrators.
- the absence of a **regional strategy** for providing services to organisations and agencies working with children and families in domestic violence situations.

The report further highlights a current lack of information regarding the effects of domestic violence, not only on children, but also on many of the other groups within the section 75 categories. It recommends that further research is needed in this area in order to meet equal opportunities and equality requirements. In regards to improving services to children in domestic violence situations, the report makes a number of recommendations which should be considered by the DHSSPS and its associated bodies.

Recommendations: Children, Young People and Domestic Violence
(OFMDFM, 2001)

Defining Domestic Violence:

- **a single, clear and all embracing definition of domestic violence must be adopted by all agencies and organisations that come into contact with the victims and perpetrators of domestic violence. The report recommends the adoption of the definition put forward by the regional forum on domestic violence.**

Screening:

- consideration should be given to developing a protocol for routine screening of domestic violence. This should include clear and specific guidance on questions which should be asked to identify domestic violence cases. Advice, particularly from organisations such as Women's Aid and Barnardo's, should be taken as to how such cases should be handled once identified.

Data Collection and Monitoring:

- a standardised monitoring form should be developed for use across all agencies and organisations for recording details of domestic violence incidents. The form should be user friendly and should be designed to facilitate data entry onto a computerised data collection and analysis system.

Confidentiality:

- maintaining confidentiality is a major barrier constraining data collection activity, it is recommended that this area be explored in greater detail and guidance issued to all relevant professionals as to best practice.

Training and Support:

- more emphasis should be placed on the training of health care professionals in matters relating to domestic violence including how to recognise and deal with incidents, the specific effects on children and appropriate responses, guidance on referral processes etc.

Inter-Agency Co-operation:

- all agencies and organisations must agree to provide a 'joined-up' service involving a co-ordinated and inter-agency response to domestic violence.

Research:

- in order to fulfil equal opportunities and equality requirements more research is needed as to how domestic violence and domestic violence policy impacts upon the Section 75 groups.

Domestic Violence in Rural Areas

The impact of domestic violence is particularly profound on children and young people in rural areas. A recent report by Save the Children (2003), into the effects of domestic violence on children and young people in rural areas of England, highlights many issues in regards to lack of service provision which may also be applicable to Northern Ireland.

The report outlines, for example, that the lack of research and policy on domestic violence services in rural areas places the children and young people in these areas at a distinct disadvantage.

The report also highlights that domestic violence campaigns are primarily targeted at women (rather than children and young people) meaning that children and young people are often unaware of the services available to them. This has important implications for young people in rural areas as they experience even greater restrictions to information due to geographic isolation. Restricted access to information can limit awareness and thus physical access to service provision. (Save the Children, 2003:5).

Further issues identified by report (2003) include:

- the need for more **outreach services** for children and young people in rural areas experiencing domestic violence. These services are viewed as an essential means of providing assistance to otherwise invisible or inaccessible children and young people.
- that **teenage boys** are often marginalised in regards to domestic violence service provision. For example, admission policies in some refuges do not permit boys of a certain age. Many of these young men are often left behind in the family home which raises questions over their safety in remaining with the perpetrator of the abuse. Young men in these situations can experience feelings of isolation and abandonment which can be especially intense for young men living in isolated rural areas with little support networks.
- the lack of service provision to met the **psychological and emotional needs** of children and young people experiencing

domestic violence in rural areas. Often counselling services are provided by voluntary organisations such as refuges. However, access to such services by those living in rural areas can be severely restricted because of their geographic location.

The Save the Children report (2003) indicates that addressing the needs of children and young people in rural areas will require an interagency approach. Outlined below are a number of recommendations for the involvement of health and social services in the provision of services for children and young people in rural areas.

**Recommendations: Children, Young People and Domestic Violence in Rural Areas
(Save the Children, 2003)**

- **There must be, at a national level, strategies for tackling domestic violence which are *child-focused* and which reflect the need for long term funding for the development of new domestic violence support services in rural areas. This will require inter-agency involvement.**
- **Local health care providers should be encouraged to facilitate joint service provision or shared facilities (such as local health centres) as a means of improving access to domestic violence services in rural areas.**
- **Health care providers should consider using more innovative methods of advertising counselling services to children and young people in remote areas, for example, internet advertising, provision of information in schools, youth clubs etc.**
- **Specific training should be provided to health and social care workers on how to detect and deal effectively with domestic abuse cases in rural areas.**
- **Schools and social services could do more to raise public awareness about the role of social workers in order to foster a more positive and accessible image.**
- **Further research is needed into the experience and access**

to services for teenage boys and domestic violence. Options must be explored in order to address their housing and emotional needs. Social services and housing providers should monitor the needs of teenage boys who do not have access to refuges.

Children, Young People and the Impact of the Troubles

There is been a long standing concern about the impact of the “Troubles” on children and young people in Northern Ireland, particularly in relation to the lack of support provided to those bereaved or injured in the conflict (Smyth et al, 2004:9).

Research by Smyth et al’s (2004) illustrates the many ways in which children and young people have been, and continue to be, victims of the political conflict including:

- children and young people as perpetrators of, witnesses to, and victims of, shootings, explosions and rioting;
- children and young people as victims of punishment beatings and shootings (particularly young males);
- the economic and emotional impact of the imprisonment of a parent on children and young people;
- the mental and emotional impact on children of members of the security forces;
- the physical and emotional impact of living in interface/conflict areas;
- the recruitment of young people into paramilitary organisations; and,
- the wider implications of the Troubles on children and young people including deprivation, unemployment etc.

Smyth et al (2004:13) highlight that not all children and young people in Northern Ireland have been equally affected by the Troubles. In relation to gender, for example, young men are more likely to be both perpetrators and victims (for example, punishment attacks) of sectarian-related violence (Reilly et al, 2004). In relation to geographic location, the distribution of fatal incidents in the Troubles tended to be concentrated around the areas of North and West Belfast, Derry/Londonderry, the border regions and the Craigavon – Portadown area (Smyth et al, 2004:13).

Smyth et al (2004:113) suggests that the level of psychological support for children and young people affected by the Troubles appears to be inadequate. Smyth's earlier 1998 study, for example, highlighted the ad hoc nature and under-funding of child and adolescent psychiatry services in Northern Ireland and the lack of appropriate in-patient provision for children and young people (Smyth, 1998:90-91).

Smyth et al (2004) make a number of recommendations regarding the provision of health and social care services for children and young people affected by the Troubles. It is important that these should be taken into consideration by the DHSSPS and associated bodies.

**Recommendations: Children, Young people and the Impact of the Troubles
(Smyth et al, 2004)**

- **There is a need to recognise that in terms of the allocation of resources and the location of services that the effects of the Troubles have been concentrated in certain locations (for example, North and West Belfast, the border regions, Craigavon area) and certain sub-populations (for example, children and young people).**
- **It is recommended that special assistance be provided for certain youth populations such as the children of victims, the children of members of the security forces, the children of prisoners and ex-prisoners.**
- **Particular attention must be given to the way in which the Troubles have differentially affected boys and girls. It is recommended that gender differences in levels of need be reflected in the level and type of provision for those needs and that all provision be gender sensitive and appropriate.**
- **Children's experiences of the Troubles vary widely from those who have been relatively unaffected to those who routinely continue to experience paramilitary presence, harassments and threats. Therefore, it is recommended that service providers strive to understand more about**

particular populations of children and young people at risk.

- **It is recommended that service providers target children and young people who are particularly at risk and engage them proactively in preventative programmes rather than wait for them to become casualties.**
- **The level of psychological support for children and young people appears to be inadequate particularly in areas of high need. It is recommended that a review of the level and focus of psychological support available to children and young people affected by the troubles is carried out.**

Children, Young People and the Juvenile Justice System

Much focus has been given in recent years on the circumstances of young people in juvenile justice centres in Northern Ireland. An investigative report published by the Northern Ireland Human Rights Commission (NIHRC) in 2002, entitled *'In Our Care: Promoting the Rights of Children in Custody'*, highlights that the right to health and health care is particularly important to young people in detention for a number of reasons.

Firstly, young people in detention usually enter the juvenile justice system with a range of poor health and associated problems which can include alcohol and drugs misuse, solvent misuse, learning difficulties and emotional problems. Secondly, these problems are often inextricably linked to the young person's offending behaviour (NI Human Rights Commission, 2002:115).

The Commission report highlights that a serious difficulty for those attempting to provide health care services for these young people is that the responsibility for juvenile justice centres lies within the remit of the Northern Ireland Office (NIO) rather than the Department for Health, Social Services and Public Safety (DHSSPS) (NIHRC, 2002:117). The Commission suggests that there is a lack of consultation and communication between the NIO and the DHSSPS on the future of health care in the juvenile justice system. In relation to this the Commission have stated that it, *"..considers that NIO's failure to consult with the DHSSPS is contrary to international standards which emphasise the need for a*

multi-agency approach to the care of children in custody” (NIHRC, 2002:117).

Whilst the health care of children and young people in detention is not within the remit of the DHSSPS it is, nevertheless, important to highlight a number of issues relating to equality of opportunity and access to health care for young people in detention that have emerged from the Commission’s report.

A brief outline of these issues is provided below and overleaf and includes:

- **Medical Provision** – concerns in the report regarding the extent to which young people’s right to health care are being met whilst in custody. The Commission states that it is not convinced that current staffing levels are sufficient to meet health care needs (2002:119).
- **Medical Assessments** – possible inconsistencies in regards to the medical assessment of young people before transfer to another centre or discharge from a centre. This raises concerns that a failure to provide a health check will increase the likelihood of being transferred without the necessary medication, prescription or health records (2002:118).
- **Administering Medication** - lack of adequate staffing in the medical facilities of juvenile centres often means that medication is distributed by non-medical staff. The Commission believes that this practice is inappropriate and unfair to staff and potentially dangerous for the young people concerned (2002:122).
- **Therapeutic Services** – the Commission expresses particular concerns regarding the state of psychological services in juvenile justice centres (especially given the high number of young people in need of these services). The Commission suggests that the current poor level of mental health service provision contrasts unfavourably to that which is on offer in the community and is exacerbated by an overall lack of provision for the mental health of young people in Northern Ireland (2002:123-124).

- **Health Promotion and Awareness** – medical staff in the centres have already taken positive steps to develop a health promotion and health education policies in the centre. The Commission suggests that much is still to be achieved and that staff shortages have delayed progress in this area (2002: 128).

The Commission report includes a range of recommendations for improved access to health care services for young people in the juvenile justice system. A number of these recommendations, which are of particular relevance to the DHSSSP, are highlighted below.

Recommendations: Children, Young People and the Juvenile Justice System (NIHRC, 2002)

- **The Commission advocate that responsibility for the health care of children and young people in juvenile justice centres should be passed from the NIO to the DHSSPS.**
- **As an interim measure the NIO should consult with the DHSSPS on all future plans for health provision in juvenile justice centres.**
- **As an interim measure the DHSSPS should be given a statutory advisory role in relation to health care in the juvenile justice system.**

Children, Young People and Poverty

A recent report by Hillyard et al (2003) entitled “Bare Necessities”, reveals that over a third of all children in Northern Ireland (37.4%) are living in poor households. Yet, despite the large numbers of children and young people living in poverty here, there is very little widely available research which explicitly makes the connections between poverty and its impact upon children and young people’s access and uptake of health and social services.

A review conducted by Le Grande et al (2003:26) into the equitability of the NHS highlights that in terms of equality of access

to health and social care middle class service users, and therefore middle-class parents, tend to be more articulate, more confident and more persistent in accessing health services. Those in higher socio-economic groups tend to be more knowledgeable of how and where to access services, they are more likely to have relatives or friends who work in the health services from whom advice and information can be sought, and are better equipped at describing their symptoms and facilitating diagnosis and treatment. Furthermore, health and social care professional are most likely to be themselves middle class and hence are more likely to empathise with middle class patients (2003:25).

Very little Northern Ireland-based research is available which explores the factors outlined above and the impact upon children from lower socio-economic groups. There is a clear need for a much greater Northern Ireland-based research focus in this area which will explore, for example, social and cultural capital and access to health services, the effect of transport availability, and the impact of health beliefs and health seeking behaviour.

Recommendations: Children, Young People and Poverty

- **There is a need for both quantitative and qualitative research into the barriers to access health and social care experienced by children from lower socio-economic groups. Research should focus on issues such as – access and utilisation of services in rural areas, the impact of the availability and affordability of transport to health and social care facilities, the effects of health beliefs/health seeking behaviour on children in lower socio-economic groups.**

“Looked After” Children and Young People

Children and Young People with a Disability “Looked After” Away From Home

McConkey et al (2003:2) suggest that debate regarding the residential care needs of children and adolescents has paid very little attention to young people with disabilities.

In a study of 108 “looked after” children in the Eastern Health and Social Services Board (EHSSB) area, McConkey et al reveal that the most frequent complaint from parents of children with disabilities has been the lack of respite care and the difficulties in securing appropriate long-term placements. The study also highlights that in the absence of suitable residential accommodation many families either struggle on with sporadic respite breaks or that children and young people experience multiple placements (2003:3).

McConkey et al (2003:16-17) highlight that these young people often present with combinations of complex needs which mainstream children’s services or community disability programmes are ill-equipped and inadequately resourced to deal with. They further suggest that these young people require specialist support from a range of health, educational and social service professionals but that administrative systems often fail to co-ordinate the planning of such services.

One third of the children in McConkey et al’s study were in some form of residential provision. Of these children, however, fewer than half were living in boarding schools or children’s homes with the remainder in less desirable accommodation including hospitals and residential homes for adults with learning disabilities (2003:17).

The study identifies key areas for development in regards to the residential care needs of looked after children and young people with disabilities. These include the need for improved respite facilities and the development of long-term residential options especially for young adolescents. Furthermore, McConkey et al (2003:20) outline the need for staff involved in mainstream services for young care leavers, to be equipped to deal with the needs of children with a disability leaving residential care arrangements.

The number of “looked after” children with disabilities in Northern Ireland is likely to increase in the future given that technological and medical advancements continue to improve the lifespan of life-limited children. Factors such as increasing numbers of single parents, working mothers and fewer extended families are also likely to further impact upon the provision of services (McConkey

et al, 2003:20). This has important equality implications in terms of current and future service provision for this group of young people.

Children and Young People from Cross-Community Families

A report published in 2003 by the National Children's Bureau reveals that children from cross-community families in Northern Ireland are over-represented in the public care system. The report argues that social services are failing to recognise that these young people are a specific group with particular needs.

The report reveals that 17% of children in public care in Northern Ireland are from cross community families and that despite this high proportion there are very few neutral or integrated support services available. One of the report's co-authors Ruth Sinclair states that, "*we have found that in their urgency to find placements for children at risk, some social workers are reluctant to address sectarian issues. In many cases children's religious identity is simply assumed rather than discussed.*" The report recommends that social work staff are provided with additional training to raise awareness of the issues faced by children from cross community families⁴⁰.

Young Refugees & Asylum Seekers

Young refugees and asylum seekers are a growing minority of vulnerable young people in the UK and Ireland. A recent report commissioned by the Prince's Trust, exploring the experiences of young refugees and asylum seekers in England and Scotland, highlights that many of these young people do not have access to appropriate family planning services and as a result tend to start families very early on in life (Prince's Trust, 2003:14).

The Health for Asylum Seekers & Refugees Portal (HARP) website further emphasises the health and social care needs of young asylum seekers and refugees, particularly underlining the need for health care assessments for children on arrival in the UK. HARP further stresses the importance of providing access to appropriate

⁴⁰ Information extracted from University of Ulster Press Release – "Children from Cross Community Families in Northern Ireland have Specific Needs, Says New Report", 5 September 2003.

psychological and emotional support services for those children arriving in the UK unaccompanied by adults.

Research on young asylum seekers and refugees is still very much in its primary stages in Northern Ireland. It is vital, therefore, that further research is commissioned in this area to further identify health and social care needs.

Recommendations: Young Refugees & Asylum Seekers

Further research should be commissioned to identify the health and social care needs of young refugees and asylum seekers.

Children, Young People and Mental Health

It is estimated that one in five young people will experience mental health problems during their adolescence with many of these problems continuing into adulthood (HPANI⁴¹, 2001). Adolescence is a particularly vulnerable phase of the life cycle with significant increases in incidents of suicide and self harm. The rise in the rate of suicide amongst young men in particular, is emerging as a major issue of concern for health and social services in Northern Ireland. From 1983 to 2001, for example, 23% of all suicide deaths occurred in the 25-34 age band and just over 20% of all suicide deaths occurred in the 16-24 age band. The suicide rate is highest for males aged 25-34 (19%) and males aged 16-24 (18%) (DHSSPS, 2004:72).

Specific groups of children and young people, such as those “looked after” by health and social services, can be particularly vulnerable to mental health problems. The report of the DHSSPS Clinical Psychology Speciality Advisory Committee (2002:3) highlights the lack of psychological and mental health services for looked after children in Northern Ireland and calls for the provision of such services. The Advisory Group report suggests that developing services will require sustained collaboration from a wide range of stakeholders including frontline carers, educational

⁴¹ Health Promotion Agency for Northern Ireland

services, child and adolescent mental health services and voluntary sector agencies (2002:7).

Child & Adolescent Mental Health Services

It has long been recognised that the current level of Child and Adolescent Mental Health Service (CAMHS) provision in Northern Ireland is inadequate and characterised by long waiting lists and gaps in service provision. The lack of specialist services, particularly for children and adolescents with eating disorders or with serious psychiatric problems, is an issue which has been highlighted by the NI Commissioner for Children and Young People⁴².

In more recent years CAMHS has become an issue which has been placed high on the agenda of the four Health and Social Services Boards and the new Mental Health Strategy. It is also an area currently under consideration by the Northern Ireland Mental Health and Learning Disability Review.

YoungMinds, a national charity committed to improving the mental health of young people, have identified a number of factors which prevent access to mental health services young people across the UK including:

- **Access Difficulties:** access to mental health services for children and young people is mostly limited to formal referral systems. Young people who are not in contact with GPs are less likely to access specialist provision and few services accept self-referrals. Studies by Garralda et al (2000) show that on the whole, GP recognition of psychiatric disorders in children and young people is limited with a wide variation between practitioners.
- **Engagement:** it is difficult to engage adolescents with mental health services. An adolescent centred approach is needed with respect for the young person's autonomy and the provision of flexible services in locations where young people feel comfortable.

BBC News Northern Ireland. "NI teens not getting best care". 11 December 2003.

- **Inadequate resources:** staff in both adult and children's mental health services often feel ill equipped and under-resourced to work with young people. Part of the difficulties faced by young people in accessing treatment is due to budgetary constraints and a general lack of resources (that is, appropriately trained staff and facilities).
- **Continuity of Care:** many young people moving from children's to adult mental health services (as they get older) cannot handle the transition arrangements and lack access to the skilled support needed.
- **Emergency Provision:** there is very little emergency provision appropriate for young people with mental health problems. Availability of CAMHS inpatient beds is severely restricted and geographically limited. Admitting young people to adult psychiatric wards, which is often the only available option, can be highly distressing for the young person.
- **Dual Diagnosis:** many young people present with a spectrum of difficulties to which there is a lack of specialist provision (for example, young people with learning disabilities and mental health problems or young people with drug and alcohol problems and mental health problems). Many adolescent services are ill-equipped to deal with dual diagnosis.

YoungMinds make a number of recommendations for the further development of mental health services which may also be applicable for the development of CAMHS in Northern Ireland.

Recommendations: Children, Young People and Mental Health (YoungMinds)

- **To meet their needs effectively, mental health services for young people must have:**
- **user sympathetic access (for example, one stop shops, via self referral or via youth counselling services).**
- **staff with specialist knowledge in areas such as eating disorders, self-harm, early psychosis, complex behavioural**

problems.

- **a multi-faceted approach, with a full range of skills and treatments available in an integrated manner and flexible to suit individual needs.**
- **facilities which are appropriate and accessible to young people, in terms of opening times, location and physical environment.**

Children & Young People's Experiences of Parental Substance Misuse, Parental ill Health and Domestic Violence

A recent literature review conducted by the National Children's Bureau on behalf of the Joseph Rowntree Foundation suggests that policies and services in the fields of domestic violence, parental substance misuse and parental ill health have traditionally focused upon meeting the needs of parents rather than children (Gorin, 2004). The study reveals that children whose parents experience domestic violence, substance misuse and/or physical and mental health problems worry about their parents more than may be recognised. The stress and isolation that children experience as a result of these circumstances can be perpetuated by the stigma and secrecy which surrounds domestic violence, substance misuse and ill health (Gorin, 2004).

Recent research (Gorin, 2004; Featherstone & Evans, 2004) indicates that children are more likely to use informal support networks (such as friends and relatives) to cope with their problems rather than accessing more formal professional support. Evidence suggests that young people who do have contact with professionals often have concerns regarding whether they will be believed or whether professionals will maintain confidentiality.

Featherstone & Evans (2004) further highlight that many children have a limited knowledge of formal helping services and that they are reluctant to contact professionals due to the stigma associated with involvement with formal agencies. Additionally, barriers to accessing support can be further compounded by factors such as disability or ethnic background.

Gorin (2004) offers a range of suggestions for improving children and young people's access to help and support. A number of these are briefly outlined below and may be of some relevance to health and social care providers in Northern Ireland.

Recommendations: Children's Experiences of Domestic Violence, Parental Substance Abuse and Parental Health Problems.

(Gorin, 2004)

- Children are often reluctant to seek support from formal sources for a number of reasons (such as fear of repercussions, fear of not being believed, stigma etc). Silence such as this often makes identifying and supporting children difficult. Where children do come into contact with professionals it is important to ensure that children have a choice of male or female helper or a helper of the same ethnic background.
- Children rarely approach professionals initially and do not know where to seek formal help. Children may be increasingly encouraged to seek help through helplines or in spaces in which they can feel safe.
- Children often state that professionals do not always communicate with them in a language they can understand. Children want to be respected and taken seriously by professionals, they want to be involved in decision-making about the care and support of parents. It is important that children's opinions and experiences are recognised and respected.
- There is an identified need for age-appropriate information for children about the problems their parents are experiencing. There is also an identified need for respite breaks for children to allow them to mix with other children going through the similar experiences.

Eating Disorders

Eating disorders are categorised as severe disturbances in eating behaviour. The term is primarily used to describe conditions such as anorexia nervosa or bulimia nervosa but may also be used to describe other eating disorders such as obesity when used in a wider context (DHSSPS, 2002:2). A consultation paper on eating disorder services in Northern Ireland, published by the DHSSPS in 2002, highlights the inadequacy of service provision for the treatment of eating disorders in Northern Ireland, particularly the lack of appropriate in-patient services. In addition to this, a report published by the Royal College of Psychiatrists also makes reference to the lack of specialist provision for the treatment of children or adolescents with eating disorders in Northern Ireland, describing services as “woefully inadequate” (Royal College of Psychiatrists, 2001:32).

The DHSSPS eating disorders consultation paper further highlights that there is a lack of epidemiological-type data with respect to eating disorder incidence and prevalence rates in Northern Ireland. However, the paper suggests that although more research is needed in this area, it is unlikely that local incidence and prevalence rates differ from levels and trends reported within the UK in general (DHSSPS, 2002:5).

The paper reveals that 1 – 2% of young adults develop some form of eating disorder, with cases more common in females than in males. Most of these cases develop between the ages of 13 – 25, however, an increasing number of being reported in children aged 10 and under (DHSSPS, 2002:5).

The issue of young men and their body image has only recently been raised as an area for concern. It is estimated that males represent around 10% of those with identified eating disorders. However, as society becomes increasingly focused on male physical appearance it is argued that the rate at which these disorders are recognised in men may rise. Research from both the US and UK suggests that symptoms in boys are less likely to be identified than they are in girls. Young men in particular are more reluctant to talk about their eating problems and professionals, parents and those who work with young people are less likely to suspect eating disorders in boys. Sexual orientation is also thought to be an important factor in relation to eating disorders with

rates reported to be high amongst young gay men (Neustatter, Young Minds Magazine article).

A number of respondents to the DHSSPS eating disorder consultation exercise highlighted the inequity of service provision in Northern Ireland in terms of both the location of services (with the majority of services available in the Greater Belfast area) and in terms of patient age. Many of the responses also highlighted that the majority of eating disorders are treated by non-specialised eating disorder services such as child and adolescent services, primary care services and the voluntary sector (DHSSPS, 2003:7). The DHSSPS eating disorder consultation responses paper provides a number of recommendations for improvements in the provision and accessibility of service in Northern Ireland. These recommendations are briefly summarised below:

Recommendations: Eating Disorders (DHSSPS Consultation, 2003)

- **There is a need for more research on prevalence rates on eating disorders and improved management information on the effectiveness and efficiency of current eating disorder service provision.**
- **A large group of disorders (many with features of anorexia or bulimia but not quite fitting the agreed criteria) should be included in any assessment of eating disorder need.**
- **Any new service model should consider models of good practice elsewhere.**
- **The Department must involve other services, for example community and voluntary services, in any future planned developments.**
- **Special importance should be placed upon the prevention, detection and prompt treatment of eating disorders in order to pre-empt long term complications.**
- **The Department should agree the development of a Regional Eating Disorder Centre with flexible outreach services.**

- **The Department should agree that a specialist in-patient service for people with eating disorders should be developed locally and financial resources and local expertise be made available.**

Obesity

Children from low income families are known to be at an increased risk of obesity. Research carried out by the Food Commission on behalf of the NCH highlights that a number of structural, economic and cultural factors interact to adversely affect the diets of children and parents on low incomes (NCH, 2004).

The NCH survey reveals that one in five families do not have enough money for food and that lack of money often makes it impossible for parents to buy nutritional foods (for example, 29% of parents in the survey stated that they could not provide their children with the types of food that they would prefer them to eat).

The study also highlights that low income families in rural areas experienced additional problems such as added expenses for transport to shops (the average journey was found to cost an extra 23% on top of the shopping budget). Additionally, healthier versions of food were found to be much more expensive and often unavailable in rural areas.

Obesity amongst children and young people in Northern Ireland has now been recognised as a significant problem. In response to this the DHSSPS has recently announced the introduction of a new initiative. “Fit Futures” acknowledges that the underlying reasons for obesity in children and young people are complex and require a cross-departmental response.

Young Carers [see dependants section]

Children, Young People and Disability [see disability section]

Young People and Sexual Orientation [see sexual orientation section]

Engaging with Children and Young People in Health and Social Care

Article 12 of the UN Convention on the Rights of the Child emphasises the right of children and young people to express their opinions in all matters which concern them. A number of Northern Ireland-based research reports (McLaughlin et al's 2001; Green, 2001) have emerged in recent years which relate to the need to respect the views of children and young people and to create mechanisms to facilitate their participation in decision-making processes.

Two particular research reports are briefly explored in this section. The first deals with children and young people's complaints procedures within the HPSS, the second relates to promoting children and young people's involvement in public decision making.

Children and Young People as Complainants within the Health and Social Services in Northern Ireland

In 2001, McLaughlin et al published the findings of an investigation into the operation of complaints procedures within the HSS Trusts in regards to complaints made by or on behalf of children and young people. The report revealed that, at the time of writing:

- Most Trusts did not produce material regarding complaints procedures for children and young people with disabilities and for children and young people from non-English linguistic backgrounds.
- Only two Trusts provided separate publicity, specifically designed for children and young people, on the Wilson complaints system. However, the vast majority of Trusts did produce separate publicity regarding the Children's Order complaints system for children and young people.
- Only three of the fourteen Trusts had produced material about the Children's Order Complaints process designed specifically for children and young people in residential care. Only three had produced such material for children in foster care.

- There was inadequate provision of independent advocates for children and young people wishing to bring forward a complaint.

McLaughlin et al's 2001 report includes a wide range of recommendations to improve children and young people's access and use of the complaints procedures within the health and social services. Since children and young people's access to effective and efficient complaints procedures has important implications in terms of equality of opportunity, human rights and for the UN Convention on the Rights of the Child, it is recommended that the Department and associated bodies reviews what progress has been made in this area since the publication of the report.

Recommendation: Children and Young People as Complainants in the Health and Social Services.

- **The DHSSPS should review its progress in regards to the recommendations made by McLaughlin et al (2001) in the report "Children as Complainants in the Health and Personal Social Services in Northern Ireland" to ensure equality of access and effectiveness in the complaints procedure for children and young people.**

Children and Young People's Involvement in Public Decision-Making

Green (2001:6) suggests that there is growing evidence to indicate that young people are becoming increasingly disillusioned with local and national organisations which service their needs. Green (2001:6) further highlights that many young people believe that their opinions are not being taken into consideration and warns of the potential danger that services may become less efficient if they decline to listen to the consumer.

Green's (2001) study provides an overview of the extent and impact of involving children and young people in decision making processes in Northern Ireland (including health and social services). A key message emerging from the study is that despite legislative and policy measures, many organisations continue to struggle in coming to terms with the participation of children and

young people in managerial and structural decision-making (2001:9).

There has been significant progress within health and social services in regards to the involvement of children and young people in decision-making in recent years. For example, involving young people in decisions about their care and increased concern in the HPSS for collective and group decision-making (Green, 2001:22). However, Green (2001:22) suggests that there is still room for improvement within many health related agencies.

It is important that the DHSSPS and its associated bodies continue to be made aware that involving children and young people in decision-making has important implications in terms of, equality of opportunity, human rights and in relation to Articles 12 and 13 of the UN Convention on the Rights of the Child⁴³.

Green (2001:10) makes a number of suggestions for improving the involvement of children and young people in public decision making. The DHSSPS and associated bodies should take into consideration these points and begin to review the mechanisms by which they engage with them.

**Recommendations: Children and Young People's Involvement in Decision-Making.
(Green, 2001:10)**

There should be:

- **a clear management vision for involving children and young people in decision-making.**
- **an organisational culture of involvement including structures, systems and processes and the creation of meaningful opportunities to engage children and young people in decision-making.**

⁴³ Article 12 – the right to express views freely on all matters affecting the child and that the view of the child must be given due weight in accordance with age and maturity. Article 13 – right to the freedom of expression including the right to seek, receive and impart information and ideas of all kinds.

- **adequate resources to support the involvement of children and young people in decision-making including professional staff employment, financial backing, training for both adults and young people.**
- **appropriate mechanisms to involve marginalised or disadvantaged children;**
- **independent Quality Assurance measures and an evaluation framework to sustain involvement in decision-making.**

Human Rights and the UN Convention on the Rights of the Child

The human rights of children and young people are protected by the 1998 Human Rights Act and, for children under the age of 18, the UN Convention on the Rights of the Child. The health of children and adolescents is acknowledged as an important concern of the Convention. Article 24 in particular states that all children have the right to the highest level of health possible and the right to access health care services.

This is, however, only one of the ways in which the health related needs and rights of children are addressed by the Convention. Examples of other notable Articles relevant to health and social services include:

Article 6 (the right to life and development); Article 9 (the right to live with one's own family); Article 12 (the right to express a view and to have that view taken seriously); Articles 13 –16 (the right to freedom of expression, thought, conscience, religion, association and privacy); Article 17 (access to appropriate information); Article 18 (support for parents in regards to their parental responsibility); Article 19 (the right to protection from all forms of physical and mental violence); Article 20 (the duty to provide care for children unable to live with their family); Article 21 (rights in relation to adoption); Article 25 (the right of children placed by the state to periodic reviews); Article 34-36 (right to protection from all forms of exploitation including sexual exploitation and the trafficking of

children); Article 38 (the right to protection and care of children who are affected by armed conflict); Article 39 (the right to rehabilitative care).

The Convention is also of relevance to health and social services in that it also protects the rights of specific groups of children including children with disabilities (Article 23), children from minority ethnic groups (Article 30) and refugee children (Article 22).

The UK Government has come under criticism for giving the Convention somewhat of a low profile (NGO Group for the Convention on the Rights of the Child, 1994). A 1994 report published by the NGO Group⁴⁴, for example, highlights that there is a lack of identified officials in each Government Department who have a continued responsibility for scrutinising proposed policy in order to ascertain consistency with the principles enshrined within the Convention. The lack of emphasis placed on the Convention by both commissioners and providers of services is clearly in conflict with Article 4 (that is, that the state has an obligation to translate the rights of the Convention into reality) and Article 42 (that the state has an obligation to make the rights contained within the Convention widely known to adults and children alike).

Potential Conflicts with Convention Rights

In a Northern Ireland context, research which makes explicit connections between the Convention rights and children's access to health and social services is now beginning to emerge⁴⁵. It is advisable that the DHSSPS and associated bodies become

familiar with this research and any recommendations which might arise from it.

The literature reviewed throughout this section illustrates there are many existing health and social care policies and procedures

⁴⁴ The NGO Group for the Convention on the Rights of the Child is a coalition of international non-Governmental organisations who work together to facilitate the implementation of the Convention.

⁴⁵ See research publications produced by the Northern Ireland Human Rights Commission - <http://www.nihrc.org/> and also recent research commissioned by the Commissioner for Children and Young People and conducted by Queen's University which examines children's rights in Northern Ireland including rights in relation to health and welfare - www.niccy.org/childrensrights.aspx

which may be in potential conflict with both the 1998 Human Rights Act and the UN Convention on the Rights of the Child.

A submission by the Children's Law Centre and Save the Children (NI) to the UN Committee on the Rights of the Child have identified additional potential breaches in relation to the provision of health and social services. For example, in relation to Article 24 (the right of all children to the highest level of health possible and the right of access to health care services) the submission highlights that there is differential access to health and social services in Northern Ireland depending upon the child's geographical location and/or ethnicity. Most acute services, for example, are located in the east of the province which tends to discriminate against children in rural areas. Even within urban environments access can be restricted to members of "one" community because services are physically located in the "other community".

These are just a few illustrations of potential breaches of the Convention in regards to children and young people's access to health and social services in Northern Ireland. This is clearly an area which requires much greater consideration in order to raise awareness of children and young people's rights and to incorporate those rights into health and social care policy and practice in a significant and meaningful way.

Recommendations: Human Rights and the UN Convention on the Rights of the Child.

It may be in the interests of HPSS commissioners and providers of services to:

- **identify policies, laws and practices which are in conflict with the principles of the Convention and the Human Rights Act and identify steps to address these.**
- **put into place rigorous standards and monitoring procedures to ensure that policies, laws and practices comply with the Convention and the Human Rights Act.**
- **for the DHSSPS in co-operation with other relevant bodies and organisations to continue to raise awareness of the Convention in relation to health and social care amongst children, adults and HPSS staff.**

PART B: OLDER PEOPLE

A number of significant steps have been taken in recent years to address the issue of age discrimination and the social exclusion of older people in Northern Ireland. The establishment of the Promoting Social Inclusion (PSI) Group on older people by OFMDFM and the publication of the “*Ageing in an Inclusive Society*” consultation paper, for example, signals what is perhaps a new opportunity to identify and address the multiple needs of older people locally.

The issues of age discrimination in health and social care in particular, continues to come under increasing scrutiny by both the media and pressure groups representing older people. In Northern Ireland there is at least a perception that age may affect quality of care in regards to health and social services, both in terms of the attitudes of providers and the treatment offered (Evason, 2004).

Data from the 2003 Northern Ireland Life and Times Survey, for example, revealed that nearly one half of respondents (46%) believed that age had an impact when it came to waiting lists for tests and operations. Additionally, 11% of interviewees aged 50+ reported that they had personally been treated with “less dignity and respect” by health and social care professionals because of their age. A total of 18% of respondents also felt that a friend or relative had not been offered treatment on account of their age (Evason, 2004).

What follows is an examination of some of the issues impacting on older people and their equality of opportunity in accessing health and social services. Themes briefly explored include acute and social care, access to services for older people in rural areas, elder abuse, mental health, learning disabilities and ageing, ethnicity and ageing, engaging with older people, and human rights. This is by no means a definitive list of relevant issues but does provide at least an illustration of some of the barriers experienced by older people in relation to accessing appropriate health and social services in Northern Ireland.

Older People & Hospital Care

Questions continue to be raised regarding the dignity, respect, privacy and quality of care afforded to older people in hospital settings. Help the Aged, for example, suggest that the quality of care that older people receive in hospital is variable ranging from excellent on some hospital wards to very low standards in others.

The main difficulties experienced by older people in relation to hospital care, which have been identified by Help the Aged⁴⁶, include:

- delayed admission to hospital and poorly planned discharge arrangements.
- a lack of help with eating and drinking.
- negative attitudes of some staff towards older people including rude and neglectful behaviour.
- little understanding of the particular needs of sub-groups within the older population including people with dementia or those from black and minority ethnic groups.
- lack of involvement of older people in decision-making regarding their care and treatment.

A number of these problems have also been highlighted in research conducted by the Eastern Health and Social Service Council (EHSSC) into the quality of care of older people in hospital. Whilst the report is limited to the six main hospitals in the Eastern Health and Social Services Board (EHSSB) area, a range of important issues and recommendations have been identified which should be relevant across all hospital services in Northern Ireland.

Some of the issues and recommendations identified by the report are briefly summarised below and, if not already done so, these issues should taken into careful consideration by the DHSSPS, HSS Boards and Trusts:

- **Waiting in A&E Departments:** the charter standards for the care of older patients in hospital settings states that once it has been decided that a patient should be admitted to hospital the patients should not have to wait longer than two hours in the

⁴⁶ Information extracted from the Help the Aged Website

A&E Department before being admitted. However, the report highlights that in almost a third of cases (17 of 56) patients had to wait longer than two hours before being admitted to beds.

▪ **Admission to Hospital Wards:**

Named nurse - almost three quarters of the older patients interviewed did not have a named nurse (44 of 61).

Involving patients in care plans - Only 4 out of 60 patients had talked to nurses about their care plans and the vast majority of older patients had no knowledge of what was written in their care plans.

Help with eating – only eight of the older people interviewed needed help with eating, however, three of the eight reported that they had to wait for help or that they did not get the help they needed.

- **Waiting Times for Surgery:** according to the report the DHSSPS recommends that hip operations should be carried out within 48 hours of attending A&E Departments. However, four of the seven patients in the study who needed hip operations waited between three and five days for their operations to be carried out.

- **Privacy and Dignity:** mixed sex wards can be particularly embarrassing for older people. Discrepancies existed between the six hospitals in regards to admissions to mixed sex wards.

- **Medications:** over one third of the older people interviewed who were given new medication were not sure about the reason for the new medication because it was not explained or not adequately explained to them by staff.

- **Consent:** DHSSPS guidance states that patient consent must be sought before carrying out examinations or giving treatment or care. 11 out of 57 of the respondents stated that staff did not explain procedures or did not adequately explain procedures before carrying them out.

- **Attitudes of staff:** the vast majority of participants in the study stated that nursing staff were always pleasant. However, seven patients stated that some nurses and doctors needed to

improve their attitudes to older people and should treat older patients with more respect.

- **Making a complaint:** almost one third of respondents did not know how to go about making a suggestion or complaint.

Recommendations: Quality of Care of Older Patients in Hospitals (EHSSC, 2003)

- **Waiting times for admittance to a ward from A&E Departments must be addressed. Other ways of providing care to older people should be developed to prevent admittance to hospital where appropriate.**
- **Ward managers and staff needed to wear name badges and introduce themselves to older patients so that older patients are aware of the individuals responsible for their care.**
- **Hospitals should explore whether it is appropriate to admit older people to Admissions Wards or Medical Assessment Units at first rather than admit them straight to medical or surgical wards.**
- **It is strongly recommended that all relevant hospitals meet the standard set out by the DHSSPS that emergency operations on patients with fractures should be carried out within 48 hours of attending A&E, particularly older people who require emergency hip surgery.**
- **Nursing staff on surgical wards in particular must ensure that older people who require help with eating and personal care receive it.**
- **To provide patient privacy and dignity, separate washing and toilet facilities for men and women should be provided.**
- **When older patients are given new medication the reasons for this should be provided along with an explanation of any side effects.**

- **In line with DHSSPS consent guidelines, nurses and doctors should ensure that medical procedures are adequately explained to older patients and consent should be sought before such procedures are carried out.**
- **Trusts need to explore ways of involving older people on commenting on issues relating to hospital care and the planning of discharge from hospital.**

Age discrimination, especially in relation to health care, has received increasing media attention in recent years. Particular interest, for example, has been focused upon the “do not resuscitate” orders placed on some older people’s records without their consent (Help the Aged, 2002:6).

A report by Help the Aged (2002) highlights that there are different types of discrimination currently in operation in the health and social care system. The report cites examples of explicit discrimination such as age restrictions in services such as routine breast screening services, age limits for surgical procedures, upper age bars for coronary care and cardiac rehabilitation units and the exclusion of older people from clinical trials. The report also suggests that there are more subtle forms of age discrimination such as the limited access to primary care services experienced by some residential and nursing home residents.

Robinson (2002) suggests that scrutinising health and social care services in order to clearly identify age discrimination is often a complex and contentious process. Arguments are often put forward to justify age based approaches to care as fair or legitimate (Robinson, 2002). As Robinson (2002) highlights, it is not always easy to judge the merits of such arguments nor to agree the actions necessary to eliminate age discrimination.

A lack of research regarding older people and their experiences of the health care system, both in a Northern Ireland and UK-wide context, makes it particularly difficult for age discrimination in relation to acute care to be identified and addressed.

Older People & Social Care

Age discrimination in social care is also not easily identifiable. A publication by the King's Fund⁴⁷ into age discrimination suggests that this is because many social care services are selectively provided, that is, older disabled people tend to receive services primarily designed for older people from a ring-fenced budget.

A survey of senior health and social service managers in England⁴⁸ reveals that three out of four believed that age discrimination existed in health and social services with many suggesting that ageism was endemic. Many of the senior managers also highlighted that, in terms of social service provision, older people's needs were defined on a more basic level than those of younger people or children (Roberts et al, 2002).

In a Northern Ireland context, research suggests that, in terms of social care, budgetary constraints for key community services (particularly the home help service), delayed discharge from hospital, waiting lists for services and charging for nursing and residential care, are the key concerns of older people here (O'Hara, 2002; OFMDFM Working Group Report on Older People, 2002?, Human Rights Commission, 2001).

The Northern Ireland Human Rights Commission report, *"Enhancing the Rights of Older People"*, identifies a number of issues which are relevant to equality of opportunity in accessing to social care. The report highlights, for example, that people receiving care packages prior to the age of 65 often experience a reduction in their care package once they become the responsibility of the "elderly care team" at age 65 (2001:6). The report further highlights differences in financial independence and autonomy between those living in their own homes in comparison to those living in residential or nursing home care (2001:10).

There is clearly a lack of Northern Ireland based research which explicitly examines age discrimination in health and social services, due in part to numerous methodological challenges. It is difficult to ascertain from the existing literature the true extent of

⁴⁷ King's Fund. Briefing Note: Age Discrimination in Health and Social Care.

⁴⁸ a telephone survey of 75 senior managers in hospitals, primary care groups, community trusts and social service departments.

the rationalisation of services or the existence of a “postcode lottery” in relation to older people and access to services.

It is evident, however, that attention must continue to be focused upon age discrimination in health and social care in Northern Ireland. There must be an increased research and policy focus which recognises that older people’s access to key services can be profoundly affected by many other factors such as gender, marital status, ethnicity, socio-economic status and geographical location.

Older People in Rural Areas

The centralisation of many hospital services coupled with a poorer transport infrastructure often creates service accessibility barriers for older people in rural areas. Currently there is a scarcity of detailed information on the needs and experiences of older people in rural areas in Northern Ireland particularly in relation to health and social services. However, OFMDFM has recently commissioned the Rural Community Network to undertake research in this area (OFMDFM, 2004). It is recommended that the DHSSPS and its associated bodies take note of this research when it is made available as it may prove to be a valuable resource in identifying needs and gaps in service provision.

Transport, Health and Social Care

The availability of transport and the ability to travel is fundamentally important to older people in terms of accessing health and social care services (for example, the provision of transport to attend a hospital appointment or to access day care) (NIHRC, 2001:26). However, as a report by the Northern Ireland Human Rights Commission (2001) highlights, older people experience a number of barriers in relation to travel and transport which can impact on access to health and social services. Barriers highlighted by the report include:

- **Costs:** many older people are unable to take advantage of free public transport. Some may have to rely on friends or relatives with cars, taxis, social services and the voluntary sector to take them to and from appointments. Some of these forms of transport will involve costs and there is varied practice amongst

HSS Trusts as to the extent to which transport will be provided (that is, a postcode lottery); and

- **Accessibility of Transport:** inaccessible vehicles are problematic for older people with mobility problems and those living in rural areas in particular.

A report published in 2003 by the Social Exclusion Unit in Great Britain highlights that over the course of one year 1.3 million people miss, turn down or chose not to seek health care because of transport problems (2003:111). Older people, particularly those in rural and/or deprived areas, are especially vulnerable when it comes to losing out on services because of transport availability. There is very little widely available research which makes explicit connections between transport and equity of access to health and social services. Therefore, this may also be an area which requires a much greater research and policy focus.

Elder Abuse

A report published by the House of Commons Health Committee in April 2004 highlights that the, *“abuse of older people is a hidden, and often ignored problem in society”*. The report argues that in recent years the Government has taken a number of steps to raise the profile of the problem of child abuse including the introduction of measures to identify and tackle the problem. Yet, the abuse of older people remains firmly in the background (2004:7).

Abuse of older people can occur in a variety of settings including, the person’s own home, a carer’s home, day care, residential care, nursing homes or hospitals. The abuse can take a variety of forms including physical, sexual, financial and/or emotional abuse, neglect and over-medication. The perpetrator of the abuse can be a partner, child or relative, a friend or neighbour, a paid or voluntary care worker, a health or social worker, or another professional. There are also various reasons why abuse can occur including, poor quality long term relationships, a carer’s inability to provide the level of care required, or the fact that the carer has mental or physical health problems. In more formal settings, such as care homes, abuse can be the result of inadequately trained staff, poorly supervised staff or staff who receive little support from management (Action on Elder Abuse Fact Sheet).

Both older women and men can be at risk of abuse. However, as Pritchard (2004) argues very little research is available about men as the victims of elder abuse. Pritchard's (2004) study indicates that male victims of elder abuse tend to be treated differently by social workers than female victims of abuse. For example, men living in squalid conditions or in a state of neglect often go unreported by some professionals who believe that men are more likely than women to choose to live in such conditions. This has quite obvious implications in terms of men and equity of access to interventions.

There is currently a scarcity of research on the issue of elder abuse in a Northern Ireland context. This issue urgently requires much greater attention in terms research and policy in order to attempt to identify the prevalence of elder abuse and to address the training needs of carers and health and social care staff. It is strongly recommended that the DHSSPS and its associated bodies take note of the recent House of Commons Health Committee report on elder abuse and its recommendations (a number of which are outlined below).

**Recommendations: Elder Abuse
(House of Commons Health Committee Report on Elder Abuse, 2004)**

- **Varying definitions of elder abuse are adopted across the health and social care sector. To enable the extent of the problem of elder abuse to be accurately determined and for the purposes of uniformity an agreed, consistent and comprehensive definition of elder abuse should be applied by all Government departments, statutory agencies, independent bodies, charities and organisations.**
- **National Minimum Standards should be put in place for domiciliary care to require the reporting of adverse incidents.**
- **Steps should be taken to review the frequency and effectiveness of the inspection of NHS establishments providing care for older people including measures to increasing user engagement.**

- **The over-prescription of medications is sometimes used in care environments as a tool for managing residents. However, measures should be taken to ensure that all people aged over 75 should have their medicines reviewed at least annually with those taking four or more medicines reviewed at least once every six months.**
- **There should be mandatory training for staff in all settings where abuse can occur including training in recognising, reporting and treating elder abuse.**

Mental Health

The 2002 Report of the Director of Public Health published by the Northern Health and Social Service Board (NHSSB) states that, *“mental health problems in old age should be treated as vigorously as physical problems in that age group, and mental health problems in younger people”* (NHSSB, 2002:23). The report further suggests that as a result of living in a society which could perhaps be regarded as ageist, the mental health problems of older people have been somewhat overlooked and viewed as an inevitable consequence of ageing (2002:27).

It is estimated that between 10-20% of older people (aged 65+) suffer from serious mental health problems including conditions such as Alzheimer's, dementia and depression. The prevalence of depression in those aged 65 ranging from 15% in the general community to 30% of those in residential homes (MacDonald, 1997 cited in NHSS, 2002:25).

MIND, a leading mental health charity, outline a number of factors which can specifically influence the mental health of older people including life changes such as retirement (in which stress and depression can result from financial loss, loss of purpose, adjusting to spending time at home, changes in social networks, boredom, low self esteem) and the increased likelihood of bereavement (such as loss of a partner, friends and family). MIND also highlight that there are distinct differences between the mental health of older women and older men.

For many older and middle aged women, for example, the menopause can lead to emotional upheaval, stress and depression. Older women in comparison to their younger counterparts also experience a wide range of losses (such as loss of fertility, loss of parental role, loss of income through retirement) and this can have a profound impact on their mental and emotional health. For many men, the “male menopause” can involve a series of physical and psychological changes which can often lead to depression and anxiety. The suicide rate amongst older men, the over 75s in particular, is an additional area of concern (MIND Factsheet).

A recently published literature review conducted by Mentality, as part of Age Concern England and the Mental Health Foundation’s UK-wide three year inquiry into “mental health and well-being in later life”, has identified a number of inadequacies in current research, policy and service provision for older people. Areas for concern arising from this review include:

- **Depression:** the review reveals that very few medical trials for treatments relating to depression included patients over the age of 60.
- **Suicide Prevention:** there is little evidence of a coherent approach to suicide prevention targeted at older people.
- **Poverty:** the review reveals that there are clear links between deprivation, poverty and poor mental health amongst older people, however, there is an absence of research relating to this in certain areas (for example, the effects of retirement on mental health in later life).
- **Participation:** a lack of evidence which suggests that older people themselves have inputs into the design and delivery of mental health interventions or the promotion of mental health.

A number of steps have already been taken to improve the mental health of older people in Northern Ireland including, the DHSSPS Mental Health Strategy and Action Plan; proposals for a new £7m centre of excellence for dementia care; and various other policy and service developments at HSS Board and Trust level.

However, there appears to be relatively little Northern Ireland specific research which explores the mental health of older people and inequities in uptake or availability of services or in relation. Nor does there appear to be widely available research relating to older people and the interaction between mental health and deprivation or other social and geographical factors. There may, therefore, be a need for greater attention in this area in order to inform policy formation and service planning.

Alcohol Misuse

Evidence suggests that alcohol use disorders are common amongst the older population and are associated with considerable morbidity. Yet, media attention and public health initiatives relating to alcohol use disorders have tended to focus upon the younger population (O'Connell et al, 2003).

O'Connell et al (2003) maintain that with the ageing population continuing to increase, health services need to improve their provision of age appropriate screening and treatment methods and services in relation to alcohol misuse. O'Connell et al (2003) suggest that the rate of alcohol misuse amongst older people is often underdetected and misdiagnosed for a number of reasons. For example, older people are more unlikely to disclose a history of excessive alcohol intake, health and social care staff have a lower degree of suspicion when assessing older people, and health care workers may be less likely to refer older people for specialist treatment.

It is clear that older people with alcohol related problems may not be receiving equitable access to available treatment and services. However, there is very little available research or information in regards to this issue which specifically refers to Northern Ireland.

Learning Disabilities and Ageing

An increasing number of people with learning difficulties are now living to an older age. This may mean that many more older people with learning disabilities will experience age related illnesses such as dementia (Wilkinson et al, 2004:1). Yet, despite this trend, research (Wilkinson et al, 2004; Davis et al, 2002) highlights that there is lack of information and policy on how best

to provide needs led, multi-disciplinary and supportive services to older people with learning disabilities.

Wilkinson et al's (2004) study of adults with learning disabilities and dementia living in a number of community based residential homes in the UK raised a number of important issues including:

- the lack of coherent and consistent practice in relation to diagnosis and follow up for people with learning disability and dementia.
- that diagnostic services tend to be ad hoc and that there is often a lack of any formalised route for the management of the individuals present and future care needs.
- that few staff had training in supporting people with dementia. There was a tendency for staff to cope rather than ask for assistance which they feared would result in the person being moved.
- relatives of people with learning disabilities and dementia often lacked knowledge and awareness of the condition and expressed a desire for more information and advice.
- that when people with learning difficulties and dementia are admitted to hospital, acute staff did not know how to deal with people with learning disabilities (feeding, washing etc). Often staff from the residential homes went into the hospital and provided care themselves.

Many of the above findings are also relevant for people with learning disabilities and dementia in Northern Ireland. A study by Davis et al (2002), into the needs of people with intellectual disabilities and dementia in the Eastern Health and Social Services Board area, identified a number of similar findings. Davis et al (2002) note that although awareness of dementia in people with learning disabilities was growing amongst both carers and health and social care staff, there was still comparatively little information as to how services would be planned in order to meet the needs of this group.

Both Wilkinson et al (2004) study and the Davis et al (2002) study make a number of recommendations for improvements in the availability and accessibility of services for people with learning disabilities and dementia. These recommendations (outlined below must be taken into consideration by the DHSSPS and associated bodies and agencies.

**Recommendations: Learning Disability and Dementia
(Davis et al, 2003)**

- **A comprehensive multidisciplinary assessment and diagnostic service should be available to everyone thought to be suffering from dementia. Such services should aim to undertake assessment at the earliest possible opportunity.**
- **In view of the high risk of people with Down's Syndrome developing dementia, services should recognise the value of undertaking brief but thorough assessments of cognitive functioning and daily living skills whilst adults are in their 20s.**
- **On diagnosis a care plan should be devised drawing on multidisciplinary and multi-agency input. Care plans should be reviewed continually to identify changing needs.**
- **Assessment of the needs of carers should incorporate both practical and emotional needs.**
- **The training needs of staff should be identified and an appropriate response implemented.**
- **Supporting people in their current residential locations until it is no longer practically possible should be the guiding principle of designing a care package.**
- **The choices and rights of individuals with intellectual disabilities should be recognised and maximised.**
- **Information for people with intellectual disabilities in relation to dementia should be developed in appropriate and accessible formats.**
- **The extensive expertise and knowledge for responding to people with dementia which already exists within elderly programmes of care should be maximised. Co-operation and the sharing of skills, expertise and services across programmes of care should be encouraged.**

- **Mechanisms should be put in place to ensure that people with intellectual disability and dementia receive equal access to drugs and treatment.**
- **High dependency services should be available when carers reach a stage where they can no longer meet the needs of the person that they provide care for.**

Recommendations: Older People, Learning Disability and Dementia (Wilkinson et al, 2004)

- **There is urgent need for health and social care staff to receive information and training regarding the early signs of dementia in people with learning disabilities.**
- **There must be clear guidelines in relation to the development of diagnostic and care pathways.**
- **There is a need for more research into the experiences of people with learning difficulties and dementia.**
- **Service providers need to take into account the needs of relatives recognising their need for support and information about dementia.**

Older Carers [see dependants section]

Black and Minority Ethnic Older People

A number of studies have been conducted into the needs of older Black and Minority Ethnic people in Northern Ireland. A study into the needs of Chinese older people, commissioned by the South and East Belfast Trust and the Chinese Welfare Association (NI)⁴⁹, for example, highlights that Chinese older people:

⁴⁹ “Who Cares: Report on the Health Related Quality of Life and Individual Level of Need of Chinese Elderly in Northern Ireland”

- are often unaware of their entitlements to services such as day care services, home helps, district nurses, chilled meals, continence nurses;
- are less likely to access services even when they have knowledge of those services;
- have difficulties in communicating with health and social care staff given that many Chinese older people do not read or write English; and that,
- the problems faced by Chinese older people tend to remain hidden because they are often reluctant to complain or impose themselves on others.

A further study commissioned by the South & East Belfast Trust into the Needs of Hoi Sum Chinese older people highlights the isolation and loneliness experienced by many Chinese older people in Northern Ireland (Chan, 2003:14). It is likely that older people from other Black and Minority Ethnic groups in Northern Ireland have similar hidden needs and service accessibility difficulties.

Age Concern⁵⁰ maintains that older people from Black and Minority Ethnic communities are not achieving equal access to services such as health and social care. As the population of older Black and Minority Ethnic people continues to increase, Age Concern suggests that Government bodies and agencies must ensure that the voices of Black and Minority Ethnic older people are incorporated into decision-making processes.

A 2001 Age Concern Conference identified five key action points for those providing services to Black and Minority Ethnic older people. It may be useful for the DHSSPS and relevant bodies to take into consideration these points (outlined below).

⁵⁰ Age Concern Black and Minority Ethnic Elders web page - www.ageconcern.org.uk/AgeConcern/about_bmee.htm

Recommendations: Black and Minority Ethnic Older People (Age Concern England Ethnic Elders: Access & Equality Conference – November 2001).

Five Action Points for Service Providers:

- **Ensure Consultation: Black and Minority Ethnic older people must be involved with consultation processes.**
- **Make Services Appropriate: services should have a sensitivity towards diverse cultural and religious needs.**
- **Make Information Accessible: information on older people's rights and how to access services needs to be disseminated widely to minority ethnic communities in new and imaginative ways and in a range of languages. Opportunities must be given to ask questions.**
- **Make Resources Available: money is needed to provide appropriate services. Resources should not be tokenistic or offered on a short term basis.**
- **End Discrimination in Service Provision: health and social care staff must have ongoing training to underline the importance of positive attitudes to all older people. This should include anti-racist and anti-ageist working practices.**

Ageing and Communication in Health and Social Services

Older people can experience a wide range of communication barriers in the field of health and social care. Such barriers can range from difficulties in accessing information on health and social services (for example, because information is not available in accessible formats) to restricted opportunities in expressing opinions or make choices in a health and social care environment.

Despite the development of a person-centred approach in health and social services, research continues to suggest that the opinions of older people are not afforded the respect they deserve.

The King's Fund highlight that sociological studies of medical consultations suggest that some health and social care professionals often modify the information, advice and interventions they provide to older people. Older people can also be viewed as passive or dependent and some professionals can either have low expectations of older people's mental capacity and/or tend to infantilise older people's behaviour (King's Fund Briefing Note on Age Discrimination in Health and Social Care).

Older people with profound communication problems (for example, as a result of a stroke or dementia) can also be excluded from expressing their thoughts and opinions (Kings Fund Briefing Note; SCARE Research Briefing). A recent small scale study into aphasia⁵¹, for example, highlights how services can be inaccessible to people with severe communication difficulties and that information, when available, is often unclear or inappropriate. The study also revealed that many service providers do not know how to communicate with people with severe communication impairments. Some service providers in the study indicated a need for more information and support in communicating with people with severe communication impairments, but highlighted that there was a lack of widely available information in this area (Parr et al, 2004).

The Government's policy drive towards e-government and the provision of electronic information-based services could present new barriers for older people in terms of accessing information and advice on health and social care. A recent small scale study by Sourbati (2004), into older people's access to new media and online service delivery, reveals a number of obstacles affecting older people's access to electronic based information and services. These included:

- a lack of new media skills and difficulties acquiring the new skills necessary;
- general literacy problems amongst the older population;
- the costs of new technology devices (such as computers);
- the costs charged by internet service providers; and,
- in terms of telephone based services, difficulties arising out of declining hearing and speech ability (2004:3).

⁵¹ a communication impairment that commonly follows a stroke.

Studies suggest that there are a high proportion of older people, particularly those in residential and nursing care with communication difficulties (Bryan et al, 2001). This is an area which requires a greater focus with an increased emphasis on training and awareness for health and social care staff in order to develop more effective strategies for communicating and listening to older people. The ability of older people to have their views taken in consideration and to be engaged in decision-making has important implications for both equality of opportunity and human rights.

Older People, Human Rights and Health and Social Care

Research published by the Northern Ireland Human Rights Commission in 2001 considers the extent to which law, policy and practice in Northern Ireland promotes and protects the rights of older people in a range of areas including health and social care. The report concludes that the real extent of age discrimination in Northern Ireland continues to remain hidden, particularly in the health and social care system, due to the absence of research in this area (NIHRC, 2001:3).

The report suggests that the difference of treatment by reason of age across a wide range of areas, contravenes a number of human rights notably – Article 2 (the right to life), Article 3 (the prohibition of degrading treatments), Article 8 (the right to private and family life) and Article 14 (the right not to be discriminated against in the exercise of those rights).

The NIHRC report provides a number of illustrations of circumstances in which health and social services providers and commissioners could potentially be in breach of the 1998 Human Rights Act. A number of these examples are briefly outlined below. It would perhaps be prudent for the DHSSPS and its associated bodies to systematically examine past and current legislation, policies and practices to identify further potential breaches and identify ways in which these could be addressed.

NIHRC Examples of Potential Breaches of the Human Rights Act in relation to Social Care (2001:13-16):

- **Residential Care:** moving an older person to a home which could have adverse impacts on their private and family life (for example, the splitting up of a couple).
- **Waiting Lists:** delayed discharge from a hospital setting to home could potentially breach Article 2 (right to private and family life). If the older person is finding hospital particularly upsetting then there may be an interference with their physical and psychological integrity, which has been taken to be included in the concept of private life.
- **Loss of Dignity:** loss of dignity through a delay in providing services (for example, a lack of assistance with person care such as washing) could be considered degrading treatment and could potentially be a breach of Article 3 (the prohibition of degrading treatment).
- **Poor Standards of Care:** abuse or neglect in residential homes due to a number of factors including inadequate staff numbers could also contravene Articles 3 and 8.
- **Charging for Care:** low level of income for those older people in residential care or hospital may (due to loss of benefits or capital) interfere with their right to private and family life (Article 8).
- **Delays in Treatment:** delays in treatment could interfere with Article 2 (right to life) or Article 8 (right to private and family life) depending on certain circumstances. If, in more extreme cases, the delays can be shown to be likely to cause death then Article 2 (right to life) could also apply.

The British Institute of Human Rights (BIHR) in an assessment of human rights and older people, suggest that many of those working in the health and social care sector lack an understanding of the principles enshrined within the Human Rights Act and their role in promoting and upholding the rights of older people (2002:57). The BIHR further suggest that there is still some way to go before the Human Rights Act is accepted in a similar way to that of equality legislation. It also maintains that the Human Rights

Act currently seems to have very little bearing on many of the decisions that are made in relation to older people's lives (2004:57). It is evident, therefore, that DHSSPS and associated bodies must continue to mainstream and raise the profile of human rights throughout its policies and practices.

Recommendations: Older People and Human Rights

- **It is clear from the evidence presented in the literature that there must be a incessant effort by the DHSSPS and its associated bodies to continue to raise the awareness of the human rights of older people in a health and social care context including the provision of training for all staff.**
- **The DHSSPS and its associated bodies should strive to work in co-operation with the Northern Ireland Human Rights Commission and the voluntary and community sectors to empower older people by providing them with information, advice and advocacy in relation to human rights.**
- **All providers and commissioners of health and social care services should conduct an audit of policies and procedures to identify and address potential human rights violations.**

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Useful Web-Links*

Children's Groups & Organisations

- **Barnardo's** - UK children's charity working with the most vulnerable children and young people.
www.barnardos.org.uk
- **Child Accident Prevention Trust** – national charity committed to reducing the number of children and young people killed, disabled and seriously injured as a result of accidents.
www.capt.org.uk
- **Child Brain Injury Trust** - aims to improve the quality of life for all children and young people who have an acquired brain injury (ABI) and enable them to achieve their full potential.
www.cbituk.org
- **Childline** - free confidential 24-hour helpline for children and young people in the UK.
www.childline.org.uk
- **Children's Law Centre (NI)** – works in partnership with children and other agencies committed to children's rights.
www.childrenslawcentre.org
- **Extern** - works directly with children, adults and communities affected by social exclusion throughout Ireland.
www.extern.org
- **Gingerbread** – leading support organisation for lone parent families in the UK. www.gingerbread.org.uk
- **Kidscape** – committed to keeping children safe from abuse. Kidscape is the only national charity dedicated to preventing bullying and child sexual abuse. www.kidscape.org.uk
- **Institute of Child Health** - leading British academic research institution for child health.

www.ich.ucl.ac.uk

- **National Children's Bureau (NCB)** - umbrella body for the children's sector in England and Northern Ireland, we provide essential information on policy, research and best practice.
www.ncb.org.uk
- **NCH** – works with children & young people affected by poverty, disability and abuse.
www.nch.org.uk
- **NIMBA** – Northern Ireland Mother and Baby Action a cross community charity dedicated to reducing premature births, illness, disability and deaths in all babies born throughout Northern Ireland.
www.nimba.org.uk
- **NSPCC** - UK's leading charity specialising in child protection and the prevention of cruelty to children.
www.nspcc.org.uk
- **Northern Ireland Commissioner for Children & Young People** – includes publication on children's rights in NI (produced by QUB).
www.niccy.org
www.niccy.org/downloads/childrensrights/Chapter%203.PDF
(QUB report)
- **OFMDFM Children & Young People's Unit** – includes information on children's rights and the NI Strategy for Children & Young People.
www.allchildrenni.gov.uk
- **Playboard** - lead agency for children's play in Northern Ireland.
www.playboard.org
- **Prince's Trust** – UK charity that helps children & young people with training, mentoring and financial assistance.
www.princes-trust.org.uk
- **Youth Action (NI)** – voluntary youth organisation working with young people.
www.youthaction.org

- **4 Nations Child Policy Network** - website contains information on the latest policy developments relating to children and young people in each of the four nations and across the UK.
www.childpolicy.org.uk

Older People

- **Age Concern** – supports all people over 50 in the UK, provides essential services such as day care and information.
www.ageconcern.org.uk
- **Centre for Policy on Ageing** – primarily directed towards informing and influencing service providers on issues affecting older people.
www.cpa.org.uk
- **Help the Aged** – provides services and support to older people on a collective and individual basis, works to improve older people's status and position as equal citizen's in society.
www.helptheaged.org.uk
- **Help the Aged (NI)** -
[www.helptheaged.org.uk/ founations/ni/ boilerplate/About+Us/ default.htm](http://www.helptheaged.org.uk/founations/ni/boilerplate/About+Us/default.htm)
- **PSI Ageing in an Inclusive Society**
www.ageinginni.gov.uk

Other Relevant Websites

- **Crisis** - commissions and publishes research to raise awareness of the causes and nature of homelessness.
www.crisis.org.uk
- **Simon Community** – responds to the needs of homeless people through initiatives aimed at prevention, provision and progression to independent living.
www.simoncommunity.org

- **Older Homelessness** - UK lobby group of housing and homelessness agencies concerned with raising the profile of older homeless people in the UK
www.olderhomelessness.org.uk
- **Action on Elder Abuse** - national organisation that operates across the four nations of the United Kingdom. It also provides support within Ireland. As a multi-disciplinary membership organisation it aims to prevent the abuse of older people.
www.elderabuse.org.uk
- **Northern Ireland Women's Aid Federation** - exists to challenge attitudes and beliefs which perpetuate domestic violence.
www.niwaf.org
- **Women's Aid Federation** – national charity working to end domestic violence against women and children.
www.womensaid.org.uk
- **Child Poverty Action Group (CPAG)** - charity campaigning for the abolition of poverty among children and young people in the UK.
www.cpag.org.uk
- **Northern Ireland Anti-Poverty Network (NIAPN)** - interactive network with over 300 members drawn from the voluntary and community sectors, public and statutory bodies.
www.niapn.org
- **Mental Health Foundation** - aims to help people survive, recover from and prevent mental health problems.
www.mhf.org.uk
- **Mental Health in Later Life** – provides information on dementia, substance misuse, depression etc –
www.mhilli.org
- **NI Review of Mental Health & Learning Disability** - independent review examining the law, policy and provisions affecting people with mental health needs or a learning disability in Northern Ireland.
www.rmhdni.gov.uk

- **Northern Ireland Association for Mental Health** – provides local support for those with mental health needs and offers a wide range of services including housing schemes, day care provision and advocacy.
www.niamh.co.uk
- **Young Minds** - the national charity committed to improving the mental health of all babies, children and young people.
www.youngminds.org.uk
- **Young People & Self Harm** – National Children’s Bureau site with key information and resources for people who self-harm, their friends, relatives and professionals.
www.selfharm.org.uk
- **Eating Disorders Association** – information and help on all aspects of eating disorders including Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder and related eating disorders.
www.edauk.com
- **OFMDFM Ageing and Rural Poverty Research**
www.research.ofmdfmi.gov.uk/ageing.pdf
- **Rural Community Network (NI)** – voluntary organisation established by local community organisations to articulate the voice of rural communities on issues relating to poverty, disadvantage and community development.
www.ruralcommunitynetwork.org

* Please note that this is NOT a definitive list of relevant websites.