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Children's Rights Alliance for England

7

State of Children's Rights in England 2018

Health

Briefing 7
Health

Article 6.1 States Parties shall ensure to the maximum extent possible the survival and development of the child.

Article 23 A disabled child should enjoy a full and decent life in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community. States Parties recognise the right of the disabled child to special care and ensure they have effective access to education, training, health care, rehabilitation, preparation for employment and recreation opportunities.

Article 24 All children have a right to the highest attainable standard of health and to healthcare services that help them to attain this. States Parties shall in particular, take measures to:

- Reduce infant and child mortality
- Ensure the provision of necessary medical assistance and healthcare to all children
- Combat disease and malnutrition
- Ensure appropriate prenatal and postnatal care for mothers
- Ensure everyone has health education and information, and understands the advantages of breastfeeding, basic hygiene and sanitation, and the prevention of accidents
- Develop preventative healthcare guidance for parents, and family planning education and services.

Article 27.1 States Parties recognise the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

Article 39 (recovery from trauma and reintegration) Children who have experienced neglect, abuse or exploitation must receive special support to help them recover their health, dignity, self-respect and social life.

Definitions and glossary

Children: All children and young people under 18 as set out by article 1 of the UN Convention on the Rights of the Child (CRC).

Mental health issues: Used to describe a variety of conditions children may experience, including mild, moderate to severe, and ensuing conditions ranging from anxiety or depression through to bipolar disorder, schizophrenia and eating disorders.

Clinical Commissioning Groups (CCGs): NHS organisations that commission health services for their local population.

About this briefing

The UK ratified the UN Convention on the Rights of the Child (CRC) in 1991. This means that all areas of government and the state including local government, schools, health services and criminal justice bodies must do all they can to fulfil children's rights.

This briefing is part of CRAE's *State of children's rights in England 2018* and assesses the progress made in England towards implementing the UN Committee's recommendations on health, including mental health. It highlights areas of progress and concern since CRAE's last *State of Children's Rights in England* report published in December 2017. It is based on written and oral evidence from CRAE's members and on additional analysis of recent laws and policies, newly published research, official statistics and responses to Freedom of Information (FOI) requests.

What is the CRC?

The CRC applies to all children aged 17 years and under and sets out the basic things that children need to thrive: the right to an adequate standard of living, to be protected from all forms of violence, to an education, to play, be healthy, and be cared for. Children's rights should act as a safety net, meaning children always receive at least the minimum standard of treatment whatever the changing economic climate.

The CRC has four guiding principles (General Principles) which are rights in themselves but also the framework through which all the rights in the CRC should be interpreted. They are: non-discrimination (article 2), the best interests of the child (article 3), survival and development (article 6), and respect for the views of the child (article 12). England's compliance with these General Principles is covered in Briefing 2.

Concerns of the United Nations

In June 2016 the UK government was examined by the **UN Committee on the Rights of the Child** (the UN Committee) on its compliance with the CRC, the first time since 2008. The UN Committee made a number of recommendations (Concluding Observations) for change.[1] In May 2017 the UK was examined on all its human rights treaties, including the CRC, by the 193 member states of the Human Rights Council as part of the **Universal Periodic Review (UPR)**.[2] This is a process where states can reiterate previous recommendations made by UN Committees and can be used by civil society and parliamentarians as an additional advocacy tool. The government can choose whether to "support" (accept) recommendations or "note" them (reject or not agree). We are very disappointed that the government has only supported 28% of the recommendations relating to children's rights compared to 42% of all the recommendations it received. Below are the relevant UN Committee and UPR recommendations for this briefing:

- Regularly collect comprehensive data on child mental health CRC
- Rigorously invest in CAHMS and develop strategies to ensure the availability, accessibility, acceptability, quality and stability of such services, with particular attention to children at greater risk CRC
- Support and develop therapeutic community-based services for children with mental health conditions CRC
- Expedite the prohibition of placing children with mental health needs in adult psychiatric wards or police stations, while ensuring provision of age-appropriate mental health services and facilities CRC
- Abolish all methods of restraint against children for disciplinary purposes in all institutional settings CRC
- Develop strategies on child health to eliminate inequalities and address underlying social determinants, using maximum resources and monitoring mechanisms CRC

- Collect data on nutrition, breast-feeding and obesity to identify root causes of child food insecurity and malnutrition CRC
- Monitor and assess effectiveness of policies and programmes on food security and nutrition of children CRC
- Promote, protect and support breastfeeding CRC
- Set out a clear legal commitment to reduce air pollution levels, especially in areas near schools and residential areas CRC

Introduction

There are worrying trends in children's physical and mental health, with evidence that England has poorer health outcomes compared to similarly wealthy countries, and increasing health inequalities between the most disadvantaged children and those in more affluent families.[3]

Increasing levels of child poverty and growing use of food banks are breaching many children's rights to have the best possible health, and jeopardising their development and wellbeing. There's also increasing evidence of the harmful impacts of pollution on children's health, both short-term and long-term.

The government's Green Paper on Children and Young People's Mental Health outlined some welcome proposals to strengthen the role of schools in promoting mental health. However, these fall short of what's needed, as many children increasingly struggle with severe mental ill health, including self-harm[4] and suicide,[5] and face huge barriers in accessing services. Children's and Adolescents' Mental Health Services (CAMHS) are struggling to cope with demand, with the system being described as 'not fit for purpose'.[6]

What progress have we made?

There have been some welcome announcements in support of children's health, including the promotion of mental health and healthy relationships in schools. The ambition in the NHS Long Term Plan for England, to improve the health and wellbeing of children and young people and tackle health inequalities is welcome, but will require resources and a strengthened workforce. The government's intention to make health and relationships education compulsory in primary schools, and relationships and sex education compulsory in secondary schools is welcome.[7] However, there are concerns that the content of sex education is too limited in scope and neglects issues such as violence against women and girls.[8] See Briefing 6.

Positively, the government has acknowledged the growing crisis in children's mental health and announced new funding for the Samaritans helpline and the appointment of a Minister for Suicide Prevention.[9] The 2018 Budget included a commitment to mental health support available in all A&E departments, to mental health crisis teams for children and young people and a 24-hour helpline.

The government has also committed to provide £300 million to implement the proposals in the Green Paper.[10] However, there are many concerns that the proposals fall far short of the scale of the crisis facing children. A joint parliamentary committee concluded that it lacks ambition and does not make specific provision for vulnerable groups; that the proposals won't be enough help the majority of children affected by mental ill health and places too much emphasis on the role of schools, without ensuring sufficient resources and expertise.[11]

The government is addressing the role of social media and its effects on children through its Internet Safety Strategy. A forthcoming White Paper will set out more detailed measures to address harmful and illegal online content, including proposals on a social media code of practice and online advertising.[12]

The government has also acknowledged the very harmful effects of air pollution on children's health, and published a draft Clean Air Strategy, subject to consultation.[13] A strategy is welcome, but there are real concerns that current proposals fall far short of what is needed and do not include specific measures to protect children from harmful air pollution.[14]

Where do we need to improve?

Mental Health

Crisis in children's mental health

One in eight 5-19 year-olds in England had a mental disorder in 2017, according to official statistics.[15] A survey carried out among secondary school pupils across the UK found that a third of them struggled with their mental health, including with depression, anxiety, a lack of focus and motivation. Many children are increasingly concerned about their future, are struggling with pressures of school and problems at home.[16]

Research has found that the number of referrals to specialist CAMHS has risen by 26.3% in the last five years, while the proportion of children in the population has only increased by 3% over the same period, indicating a substantial increase in children's mental health needs.[17] The research found that between one fifth and one quarter of children referred to specialist CAMHS were rejected as not deemed eligible for specialist care. This amounts to a conservative estimate of 55,800 rejected referrals in 2018 with great variation between providers. Worryingly, there was limited follow up for those rejected, with only a minority of CAMHS providers contacting other agencies after signposting, or checking that the signposted service had been accessed.[18]

Funding restrictions, increased demand for services and insufficient capacity have contributed to more restrictive eligibility criteria, with some children being advised to say that their condition is more severe in order to be eligible for care.[19] More restrictive eligibility criteria risks increasing costs and ill-health in the future, as children who do not receive timely support are likely to need more help if their mental health worsens further.

In 2017-18 there were 27,487 attendances to Accident and & Emergency departments in England by young people aged 18 or younger with a diagnosed psychiatric condition.[20] This represents almost a threefold increase in numbers in 2010-11 when there were 9,372 recorded attendances, and almost a doubling of 2012-13 figures when there were 13,800 recorded attendances.[21] These alarming statistics highlight the failures to ensure timely mental health support for children before they reach crisis levels. YoungMinds found that almost two thirds of parents described the care their child received as *"bad"* or *"unacceptable"*. 86% of parents agreed it would have been better if their children had received support before reaching crisis point.[22]

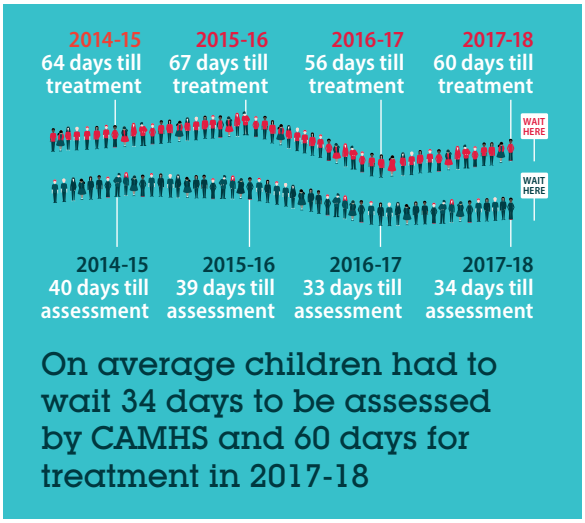
55,800 child referrals for specialist services were rejected in the past year

Source: Crenna-Jennings, W. and Hutchinson, J. (2018) *Access to children and young people's mental health services – 2018* Education Policy Institute

Many CAMHS services failing to meet children's needs

The Care Quality Commission has highlighted staffing shortages, restrictive criteria, long waiting lists, gaps in service provision, services that are far from home and reductions in early interventions and early years support as among the barriers to children's access to services.[23]

A survey found that CAMHS were not able to meet the needs of children and young people, especially those with severe conditions, with 33% of respondents describing CAMHS as inadequate or completely inadequate.[24] The Association of Child Psychotherapists identifies a lack of sufficient resources, as well as changes to services, as major factors in the inability of providers to meet the range, scale and severity of children's needs. Financial pressures and increased demand has eroded NHS practitioners' ability to provide quality, specialist, multi-disciplinary and timely services for children.[25] Some children, particularly in rural areas, face long distances and travel times to reach services. Travel costs and



Source: Crenna-Jennings, W. and Hutchinson, J. (2018) *Access to children and young people's mental health services – 2018* Education Policy Institute

having to miss school to attend appointments far away have been cited by families as obstacles to accessing support.[26] Where children don't receive support, or where out-of-hours services are unavailable, they are forced to go to emergency departments for help.[27]

Worryingly, children are still falling through the gaps between CAMHS and adult mental health services and, as a result, not receiving the support they need as they reach young adulthood. Many drop out of care altogether leading to calls for CAMHS to be extended to 25 years of age.[28]

Increased investment in CAHMS needed

The government's aim to get 35% of children and young people with a mental health condition receiving NHS community treatment by 2020-21 is laudable but falls short of what's needed. If this target was achieved, it would still leave a large proportion of children with unmet needs.[29] **The All-Party Parliamentary Group on Mental Health has highlighted the need for additional resources for CAMHS, including support for complex needs.** Despite a welcome focus on expanding perinatal mental health, the government's Five Year Forward View for Mental Health did not include recommendations on early years provision, before the age of five, despite evidence that adverse childhood experiences can have a profound impact on mental health.[30]

While investment in mental health services in England is set to reach £11.9 billion in 2017-18, up from £11.6 billion in 2016-17,[31] there are ongoing concerns that funding is not sufficient to meet the scale of need and that increased investment in mental health is not reaching frontline services.[32] **The commitment to ringfence £2.3 billion a year by 2023-24 for mental health care, is welcome, but it's unclear how much will be directed at CAMHS**. Inadequate funding has also had a disproportionate impact on particular groups such as LGBTQ and BAME children.[33]

Historically there has been a double disparity, with funding of children's and young people's mental health services receiving disproportionately less than both physical health services and adult mental health services. YoungMinds' research estimates that less than 9% of all NHS spending on mental health services goes towards children and young people's services.[34]

Waiting times for CAMHS a postcode lottery

Information from FOI requests obtained by the Education Policy Institute found that average median waiting times in 2017-18 were 34 days for an assessment and 60 days for treatment, but with wide variations across regions and CAMHS providers. The responses also found that there has been progress in decreasing average maximum waiting times for CAHMS in the last year, although these remain worryingly high.[35] Different data found that 539 children who were assessed as needing Tier 3 CAMHS had to wait for over a year to get treatment and only 14% started treatment within four weeks.[36]

The Green Paper proposal to trial a four-week waiting time for access to specialist services in 'trailblazer areas' doesn't go far enough and will continue the 'postcode lottery.'

Vulnerable children more likely to experience poor mental health

Some children, including looked after children, those leaving care, those in the criminal justice system, disabled children and LGBTQ children are more vulnerable to mental ill-health. Children who experience trauma, neglect, abuse, exploitation and conflict are also at higher

risk.[37] Separated asylum seekers and refugees are particularly vulnerable and often require specialised care and support.[38] The 'hostile environment' has made it even more difficult for them to access services. See Briefing 5.

45% of looked after children in England have a mental health condition compared with 10% of all children. An estimated half of all those in care have a possible mental health disorder compared to one in ten of those *not* in the care system.[39] Ofsted figures show a 31.4% rise in the number of suicides among at-risk children, from 35 in 2016-17 to 46 in 2017-18, the highest level in recent years.[40]

Cuts to local authority funding have led to support for vulnerable children reaching breaking point, with inconsistent and inadequate mental health assessments of children entering care and children being turned away from overstretched services. Government plans to pilot improved mental health assessments for children in care have been delayed until June 2019.[41]

There are roughly 70,000 young carers in the UK, who spend significant time looking after someone in their family who is ill or disabled. The Carers Trust has highlighted the impact that this role has on their mental health, and the barriers in support that they receive. While caring for a family member is often a source of pride it can also cause worry, stress, tiredness, isolation and difficulty accessing support services.[42]

Increase in children with learning disabilities in inpatient units

Through its Building the Right Support programme, NHS England aims to move people with learning disabilities or autism - or both - out of inpatient facilities and enable them to live in the community. However, deplorably, many children continue to be inappropriately and unnecessarily kept in inpatient units. The number of children in these units has almost doubled[43], and the average length of stay is 5.4 years.[44] This is hugely detrimental to children and puts them at risk of abuse and neglect (see below).

Use of restraint continues to cause harm

The use of restrictive interventions on children in inpatient care, including services for children with learning disabilities and/or autism, continues despite the harm to children. The government has ordered an investigation into the use of seclusion and segregation in Assessment and Treatment Units for people with learning disabilities/autism, following evidence of abuse and mistreatment.

In England in 2017-18, over a thousand under 20 year-olds were subject to restrictive interventions in NHS funded secondary mental health, learning disabilities and autism services.[45] These interventions include physical restraint, mechanical and chemical restraint and segregation and isolation. In this period there were over 26,000 uses of such interventions used against those under 20 years-old, including almost 3,000 cases of face down restraint, which is particularly dangerous.[46] Worryingly, there is currently no publicly available disaggregated data on the ages of children subject to restrictive interventions.

Positively, the Mental Health Units (Use of Force) Act 2018, which will come into effect in 2019, requires the recording of all incidences of use of force on people in mental health units and similar institutions, and for each record to include data on age, gender, ethnicity and other protected characteristics. The Act will also require all units to have a policy on the use of force including steps to minimise it. All staff will be trained on alternative methods of de-escalation.

Physical Health

Inequalities in child health

Inequalities in child health outcomes begin very early in life, with a percentage of babies born with low birth weight in the most deprived areas twice as high as in the least deprived areas.[47] Children from deprived areas are more likely to face greater health risks from birth and experience worse health outcomes in their early years and when they start school, compared to children in affluent areas.[48]

Projections by the Royal College of Paediatrics and Child Health (RCPCH) show that the stark inequalities in health outcomes such as infant mortality and levels of obesity are likely to increase over the next decade – and worsen among the most disadvantaged children.[49] According to the Equality and Human Rights Commission, disabled children report good health less often than non-disabled children, 65% compared with 96.9%[50]. **The RCPCH has called for a Children and Young People's Health Strategy for England to ensure coordinated and transformative action on children's health.**

Rise in food poverty and insecurity

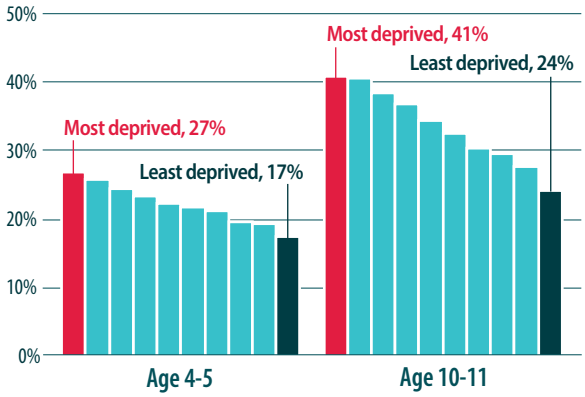
Alarmingly, food poverty and insecurity affect increasing numbers of children and families, with reports that 3.7 million children in the UK may be unable to afford a healthy and balanced diet.[51] Food bank use in the UK is at unprecedented levels.[52] A survey carried out by the National Education Union, among secondary school teachers, revealed significant concerns over teenagers having to rely on free school meals and not having enough to eat during the holidays. 59% of those polled said that children in their school experienced 'holiday hunger'.[53] The RCPCH has highlighted the harmful impacts of poverty on children's health. Paediatricians have seen parents depriving themselves of food in order to feed their children, which also made children anxious and frightened.[54] See Briefing 3.

Rising levels of obesity

In 2016 the UN Committee highlighted the *'high prevalence of overweight and obesity'* among UK children.[55] According to Public Health England, severe obesity in children aged between 10-11 years has reached the highest levels since records began.[56] It's estimated that almost one third of children aged two to 15 are overweight or obese in the UK, with younger generations becoming obese earlier and remaining obese for longer.[57] Childhood obesity is recognised as a top cause of health inequality, with children aged five from the most deprived backgrounds twice as likely to be obese as those from wealthier families.[58]

In England, obesity rates among reception-age children have reduced very slightly, from 9.6% in 2016-17 to 9.5% in 2017-18, and in year 6 rose slightly from 20% in 2016-17 to 20.1% in 2017-18.[59] A clear gender divide in obesity levels begins in reception. Obesity among boys in reception is higher, 9.9 %, compared to 9.1 % among girls, and by year 6 obesity among boys is 22.2% and 18% among girls.[60] Deprivation remains a strong indicator of childhood obesity, with rates of 12.8% in the most deprived areas compared to 5.7% in the least.[61] Worryingly, this gap has increased 5% between 2006-07 and 2017-18.[62]

Graph 1: Obesity levels by deprivation



Source: House of Commons Library, Briefing Paper Number 3336, *Obesity Statistics*, 20 March 2018

The government aims to *'significantly reduce'* the deprivation gap in childhood obesity by 2030.[63] The launch of a scheme to provide five local authorities with £100,000 funding for health initiatives is welcome.[64] However, campaigners call for expanded plans and deeper systemic change.[65]

After the introduction of the "sugar tax" manufacturers have started to reduce the amount of sugar in drinks. However there is little progress in food manufacturers voluntarily cutting 20% of sugar from a range of products by 2020. The RCPCH is concerned that only a third of the top 20 brands are making reductions in sugar content and 12% actually increased sugar in food products.[66]

Concerning levels of tooth decay

Figures in 2017 found 31-41% of five-year-olds across the UK with evidence of tooth decay.[67] Between ages five and nine, children's tooth decay admissions had risen from 25,923 in 2016-17 to 26,111 in 2017-18.[68] The leading cause of hospital admissions in five to nine year olds is dental extractions under general anaesthetic.[69]

Starkly, only 6.9 million children (58.4% of the child population) attended a dentist appointment in the 12 months up to 31 March 2018.[70] Social deprivation increases the likelihood of childhood tooth decay. In the highest-income areas of the country, 83% of five-year-olds had healthy teeth compared with 70% in the UK's poorest areas.[71] *The Starting well: A smile4all initiative*, launched in 13 priority areas, is welcome. It aims to improve preventative care and address oral health inequalities but experts have called for it to be rolled out more widely.[72]

Illegal levels of air pollution harming children's health

The World Health Organisation (WHO) has raised the alarm on the harmful impacts of air pollution on children's health, including harm to neurodevelopment and cognition and damage to lung function.[73] The first UN Special Rapporteur on Human Rights and the Environment made several recommendations on children's rights to be protected from environmental harm, including air pollution.[74]

Many children across England are exposed to polluted air on a daily basis, with hundreds of schools situated near roads with illegal and harmful levels of pollution.[75] In London alone, 802 schools, nurseries and colleges are in areas that breach EU legal limits for nitrogen dioxide levels.[76] Research estimates that one in three children in the UK are growing up in areas with unsafe levels of particulate pollution and recent studies of London children's exposure to air pollution found major peaks linked to the journeys to and from school and break time.[77]

Due to failings in reducing dangerous pollution levels, the UK is currently being taken to Court in the European Court of Justice.[78] The government's Clean Air Strategy 2018 announced £3.5 billion to tackle poor air quality through cleaner road transport[79] and a ban on petrol and diesel cars after 2040, but has been criticised as 'inadequate' by campaigners and city leaders.[80]

Low rates of breastfeeding

The UK has among the lowest rates of breastfeeding beyond six weeks, in Europe, reflecting the UN Committee's 2016 concern over *'extremely low rate of breastfeeding'*.[81] Exclusive breastfeeding for six months is recommended by WHO for a range of benefits to both mothers and infants.[82]

Worryingly the total rates of breastfeeding in the UK after six-eight weeks continued to fall to 42.7% in 2017-18, a decrease from 44.4% in 2016-17 and 43.1% in 2015-16.[83] Only 24% of infants in Sunderland were partially or fully breastfed until six-eight weeks in 2017-18, compared to 79.6% in Kingston upon Thames, revealing wide regional variations.[84] In contrast, efforts in Scotland have increased breastfeeding rates from 32% in 2010 to 43% in 2017.[85] In England, there is currently no data on breastfeeding continuation rates up to six months, one year or beyond, and no qualitative data on mothers' experiences. The government's refusal to re-instate the Infant Feeding Survey hinders the development of an informed national breastfeeding strategy.

Implementation of breastfeeding interventions is uneven and inadequate. Every NHS Trust in England should be aiming to achieve Unicef UK's Baby Friendly Initiative status, according to the NICE guidance, but some facilities are not even working towards this – while Scotland has now achieved 100% accreditation in both hospital and community facilities.[86]

Cuts to breastfeeding support services[87] and to local authorities, alongside a 20% reduction in the health visitor workforce in England, have made peer and expert support more difficult for many mothers.[88]

Concerns Brexit will impact on child health

The planned UK withdrawal from the European Union raises concerns for children's health and rights. There are questions over the UK's future role in cross-border cooperation on research, development and approval of paediatric medicines, and uncertainties on how reciprocal healthcare arrangements will be organised after Brexit.[89] There are also fears over a loss of EU nationals working in health and social care, such as shortages of nursing staff and risks to standards of care.[90]

Recommendations

1. The government should develop a cross-departmental child health and wellbeing strategy which is coordinated, implemented and evaluated across the four nations. Particular attention must be given to addressing health inequalities among children.
2. The government's additional investment in mental health must be ringfenced and spent on frontline services, including CAMHS and community services for children.
3. The government should develop a plan for assessing and addressing the wider underlying determinants of children's mental ill-health and a strategy to tackle these.
4. The government should publish maximum access and waiting time standards for CAMHS following the trailblazer areas. Performance against these standards should be measured at CCG level.
5. The government should establish emotional wellbeing and mental health as a fundamental priority of schools, as part of its proposals for health, relationships and sex education.
6. The government should commence the pilots to improve mental health assessments for looked after children without further delay.
7. The Mental Health Units (Use of Force) Act 2018 and accompanying guidance must end all inappropriate use of force and restrictive interventions against children and ensure the collection and publication of disaggregated data on all such incidents.
8. The government must ban the use of all pain inducing restraint against children and ensure that restraint is only ever used against children as a last resort and to prevent harm to the child or to others.
9. Following publication of the national prevalence survey for children and young people's mental health, the government should commit to commissioning national prevalence surveys no less than every seven years as recommended in the 5 Year Forward View for Mental Health.
10. As a matter of urgency, the government's commitment to ensure that no child with learning disabilities and behaviours that challenge is placed inappropriately in an inpatient unit should be fulfilled, with sufficient investment directed to community services, prevention and early intervention services.
11. The government should ensure universal early years public health services, including health visiting and school nursing, are prioritised and supported financially, with targeted help for children and families experiencing poverty.
12. The government must take action to ensure healthier food with reduced sugar, saturated fat and salt as well as overall calories, with ambitious targets, monitoring and sanctions where necessary.
13. The government must ensure that there is a national dental health strategy focused on prevention and oral health education and on improved access to NHS dental care for families living in deprived areas.
14. The government should pass a new Clean Air Act to bring together existing (but fragmented) national, EU and international air quality legislation, particularly in light of Brexit. Legislation to prevent new schools from being built in areas testing above the legal air pollution limit should be introduced.
15. The quinquennial UK National Infant Feeding Survey should be reintroduced alongside the appointment of National Infant Feeding Coordinators, and the requirement for all hospitals, maternity, health visiting and neonatal services to work towards baby-friendly accreditation.

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About CRAE

The Children's Rights Alliance for England (CRAE), part of Just for Kids Law, works with over 100 members to promote children's rights and monitor government implementation of the UN Convention on the Rights of the Child.

We believe that human rights are a powerful tool in making life better for children. We fight for children's rights by listening to what they say, carrying out research to understand what children are going through and using the law to challenge those who violate children's rights. We campaign for the people in power to change things for children. And we empower children and those who care about children to push for the changes that they want to see.

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