Best Health
for adolescents

Get Connected

Developing an Adolescent Friendly Health Service

Reports from Working Groups

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Foreword

Get Connected: Developing an Adolescent Friendly Health Service is the first major document, which has arisen through the work of the National Conjoint Child Health Committee, and follows on from the report, 'Best Health for Children'.

'Best Health for Children' looked at the health of children up to twelve years of age, particularly in relation to the promotion of positive health through supporting families and the provision of high quality screening and developmental checks. Valuable though this was, it presented only part of the picture, and there was an obvious need to commission a next phase, a review of the issues that related to the health of adolescents and young adults in Ireland. This was also highlighted in the recently published National Children's Strategy.

It was clear from the outset that this review would need to be different from the first. The issues were more complex, and there had been to date very little attention given to the area of adolescent health. For any review to be successful it would be essential to try and engage with young people themselves. Therefore the involvement of young people, particularly in relation to the key theme of developing an adolescent friendly health service, is a major strength of this report.

To their credit, the members of the Adolescent Health Sub-Committee who contributed to this report were not put off by the daunting size of the task they were assigned. Given a very tight timetable, they put in a huge amount of effort, which reflected their strong commitment to improving the health of young people in Ireland. It was particularly gratifying that people working outside of the health services, but who were very much involved with working with young people in other areas, saw the potential of this project for improving health in its broadest sense.

The report sets a very challenging agenda for the health services and for other agencies that have an influence on the health and well being of young people. It also demonstrates the potential for conjoint working by Health Boards in partnership with other agencies.

This document presents the detailed reports of the working groups and as such is an important resource supporting the main strategy report.

I would like to thank all those who contributed or commented on the report during its development. Thanks are due to the Best Health for Children Team, with a special mention for Celia Keenaghan who acted as project manager for the report, and did much of the work involved in pulling together the excellent work undertaken by the Working Groups.

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1.0   Introduction

1.1   Background

To date in Ireland, the focus of health service planning and delivery has been on adult and child services. Young people have been named in many strategy documents as a `target population` and generally in the context of health promotion and risk prevention activities. Increasingly it is being recognised that adolescence is a time of often untapped energy and enthusiasm, physically, socially and politically.

"the health of young people is significant for the well-being of this age group, and also for future public health (WHO 1999).

The 1999 report "Best Health for Children" reviewed child health services for the 0 to 12 year age group. The Chief Executive Officers of the Health Boards who had commissioned the original review, requested that a review of the health services for the 12 to 18 year age group should be carried out as part of the development of this project.

A sub-committee of the National Conjoint Child Health Committee was appointed with the following purpose:

- To establish the current health status of adolescents in Ireland
- To correlate the existing research on adolescents and to identify areas for future research
- To identify the health needs of adolescents
- To establish the current provision of services for the health needs of adolescents
- To evaluate the capacity of the services to meet the health needs of adolescents in relation to:
  - equity, accessibility, appropriateness, effectiveness, acceptability
- To recommend future areas of action in relation to the planning, delivery and evaluation of adolescent health services with special reference to vulnerable groups

1.2   Working Group Approach

The topic area for Working Groups were informed by priorities identified at a Best Health for Children workshop in 1999 entitled "Adolescent Health: Setting the Agenda for the 21st Century". These were modified and refined in the light of a literature review, the available time-scale and the terms of reference developed by the Working Groups. An external consultant was involved in facilitating the Committee's development and provided groups with a template to guide their reviews. The template covered:

- Definition of topic

- Literature review

- Needs assessment

- Report on findings of this research having regard to following principles:

- Capacity of services to meet health needs of adolescents in relation to:

  – equity
  – accessibility
  – appropriateness
  – effectiveness
  – acceptability

- Poverty and Justice to be considered as themes throughout all areas

- Recommendations regarding future actions in relation to planning, delivery and evaluation of adolescent health services pertinent to this area

While the Working Groups had autonomy in how they approached their task they were given support and direction to ensure a strategic approach to their work. The recommendations of each Working Group were considered by the Committee collectively to ensure a co-ordinated approach to the review. Reflecting the diversity of adolescence, the reports have produced a wealth of information drawing on literature reviews, professional expertise, adolescent expertise and information from representative organisations.

The Sub-Committee was charged with the task of setting the agenda for adolescent health in the 21st Century. A number of issues and topics have been raised. Many have concrete recommendations, some need further consideration, and some need to be added/raised. The agenda is now open for discussion and debate. This document is a supporting document to the adolescent health strategy Get Connected: Developing an Adolescent Friendly Health Service and should be used as a reference for much of the recommendations of the strategy.

2.0 Chronic Physical Illness and Disability in Adolescents

2.1 Introduction

Current health services for adolescents are poorly developed in Ireland. International research has identified how services can be developed and the recommendations in this report are an initial step in responding to the needs of this client group.   It is hoped that their implementations, alongside ongoing research into the services in Ireland, will not only improve the lives of adolescents but also their families and society in general.

International research has shown that adolescents with chronic physical illness and disability have distinct needs. In 1990 the Faculty of Paediatrics (1) produced a discussion paper which outlined deficiencies in the acute hospital service for adolescents but to date, the development of appropriate services for this group has been very limited. Following the publication of Towards an Independent Future, (2) there has been an emphasis on the development of community services for people with physical and sensory disabilities. However, even in this document, no specific mention is made of adolescents. The aim of this chapter is to identify the gaps that are present in hospital and community services in relation to adolescents with chronic physical illness and disability and to make recommendations for future research and service development.

2.1.1 Definition and Terms of Reference

Chronic physical illness is defined as any physical condition, illness or disease which would cause an impairment, disability or handicap for the individual adolescent and would be expected to last for greater than six months. Disability is any restriction or lack of ability to perform an activity within the range considered normal as a result of an impairment.

Terms of Reference agreed by the Working Group were:

(a)   To review any existing research on issues relating to chronic physical illness in adolescents and to identify areas for future research

(b)   To establish current levels of chronic physical illness and disability among adolescents in Ireland

(c)   To establish current provision of services for adolescents with chronic physical illness and disability

(d)   To identify gaps in existing services which result in unmet needs

(e)   To examine protocols in place for transition of care from Paediatric to Adult services

(f)   To recommend future areas of action in relation to planning, delivery and evaluation of health services for adolescents with chronic physical illness and disability.

2.2 Review of Literature

With improved management of chronic disorders in childhood, an increasing number of chronically ill and disabled children are surviving into their second and third decade. It is estimated that 90% will survive into adulthood and many of these will have serious impairment (3). For those with less severe functional disability, survival to 20 years approaches that of the normal population (4,5,6). In the severe group of children with cerebral palsy, 50% will survive into adulthood. The prevalence of cystic fibrosis in the United Kingdom has more than doubled in the 8-year period 1977 – 1985, reflecting improved survival rates (7).

In planning services for children with chronic illness and disability, and in providing appropriate support to them, one must do so on the basis that they will survive into adulthood. Issues that need to be considered include the medical problems that may develop, psychosocial difficulties that may be experienced, the provision of vocational opportunities and appropriate consideration of independence needs. In a Finnish study (8) it was noted that young adults with motor disabilities are more susceptible to psychiatric morbidity, especially depression and psychosomatic symptoms, than controls (8). In contrast, studies in the United States have shown that the majority of young people with chronic health problems complete their transition to adulthood with success (9). However where there is a chronic medical problem with at least a mild impairment in daily living skills, there is more likely to be an associated psychosocial problem (10). In England, Thomas and colleagues, in reviewing the health needs of young adults with physical disabilities, found that the state of health of young adults with physical disabilities was poor and organised health care for physically disabled young adult were virtually non-existent; the services that were available were unfocussed and fragmented (11). Young people with physical disability in this study were also likely to lack the social skills to seek or maintain services and personal relationships.

The effects of chronic physical illness and disability on parents and other family members cannot be underestimated. Appropriate strategies need to be in place to support this group (12,13,14).

The decline in service provision as the person with a chronic illness moves from the Paediatric to adult services is well documented (15,16,17). Currently, the transition from Paediatric to adult services takes place, in most cases, in an unplanned and haphazard manner. Proper transition of care involves not only the establishment of combined clinics with both a Paediatric and an appropriate and interested adult service involved, but also the preparation of the adolescent and his/her family for the transfer process. The adolescent needs to be empowered to manage his or her own illness, independently of the family and medial carers, and also taught how to access medical services and other supports. In Ireland, few dedicated adolescent services have been established (18). Only three hospitals have dedicated facilities for adolescents and in the majority of hospitals, adolescents are cared for on adult wards (19).

In the absence of dedicated services, it will be difficult to prepare the adolescent for transfer to the care of an adult service. Not surprisingly – therefore, for many adolescents and their families, transition is associated with feelings of abandonment and insecurity.

Recommendations and models of good practice in providing transitional care for adolescents with special care needs have been published (17, 20). Recognising the deficiencies that currently exist in the care of adolescents with chronic health problems in Ireland, many of these recommendations could be appropriately applied with a view to improving service provision in this age group.

Recommendation

- Promotion of quantitative and qualitative research involving adolescents and reviewing Irish services.

2.3   Data Collection

The members of the Working Group reviewed current databases within their own professions in relation to services for adolescents with chronic physical illness and disability. As outlined above, no comprehensive review of services for this client group exists within the Irish context. With this in mind, a submission document was prepared and sent to voluntary agencies working with chronic physical illness and disability, to tertiary consultants specialising in chronic disability in this age group and to a random selection of Paediatricians working in General Hospitals throughout the country. The aim of this document was to obtain an overview of the current services available and to assess what data is currently being collected on adolescents in a variety of organisations. The respondents were asked to identify gaps in the service they were providing and to inform the Working Group of any research projects that were occurring within their organisations. Specific questions were asked in relation to transition of care and joint clinics. Suggestions were sought on how the gaps identified could be rectified. As part of the research, a questionnaire for completion by adolescents was included.

2.4   Current Levels of Chronic Illness and Disability:

The group was unable to establish current levels of chronic illness or disability, as there is no comprehensive national database. Some specialist clinics that see all adolescents with a specific condition do have complete databases but there is no other complete source of information available in either the Acute Hospital or Community based services, including Primary Care. To respond to this situation the Department of Health and Children, following a recommendation from Towards an Independent Future established a Database Development Committee to oversee the development and implementation of a national Physical and Sensory Disability Database. The Health Research Board (21) recently published a progress report on the work of the Committee. It is agreed that the aim of the database is the planning of services at national, regional and sub-regional level. Inclusion and removal criteria have been agreed and will include people under the age of sixty-five who currently require, or will require, within the next five years, a specialised health or personal social service. Information on adolescents will be available from the register.   While many issues are still outstanding, the work of the Committee is ongoing.

Recommendation

- •   Establishment of national database which is complete, accessible and reliable.

2.5   Identified Gaps

Following the deliberations of the Working Group and a review of the submissions received, a number of gaps were identified within current services and will be dealt with individually. These are outlined below.

2.5.1   Disability and Illness Awareness

The need to increase awareness of the impact of disability and chronic physical illness was highlighted. This view was re-iterated by the adolescents surveyed. The inclusion of disability awareness in the national curriculum in the senior cycle would promote a more positive attitude towards disability and allow greater understanding of the restrictions it may place on people.

Workers who have regular contact with young adolescents with chronic physical illness and disability should be made aware of their need to have additional time to complete tasks, or increased rest periods. This group includes teachers, nursing staff, care workers and family members.

Recommendation

- Illness and disability awareness programjmes should be linked to the National Educational Psychology Services (NEPS) and the Social, Personal and Health Education (SPHE) Programme.

2.5.2 Hospital Care

The need for improved hospital care and facilities for adolescents has been identified by many groups within the Irish system. A recent survey found that 71% of adolescents were cared for with adults and in facilities that do not meet their psychological and developmental needs (19). As far back as 1959, the Platt Report in the U.K. (22) encouraged the provision of separate accommodation for sick adolescents; the perceived advantages of this were improved outcomes, allowed tailoring of information and development of expertise. **All the respondents to our submission document identified the need for separate facilities for adolescents with chronic physical illness and disability**. This has been supported by the Children in Hospital Document (19) and the Faculty of Paediatrics (1).

In addition to separate designated hospital facilities for adolescents, it is recognised that the development of appropriate skills amongst the medical and nursing profession is a priority, as is the inclusion of the views of adolescents in the planning and provision of services which they use. A recent study questioned Irish adolescents with cancer and elicited their viewpoints on the current hospital environment and what they perceived as an optimal environment to meet their needs (23). They identified the availability of specific units with suitable decor, furnishing, recreation facilities, suitable personnel, flexibility of routine, facilities for schooling and specific teenage information and involvement in the decision making process. The need for privacy for interviews and examination is paramount. Adequate parental accommodation should also be available. Ongoing research is required in the area of In-Patient facilities and models of care provision. A model of good practice at the Adolescent Unit of the Middlesex Hospital, London was examined; new units in this country could adapt this model of service to the Irish context.

A recent review of adolescent services in an Accident and Emergency Unit in Ireland again demonstrated how the particular needs of this group are not being adequately met in the Acute Hospital sector (24). In addition, there is a need for an increase in the number of sub-specialists to address the unmet needs of this population. The development of outreach clinics from the tertiary centres would improve access to services for the many adolescents who do not live close to such centres.

There is a national shortage of Psychologists and Social Workers to support this group of adolescents. Even in tertiary centres where services are developing, there is inadequate expertise to deal appropriately with the problems identified. This is more marked in General Hospital and Community Services, where there is often no proactive approach to the psychological and social needs of this group of adolescents, despite their increased sense of isolation, low self esteem and psychological problems. This results in an inequitable service, not only between tertiary and secondary centres, but also between Acute Hospital and Community based programmes.

Recommendations

- Hospital departments, including Accident and Emergency and Out-Patients, should aim to provide a suitable environment for adolescents. This includes the physical environment – facilities and wards/spaces, and the professional environment – staff attitudes, behaviours and responses. All hospital departments should produce a plan to improve the current environment for adolescents in hospital, incorporating the expressed views of adolescents.

- The Faculty of Paediatrics should ensure Paediatricians in training have a module on adolescent issues.

- Training in the nursing of adolescents should be included in the curricula of nurse training programmes. Appropriate models are available and should be incorporated into training.

- Service planning in hospitals must include ongoing qualitative research with adolescents to improve facilities and quality of care.

- Hospitals need to review the range and level of professional support available in order to plan a proactive approach to the needs of adolescents.

2.5.3   Community Services

Differences in the extent to which services in the community have been developed continue to exist between Health Boards, and even within Health Boards. This results in inequity of service provision for adolescents with chronic illness and physical/sensory disability. This inequity is exacerbated even further by the fact that tertiary referral centres for adolescents with chronic illness and physical/sensory disability are, in the main, located in the Dublin area.

Many public buildings are inaccessible to people with disability and even those that are said to be accessible, have poor internal design, limiting free movement. The inadequacy, or indeed total lack, of public transport, particularly transport accessible to those with a disability, remains a major contributory factor to the inaccessibility of services for those living in rural and urban areas.

The organisation and availability of community therapy services vary between Health Boards and between Community Care areas of the same Health Board. In spite of the recommendations of *Towards an Independent Future*, these services remain underdeveloped and inadequate to meet the demand. Community based services are provided by many different professionals and support services. Many of these professionals have no specific training in adolescent issues. Service provision is limited in terms of geographic availability, flexibility and the level of service provided. Young children and older people usually receive the highest priority for the services that do exist.

The constant care required can put a considerable physical, mental, and emotional strain on the person with the illness/disability as well as on their carers. Improved carer support and appropriate respite facilities are needed. Primary Care has a pivotal role in overseeing the care of these adolescents and in many cases, may be the only service provided. It is not unusual that a General Practitioner may be unaware of the treatment issues which arose during childhood because the patient attended specialist clinics, yet he or she is expected to take over care in adolescence. There is no national registration with G.P.s and therefore it is possible that

adolescents could slip through the net. Vocational training programmes now contain modules on adolescent health and disability and these need to be built on in the future. In addition, existing General Practitioners require ongoing training and support to ensure that they can provide a comprehensive service.

Personal Assistant (PA) services are not readily available for adolescents with disability and they often end up "falling between two stools"; neither the Department of Health and Children, through the Health Boards, nor the Department of Education and Science, are willing to take responsibility for the funding of Personal Assistants. Personal Assistants schemes are available through voluntary agencies but there is serious under funding of them. To avail of a Personal Assistant, the leader (i.e. the person with disability), has to be involved in the recruitment of a suitable person and form a contract with their assistant. In practice, the majority of people who have PAs are over eighteen years of age.

Adolescents may often be burdened by concern about the strain that their illness/disability places on their parents'/guardians' financial resources, particularly those on low income. The Long Term Illness Scheme, which provides for the provision of free medicines and medical/surgical appliances, is only available to those with a limited number of prescribed conditions. Greater flexibility is needed in the discretionary granting of personal Medical Cards to adolescents with a chronic physical illness or physical/sensory disability, independently of their parents.

Following the dissolution of the posts of Director of Community Care/ Medical Officer of Health, the approach to the co-ordination of services in the community for persons with chronic physical illness or physical/sensory disability has not been standardised throughout the country. There is a need for the appointment of Co-ordinators to oversee the development of services for this group. Some Health Boards have already made such appointments and it is essential that all Boards make appropriate arrangements for co-ordination as a matter of priority.

Many adolescents and their families find accessing appropriate information cumbersome and what is available often fails to meet their needs. This can include appropriate information regarding their condition, as well as access to technical aids which may assist them overcome their difficulty. Information regarding their entitlements is required both from Health Board and the Department of Social, Community and Family Affairs. We recommend the establishment of "one stop shops", where a wide range of information across statutory and voluntary agencies would be easily available.

Recommendations

- A review of services in the community for adolescents with chronic physical illness and disability should be undertaken to aid in strategic planning, development and delivery of services.

- All relevant staff in Community Services should take part in training in adolescent issues.

- Appropriate management structures should be developed within Community Services to aid in strategic planning, development and delivery of services for adolescents with chronic physical illness and disability.

- All adolescents should be registered with their General Practitioners.

- A designated officer should review communication systems between Hospital, Primary Care and Community Services. An action plan should be developed with protocols to ensure that essential information is transferred in a timely fashion.

- Each Health Board should review the level of support given through the Personal Assistants scheme. Adolescents who would benefit from this support should have appropriate access to it. Good practice in relation to the training and provision of Personal Assistants should be identified in the review.

- Each Health Board should produce a plan for the development of respite facilities.

- The Long-Term Illness Scheme should be reviewed, with a view to broadening the inclusion criteria.

- Until free access to Primary Care is established at a national level, there should be greater flexibility in the provision of Medical Cards to adolescents with chronic physical illness and disability.

- Physical structures should be improved to give access to public buildings and public transport.

- In respect of new Technology, there should be
  - Appropriate assessment of new technology needs, including a review of current practices and an assessment of potential new technology demands with appropriate planning to meet identified needs
  - Advice and support to professionals who recommend use
  - Provision of and access to new technology locally
  - No unacceptable delays in provision of essential technological aids and equipment
  - Ongoing Quality Assurance
  - Appropriate use of new technologies in the establishment of 'one-stop-shops' for advice on services, entitlements, training etc.

2.5.4 Transition of Care

Recent medical advances have resulted in over 90% of children with chronic illnesses now surviving into adult life. This increase in survival rates results in the need for ongoing services to adolescents and adults who have diseases which were primarily Paediatric in origin. Ongoing surveillance of these existing conditions is required as well as anticipation of new problems e.g. secondary tumours in people treated for leukaemia. In addition, while continuing to address the emotional and psychological needs of the adolescents and input into their educational and vocational requirements, services must also focus on anticipated new problems. The survey undertaken by this Working Group revealed that there is currently little planning around transition of care within Ireland and there has been a reluctance among adult Physicians to take over the management of these clients, as they feel they have not had appropriate training to do so. There are also issues around Paediatricians letting go of their clients and parents allowing their children to develop autonomy and move from a family-centred Paediatric service to a client-centred adult service.

Work in other countries, particularly USA (17) and Australia (22), has identified the requirements for a successful transition of care. In Ireland, joint working practices, particularly with young people with cystic fibrosis, is beginning in some centres around the country. There are also some initiatives involving young people with diabetes and recent progress in relation to cardiology, but all of these are isolated cases and there is no overall national programme. Even in tertiary centres, the links for transition of care that are being developed are ad hoc and need to be formalised.

Recommendations

- Each Health Board should ensure that every Hospital has a transition policy.

- Each Speciality Team should ensure that each individual has a transition plan, which has been developed in partnership with the client and his/her carers.

- Royal Colleges should incorporate training on the management of chronic illnesses in adolescents in the curriculum of adult specialists.

- Specialised nurses increase compliance with care; therefore there should be a dedicated post within each relevant specialty, to offer continuing links into the adult service.

- There needs to be a general increase in the number of specialists with an interest in adolescents but particularly in the areas of Neurology, Cardiology and Rehabilitation Medicine.

- A plan should exist to ensure provision of joint-clinics by Paediatricians and other Physicians over an appropriate transition period. These should be actively encouraged through appropriate Health Board funding.

2.5.5   Education

Under current Department of Education and Science rules, each child with special needs will have these needs met at the Primary level. The situation at second-level is not as developed but is being addressed. Current practice involves a parent informing the school of their child's special needs and an effort is made to try to meet the needs of this child. The availability of Care Assistants at second-level has been a problem; for example, adolescent boys may wish to have male carers at second-level but this option is often not available. In many schools, adolescents with chronic illness are unable to avail of therapy or have a period of rest owing to a lack of physical facilities. The absence of a school nursing service at second-level is seen as a gap that should be addressed.

If a young person has been officially diagnosed as having a disability, either physical or learning, assessment by the Educational Psychological Service may result in the provision of a Resource Teacher to assist in his earlier education. Currently the number of Resource Teachers available to second-level schools is increasing but is felt not to be adequate to meet the needs. Those children who are unable to attend school may be assigned visiting teachers, but again, provisions in this regard are limited.

A special needs provision group, currently sitting within the Department of Education and Science, is due to publish a report shortly. The emphasis, however, is mainly on specific learning difficulties but it is hoped that the group will also address issues like transport, escort and

physical supports within the school. Currently funding is provided to the school Principal to make adaptations as necessary but the amount is often inadequate. The Department of Education and Science is supporting schools who admit young people with chronic physical illness and disability by supplying resource teaching hours / posts.

There are currently five designated schools in Ireland who cater for a wide range of disability and could act as models for service development in facilities and staffing for other schools, to allow integration for the adolescents and provide adequate facilities.

Lack of appropriate career advice to this group of young people has also been identified as an issue and this may inhibit access to third-level education and appropriate training opportunities. Current structures, with career advice being given through schools by teachers who may not be fully aware of the implications of the illness for the young person, are inappropriate. Career advice should be given as part of the ongoing Out-Patient service to these young people and in association with the transitional care plans. An input from the school in relation to the child's ability and linkage with FÁS and third-level colleges is essential, to allow appropriate planning and career opportunities for all adolescents with chronic physical illness and disability.

An associated problem is the need to improve motivation and allow completion of second-level education, either by the use of assistive technology or additional time at examinations. Many respondents to the adolescent survey sent out by this Working Group reported that they felt teachers did not understand their illness or its implications. Frequent hospital admissions interfere with education. There is no formal provision of education within hospitals for second-level students. For those adolescents who require long-term admissions, there should be access to teachers. Models of providing such services should be piloted on a partnership basis between the Department of Education and Science and Irish hospitals.

Recommendations

- All adolescents who require Care Assistants in second-level schools should have access to them. Care Assistants in schools should have adequate information regarding students' needs, especially those students with more complex difficulties. The NEPS Psychologist could be a channel for some of this information.

- There should be a transition plan to re-integrate students into school following a long illness; this should involve health professionals, student, parents/carers and school.

- Developments in the provision and training of Resource Teachers are welcomed. A joint review of the way in which Resource Teachers are used is recommended. The review should produce a plan with detailed monitoring procedures, implementation points and outcomes.

- Child Care Policy Unit, DoHC, Fás and other relevant groups should work with the National Centre for Guidance Counselling in developing strategies for the delivery of career guidance.

- The physical environment within second-level schools should accommodate students with special needs and facilitate the involvement of therapists and health professionals.

- Initiatives such as mentoring and youth leadership should be supported and developed as methods of promoting a seamless transition from primary to secondary school.

- The development of appropriate health information material for adolescents with chronic physical illness and disability should be undertaken by the Department of Health and Children, in consultation with other relevant agencies e.g. NEPS, representative agencies of parents and young people.

2.5.6   Adolescent Views

As indicated earlier, the views of adolescents were sought as part of this review. The issues identified by them were:
- Lack of awareness by the general public of illness and disability and its implications for the person
- Lack of accessibility to activities and difficulties with public transport
- Restrictions placed on their lifestyle due to illness or disability
- Need for educational integration

Overall the adolescents were happy with their medical services and the support from specialist nurses.   However, they stated that they did not feel supported within the school setting and felt their social activities were limited. They also found making friends more difficult. Lack of emotional support was identified by some of the group; this would be in keeping with the inadequate provision of psychological and social support as previously identified. Compliance with medication was seen as a problem and this was also identified by the Consultant medical staff caring for them. It is beyond the scope of this review to identify the reasons for this but it is a topic which lends itself to further qualitative research.

Recommendation

- Adolescent opinions should be incorporated into hospital, community and educational developments for young people with chronic physical illness and disability.

2.5.7   Outstanding Issues

During the consultation process some other issues were raised which it was felt would require a more in-depth review. These include:

- Consent for treatment or refusal of treatment

- Conflict between confidentiality for adolescent and informing parents of "at risk" behaviour

- Issues relating to sexuality causing dilemmas for physicians and their patients

The mental health needs and health behaviours of adolescents with chronic physical illness and disability should be given particular attention in considering the recommendations of other sections of this document.

Research is needed to assess the factors, which might improve compliance with treatment and improve general motivation for young people with chronic illness and disability.   The development of age appropriate material is needed and should be undertaken by the Department of Health and Children.

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3.0   Mental Health and Adolescence

3.1   Adolescent Mental Health

To date, research on young people's health issues have concentrated on negative and problematic aspects and on the "high risk" aspects of adolescence. More recently there has been a shift in focus to various skills and strategies used by adolescents to protect and promote their health and to enable them to overcome the risk factors. Certain characteristics of the social environment encourage the development of this quality of resilience e.g family, community, housing and income.

Adolescence is a developmental stage offering tremendous opportunities for growth and positive outcomes (1). The importance of successful negotiation of the adolescent period, with its various hurdles, is emphasised by Banks et al (1992) as constituting the basis for becoming an effective adult (2). Coleman & Hendry (3) argue that mental health for adolescents can be influenced, positively or negatively, by failing or succeeding to achieve the developmental tasks involved in this transitional period of life.

According to Antonovsky (4) the health and well-being of an individual (or community) is determined by their ability or inability to develop adaptive coping strategies. Everyone experiences stressors throughout their lives but people cope with these in a variety of ways. The author states that the ability to develop adaptive coping strategies is dependent on life experiences and **resilience factors**.

The concept of resilience is important because it identifies how children, families and communities are able to cope and to thrive despite environmental challenges (5).

Conversely, **risk factors** are those mechanisms which contribute to adolescent susceptibility to increased risk of mental health problems. Although each risk factor can have a direct influence on children's mental health and well-being, **risk factors accrue cumulatively to place children and adolescents at exponentially greater risk for youth maladjustment** (5).

Jessor (6) has argued that the association among various health compromising behaviours is one of the clearest facts to have emerged from recent decades of research. **The significance of this observation is that a number of problem behaviours (or maladaptive patterns) in adolescents seem to be caused by the same underlying risk factors**.

Garland & Zigler (7) cite the example of suicide to highlight this argument. They state that because the known risks for suicide are also common risk factors for other problems, such as substance abuse, criminal behaviour, early school leaving etc, successful efforts to reduce any of the fundamental risk factors for these behaviours would provide excellent primary prevention for suicide also. Prevention efforts could be focussed on the underlying constructs that are known to be risk factors for these behaviours, such as depression, lack of social support, problem solving skills and hopelessness.

3.2   Mental Health Disorders in Adolescence

Mental health has been defined as the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Mental health disorders are health conditions that are characterised by alterations in thinking, mood or behaviour, or some combination of these, associated with

distress and / or impaired functioning (8). The presence of a mental health disorder in adolescence can interfere significantly with the accomplishment of the psychological tasks of adolescence (the development of a sense of one's own identity, separate from but linked to family, career choices, and the establishment of intimate relationships), and thus can have lifelong implications.

Mental health disorders in adolescence fall into two categories: those that are continuations of childhood disorders, such as conduct disorders, autism and attention deficit disorder, and those disorders that appear with increasing frequency in adolescence, such as depressive disorders, eating disorders, substance abuse and schizophrenia (9). Numerous epidemiological studies have looked at the prevalence of these disorders in adolescents in the developed world. Despite many methodological differences between the studies, a number of common themes emerge. These include:

- Population based studies consistently show that about 15% of adolescents have a mental health disorder with about a quarter of these showing 'significant functional impairment' (10,11,12).

- Mental health disorders in early adolescence are much more common in boys than in girls. The prevalence rate in girls rises throughout adolescence, so that by late adolescence female prevalence rates are significantly higher than male rates. The rise is mainly accounted for by the increase in anxiety and depressive disorders in adolescence. There is evidence to suggest that a significant number of young men with mental health disorders are not diagnosed as such, and are dealt with by the criminal justice system.

- Mental health disorders in adolescence occur in all social classes and backgrounds – no group is immune. However there are adolescents who are at greater risk by virtue of a broad array of factors. These include those experiencing physical problems, learning disability, parental mental illness or substance abuse, family breakdown, multi-generational poverty, separation from care-givers, and abuse or neglect (13).

- It is unusual for adolescents with mental health disorders to have a single discrete disorder. Co-morbidity (the presence of more than one disorder), is very common and contributes to much of the functional impairment associated with mental health disorders (11). For example, in adolescents with attention deficit hyperactivity disorder and associated conduct disorder, it is often the anti-social behaviour which causes most difficulty for the adolescent, his family and his community and which may lead to school dropout or exclusion and involvement in delinquent behaviour (14).

- **Only a tiny proportion (between 5% and 10% percent) of young people with mental health disorders are in contact with helping agencies** (15). Most mental health disorders in adolescents are unrecognised and untreated. This is due to the complex interplay of many factors including the difficulties experienced by parents and teachers in distinguishing between the normal 'ups and downs' of adolescent mood and behaviour and mental health disorders, stigma leading to reluctance to acknowledge the presence of mental health disorder, and lack of appropriate mental health services for adolescents.

3.3   Suicide and Adolescence:

Youth suicide is now a major public health problem in Ireland (16, 17).

• Youth suicide rates in Ireland have increased dramatically in the past ten years.

	1990	1995	1998
Total deaths from suicide	334	404	504
Suicide in those under 25 years	60	93	139

Forty children under fifteen years are known to have committed suicide in Ireland in the past ten years.

• Males outnumber females at a ratio of about 7 to 1.

• Suicide is the leading cause of death in the 15 – 24 year age range, and occurs throughout all socio-economic groups.

• Within the European Union, Ireland's suicide rates are about half way between those countries with the highest rates (Scandinavian countries) and those with the lowest rates (Mediterranean countries) (18).

• Risk factors for suicide in young people include depressive disorders; excess use of alcohol and drugs; previous history of self harm; lack of family cohesion (19).

• We do not know how common depressive disorders are in children and adolescents in Ireland, but studies from other countries suggest that about 5% of adolescents suffer from a depressive disorder, and that this is usually unrecognised by family and friends.

• Only a tiny proportion of young people who commit suicide have had any previous contact with mental health services.

Mental health disorders in adolescence are common and disabling. They affect young people's functioning in several areas of their lives, personal, social, behavioural, academic and vocational, and they interfere with their ability to undertake the developmental tasks of adolescence. **The cost of these disorders – in suffering for the young person and his/her family, in the effects on community resources, in loss of productivity and unfulfilled potential – is enormous.**

The increasing rate of youth suicide, particularly in young men, is a major public health problem. Little is known about what lies behind these stark figures. Research in this area is needed as a matter of urgency, to provide the background information which is essential before preventative programmes can be planned or evaluated.

3.4 Service Provision to populations with Symptoms of Mental Disorders

The Working Group attempted to find out the level of services for this population within the health services in Ireland. A questionnaire was sent to all CEOs and Child and Adolescent Psychiatrists of the 10 Health Boards. All Health Boards provided responses and two Health Boards sent a response from Psychologists as well as Psychiatrists. The emerging picture of service provision is as follows:

- Each Health Board employs on average, 2 - 4 Consultant Child and Adolescent Psychiatrists.
- Each Consultant is generally supported by 9 complimentary staff (Psychologists, Social Workers, non-Consultant Medical staff etc).
- Most Health Boards do not have In-Patient beds. However, access may be obtained from EHRA, WHB and SHB. Some Health Boards access beds at Paediatric Units or adult Psychiatric Units.
- All Health Boards have access to social Day Care centres. However, the picture is very confused in relation to the use, access or utilisation of such centres by Psychiatric services. This area needs a more thorough investigation than was possible within the time-frame of this project.
- Most Health Boards acknowledged the expertise and support of other services in dealing with clients seen by Child and Adolescent Psychiatrists, for example, Addiction Counsellors, Clinical Psychologist and Social Workers.
- In spite of the above, on average, each Child and Adolescent Psychiatrist has a waiting list of 50 people.
- Every Health Board has Health Promoting programmes and projects. These ranged from strategic development to community and welfare programmes.
- In relation to providing services to adolescents with mental health difficulties, respondents indicated the need for:

  - Access to appropriate In-Patient beds and improved Day Care Services
  - Improved access to group homes
  - Support to parents and parenting programmes

- For young people generally, respondents indicated the need for:

  - Better access to health services
  - After-schools services and facilities
  - Training in social and life skills
  - Self referrals and walk-in services

- Finally, almost all respondents spoke of good working relationships with the voluntary sector and the benefits of joint approaches such as social housing schemes. Respondents were keen that close working with the voluntary sector would continue and be developed further.

3.5 Effective Approaches to Mental Health Promotion and Problem Prevention in Adolescents

Significant progress has been made in the development of successful evidence-based mental health promotion programmes (for reviews see 24). Several of the authors reviewed have summarised the types of programmes, which are most effective and have made recommendations for the future success of mental health promotion programmes for young people.

The Health Education Authority (HEA) (21) has found that broadly similar approaches across the spectrum of mental health promotion have proved to be effective. These include:

*   Promoting good social relationships, for example, through social skills and assertiveness training, as well as communication and relationship skills
*   Developing effective coping skills, such as problem solving skills, cognitive skills and parenting skills
*   Providing social support and making social changes such as changing school attitudes to bullying
*   The evidence also suggests that mass media campaigns, supported by community activities, can have a measurable impact on knowledge, attitudes and behavioural intentions.

With regard to school aged children, the HEA cited school-based programmes which focus upon improving social and cognitive competence, as well as reducing substance misuse and aggressive behaviour for a particular age group, as being effective. School-based programmes for children exhibiting behavioural problems were also effective – such programmes focus mainly on social relationships, approval for good behaviour and involve some parental involvement. They can reduce aggressive behaviour, improve school performance and reduce delinquent behaviour. Programmes for children experiencing bereavement or parental separation or divorce were also highlighted as being particularly effective.

Weissberg et al (25) selectively review illustrative prevention programmes that have had positive behavioural effects on young people and then describe elements that appear to be critical for their success. **For adolescents, they found that the most promising strategies involve multi-year, school-based, social competence and health education programmes with peer, parent, school-support as well as community components** (25). For the future they recommend increased attention to programme design, implementation and institutionalisation.

Dryfoos (26) has conducted an informative, influential review of about 100 successful programmes to prevent delinquency, substance abuse, adolescent pregnancy, and school failure. Based on her analysis of programmes and interviews with experts, she identified the following common learning points associated with successful prevention programmes:

*   There is no single programme component that can prevent multiple high-risk behaviours. A package of co-ordinated, collaborative strategies and programmes is required in each community.
*   Short-term preventive interventions produce (at best) time-limited benefits with at-risk groups, whereas multi-year programmes are more likely to foster enduring benefits.
*   Preventive interventions should be directed at risk and protective factors rather than at categorical problem behaviours. With this perspective, it is both feasible and cost-effective to target multiple negative outcomes in the context of a single programme.

- Interventions should be aimed at changing institutions and environments as well as individuals.

Compas (1) states that the continued development and refinement of mental health promotion interventions for adolescents are dependant on a number of conceptual and pragmatic tasks. These include:

- Formulating goals for interventions that reflect divergent perspectives and values of all interested parties
- Providing seamless interventions between childhood, adolescence and adulthood
- Identifying the most beneficial ways to sequence & combine generic and problem-specific interventions
- Ensuring that interventions facilitate change in both adolescents and their social environments
- Evaluating the implementation and effect of such programmes

Black and Krishnakumar (5) in their review of mental health promotion for urban adolescents, present 11 recommendations for interventions with young people that build on individual, family and community strengths:

- Consider the social context when evaluating children's needs and developing interventions
- Build programs with community initiatives and participation
- Examine alternate pathways and linking mechanisms in the association between context and the well-being of children
- Consider development changes among children in urban settings
- Address issues of resilience in individuals, families, and communities as protective factors that determine youth behaviour
- When preparing policy recommendations, incorporate accountability and cost into intervention programs
- Train young professionals to work in urban settings
- Make intervention programs accessible to urban children and their families
- Develop interventions based on theoretical frameworks and methodological rigor
- Combine cultural and developmental sensitivity into intervention programmes (5).

The IUHPE (24) call for such effective model programmes to be disseminated across Europe and analysis undertaken as to the likely outcomes following their large scale implementation.

Weissberg et al. (25) warn that despite the empirical effectiveness of mental health promotion interventions, it may take considerable time before research convincingly resolves whether such improvements will actually reduce the incidence of mental disorders. However, they contend that if these programmes improve the social functioning, academic performance, and health behaviour of a large number of young people, then the investment of resources seems well spent – especially insofar as young people with diagnosable disorders can participate and benefit from them (25).

3.6   Recommendations

The recommendations of this chapter are presented within the following framework. This model promotes opportunities for mental health promotion by way of a population perspective (22).

Healthy Populations	Population at Risk	Population with Symptoms	Populations with Mental Disorders
Build resilience & maintain healthy lifestyle & environment	Reduce avoidable risks	Early diagnosis & intervention	Treatment & recovery of avoidable disability
Health Promotion	Prevention of disorders & mental health problems	Detection & identification	Optimal management & care

Source: Opportunities for Mental Health Promotion – a population perspective

Health Promoting Schools

•   The Health Promoting Schools approach is an ideal context for promoting the health of adolescents in school. Consideration should be given to adopting it in all schools.

•   Health Boards should review the opportunities presented by Social, Personal and Health Education (SPHE) to work with the Department of Education and Science (DoES).

•   SPHE should be a mandatory and time-tabled subject for every age group during primary and post primary education.

•   SHPE should be broad based in content and holistic in nature, and directed at building resilience and maintaining a healthy lifestyle.

•   Schools should be supported to facilitate training for teachers. This training should include multiple methods of delivery and skills training for teachers.

•   A SPHE module should be included in all pre-service teacher training.

Health Promotion for Adolescents Who Are Not In School

•   A similar SPHE/Lifeskills programme for adolescents who are not in school should be developed.

•   Those working with adolescents who are not in school should be facilitated to engage with training and support through:
    –   Inclusion of SPHE module in relevant training programmes
    –   Provision of training for multiple methods of delivery and skills training

•   Parallel Lifeskills programmes, with specific emphasis on parenting skills, should be implemented with parents to complement programmes being implemented in school and out-of-school settings. These programmes should be accessible, affordable, acceptable and community based.

Reducing Risk

- Those working with adolescents in school and out-of-school settings should be trained to identify adolescents experiencing difficulty and to implement a referral procedure where appropriate.

- Specific preventive programmes aimed at populations at risk should adopt a health enhancing lifeskills approach. Such programmes/interventions should be implemented at appropriate times to target particular crisis points or time of transition within adolescent life. These include:
  - Bereavement
  - Illness (of adolescent or family member)
  - Abuse
  - Financial Strain in the family
  - Moving to secondary school
  - Conflict in school and/or with peers
  - Early School Leaving
  - Incidents relating to substance misuse
  - Suicide (attempt or exposure)

Preventing Disorders

- The extension of the National Educational Psychological Service (NEPS) to all schools is welcome. One of the stated aims of NEPS is the promotion of mental health. A similar service should be available to adolescents who are not in school.

- All schools should have a Guidance Counsellor with responsibility for interventions aimed at "at risk" adolescents. The quota of students per Guidance Counsellor should be 250:1

- A School Health Service for second level schools should be developed. A first step should be an area based pilot project to be evaluated and acted upon after two years.

Strategies for those displaying early symptoms of mental illness

- Training programmes should be provided for Primary and Community Care personnel who come into contact with adolescents, to ensure early diagnosis and appropriate referral.

- Counselling services should be available and attractive to adolescents in a variety of settings including schools, youth organisations, Health Boards and community settings.

- Standards and accreditation for Counselling Services must be developed nationally and adopted by all agencies offering Counselling Services to adolescents.

Level of Service Provision

- Health Boards should undertake an assessment of the need for care placements (including Day Care) for adolescents in need of "out of home" care.

- There should be specific mental health teams in each Health Board area. The Southern Health Board Development Plan provides a useful model in this regard.

- Health Boards should assess the treatment needs of young people with Attention Deficit Hyperactivity Disorder (ADHD) and their families, including Speech and Language and Occupational Therapies.

Service Development

- Development of appropriate and attractive treatment facilities in most Health Boards (accessible to all Health Boards) for adolescents experiencing mental illness should include:

  - Appropriate prevention and support
  - Regional or super-regional adolescent treatment facilities
  - High quality Day Care that is subject to audit
  - Improved access to appropriate placements, eg. Group Homes, Foster Care
  - Self referrals and walk-in services
  - Home support and treatment services

- Each Health Board should ensure that every acute mental health facility has a transition policy which should cover:

  - A transition plan involving professionals, adolescent and parents
  - Access to training for staff in relation to specific needs of adolescents

- Appropriate service responses need to be developed for young people and their families following an act of para-suicide.

- Protocols should be developed to ensure that every case of para-suicide seen in an Accident and Emergency Department is examined by a liaison Psychiatric Team (Task Force on Suicide).

- Services should be organised to respond to issues arising from a major incident. In doing so, the model of the Restore Team in the North West should be considered by all Health Boards.

- Addiction counselling services aimed specifically at adolescents should be developed where they don't already exist.

- Health Boards should undertake an assessment of the need for supports for adolescents with mental health problems in Primary Care settings.

- Current tertiary care provision should be evaluated by Health Boards, using simple Performance Indicators eg. Length of stay.

Quality Standards

- Specific quality standards might include:

  - An adequately staffed professional and multi-disciplinary service for each 250,000 population
  - Geographically and temporaily convenient services
  - Appropriate child-centred accommodation that facilitates the full range of assessment and treatment
  - Ready access to more specialist services, on a larger population base
  - No professional staff working in isolation

- Specific quality standards might include:

  - Following assessment, no adolescent should have to wait more than four weeks after referral for specialist assessment by a local professional or multi-disciplinary team (a multi-disciplinary assessment is not necessary in every case).

  - Following assessment, no adolescent should have to wait more than two weeks for the start of a treatment programme.

  - If the referring professional considers the case to be urgent, an adolescent who may require In-Patient care should be assessed within 24 hours.

  - An adolescent who, following assessment, is considered in need of urgent In-Patient care should be admitted within 24 hours.

  - In non-urgent cases, an adolescent requiring In-Patient care should be admitted at an appropriate time, as advised by the clinician responsible for the case, and the family should be given at least one week's notice.

  - No adolescent should be admitted to an adult psychiatric In-Patient Unit unless there is a positive indication for doing so. If this is not considered an appropriate setting, the child or young person should be transferred to appropriate accommodation within one week.

  - Senior staff should meet in 'difficult to place' cases and decide which agency will take responsibility and set a timetable for placing the child in appropriate care.

  - Adolescents admitted to hospital or seen in Accident and Emergency Departments as a result of actual or suspected physical, sexual or emotional abuse should be referred for assessment. Local Child Protection procedures should clearly explain the correct mechanism for referral.

  - Children or young persons admitted to hospital or seen in Accident and Emergency Departments as a result of deliberate self-harm should be seen by a Child and Adolescent Psychiatrist before discharge or by a professional with appropriate training and ready access to a Psychiatrist.

  - All services should have explicit procedures for the situations set out above.

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4.0   Adolescent Minorities

4.1   Introduction

The period from adolescence through to adulthood involves most young people undergoing a major transition in their lives. This can be a particularly difficult transition, especially if the young person is experiencing difficult circumstances, due to poverty, exclusion from society, problems within the family or they may even be encountering prejudice and discrimination. These factors are often common in the case of young people who are members of minority groups. These individuals may be discriminated against at the individual or institutional level.

Many young lesbians and gay men are bullied and intimidated at school, just as young Refugees and Asylum Seekers may be excluded in society; young homeless people have little or no support networks and young Travellers are frequently isolated from recreational services with the result that an increasing number of them are beginning to turn to drug-taking (1). It is because of such difficulties that these adolescents very often have special health requirements that must be recognised and addressed.

Policies should be developed and staff should be trained to work with minority groups. These young people need to be respected for their differences and, at the same time, they should have access to all necessary services. Schools should educate young people and raise awareness on issues pertaining to minority groups, in order to ensure the successful integration of all young people attending school. Educational workshops also need to take place in the community to raise awareness of health issues among those young people who are not attending schools, as is the case with many young Travellers.

4.2   Homelessness in Adolescence

During the later stages of adolescence, through to early adulthood, the majority of young people undergo the transition of leaving their family home and living independently for the first time. This transition usually happens quite smoothly, over a period a time, as long as the person's network of family and friends continues to support them. Conversely, this transition can be complicated for some young people, due to difficult personal circumstances, poverty or problems within the family. Many young people have no parental home, or else they feel that they cannot return to it, for a variety of reasons.

4.2.1   Homelessness in Ireland

It is difficult to gather accurate statistics on homelessness in adolescence, within Ireland. The most up-to-date statistics are those provided by 'Focus Ireland', the main agency offering a wide range of services to people who are 'out-of-home'. Focus Ireland works on the premise that "everyone has a right to a place that they can call home" (2). In 1998, a total of five thousand nine hundred and eighty five (5,985) people made use of Focus Ireland's services; 64% of these were male and 33% female (information was missing on the other 3%). Although the circumstances of some people was unknown, 71% of service users were homeless, i.e. they were 'sleeping rough' or were staying in temporary accommodation such as a hostel or B&B. The amount of people sleeping rough who have been in contact with Focus Ireland has more than doubled since 1996. In 1998, the majority of Focus Ireland service users were young people, with 40% aged under 26 (2,394 customers) and 9% were younger than 18 years of age (539 service users). Excluding missing information, 58% were from Ireland (both North and South), 6% were British and 36% were from elsewhere. Focus Ireland also provides services (such as the 'flat finding' service) to a substantial number of Asylum Seekers.

4.2.2   Choice of Accommodation for Young People Out-of-Home

There is practically no public sector housing or housing association accommodation for young people who do not have children. Renting private accommodation is often the only available option for most of the homeless youth population. Focus Ireland's work involving young people has highlighted the fact that having a lack of skills or money causes problems when they attempt to get accommodation in the private rented sector.   A small rent allowance is available to young people over 18 years of age; however this only allows one to rent at the bottom of the private rented sector, where conditions are often extremely poor.

4.2.3   Services Offered by Focus Ireland

In 1998, two thousand, four hundred and forty seven people (2,447) made use of the 'crisis service', which offers advice on housing and social welfare and also refers people on to emergency accommodation and Social Work services. One thousand, three hundred and twenty three people (1,323) used the "flat-finding" service, the majority of these were Asylum Seekers. The outreach service met with five hundred and thirty three people (533) on two thousand, nine hundred and twenty four (2,924) occasions. 56% of all outreach services were with young people who were sleeping rough and 40% were younger than 18 years of age (213 people). Fifty-eight (58) different young people were residing in Focus Ireland's 'Off-the-streets' hostel in Dublin, most of whom were aged 16 or 17 years. In addition, 303 young people attended the 'Extension' day facility centre, which offers informal activities, provides 'personal support and structured development'.

4.2.4   "Left Out on Their Own: Young People Leaving Care in Ireland"

Focus Ireland, and Focus Point (the organisation before the formation of Focus Ireland) have consistently shown that, over the last 15 years, young people who have presented themselves as being 'out-of-home' have usually been raised in Care or have spent some time in the Care of the state. Recent research has consolidated these findings. One third of young people who leave Health Board Care and more than half of those leaving schools for Young Offenders, experience spells of homelessness or else they spend time in Detention Centres at some point during the first six months (3). Moreover, two years after their release from Care, their situation is likely to have worsened. One quarter of those young people leaving Health Board Care will have been in Detention Centres and two-thirds will have experienced being homeless. Two years after leaving Special Schools for Offenders, two-thirds of the young people in question will have spent time in a Detention Centre and one-third will have been homeless.

What leads to young people becoming homeless?

The reason that these figures are so high is because these young people are making the transition from adolescence to adulthood, without the support and encouragement that others have available to them from their families.   Many of these young people leave the Care situation without adequate preparation and, to add to this, they often have poor relationships with their families and no alternative forms of support are available to them. However, Focus Ireland believe the main precursor to this problem is a "lack of strategic planning and lack of a single vision and policy for Child Care in this country" (3).

Most of the young people using Focus Ireland's services come from a family background where relationship problems exist, and conflict and violence are also evident. Young people with a Traveller background and those who have been in Care account for a large number of individuals needing the 'out-of-hours' services. The breakdown of the sample was as follows:

- 26% were Travellers
- 40% had spent time in Care
- 81% were not in work/school/training
- 44% had a serious drug problem
- 22% had been involved in prostitution
- Most of the sample had slept rough intermittently

It is evident, therefore, that a high proportion (at least in the aforementioned sample) of young people who use the services provided by Focus Ireland participate in high-risk behaviours and while living on the streets, education/training is definitely not a priority for them. In addition, 26% actually belonged to two minority groups, i.e. over a quarter of those who were homeless were also a member of the Travelling community.

Recommendations

- Every public service should have a policy and protocol regarding youth homelessness. A designated person should ensure that these protocols are upheld: e.g. that information regarding what is available for a young homeless person is made accessible to them. Given the high levels of reported health and in particular, mental health problems among young homeless persons and their reluctance to approach services, services should be more proactive in encouraging and facilitating service use.

- Under the Child Care Act, 1991, each Health Board should review its services to young homeless persons as a matter of urgency, with a view to identifying gaps in service provision and producing a strategic plan. Protocols in respect of the existing law should be established to ensure enforcement of legislation regarding youth homelessness.

- In the context of prevention, each Health Board should produce a plan which incorporates Family Support intervention in cases where adolescents are likely to leave home early. In this regard, it may necessitate one Health Board taking a lead role in the identification and piloting of specific support programmes.

- Schools and Health Boards in each Community Care area should have designated support workers (Youth Homeless Liaison Team - YHLT) to work with young people who are likely to drop out of school and/or leave home early.

- A reference panel comprising young people themselves should be established by the Child Care Advisory Committee (CCAC) to advise the CCAC on issues relating to youth homelessness.

- Service providers should seek to identify and implement multi-disciplinary service models of 'best practice' which integrate the young person into community life in a holistic fashion.

- Youth Homeless Liaison Teams (YHLT) should be established in each Health Board area. This team should be multi-agency/disciplinary and comprise family support workers, hostel child care staff, community youth workers, community Gardaí, home-school and community liaison teachers, etc.

- YHLT should receive training in practical methods of working with homeless youth, for example, Family Group Conference methods, outreach, and direct work with adolescents.

- The current bar to Social Welfare payments in respect of adolescents between the ages of 16 and 18 years should be removed.

- The Child Care Advisory Committee (CCAA) in each Health Board should receive a bi-annual report on the adequacy of services within the Board's area in respect of youth homelessness.

- The issue of homelessness should be addressed in schools through existing health promotion initiatives.

- All Garda stations, GP Surgeries, public venues (e.g. Rail Stations and large shopping centres) should provide information regarding service availability for young persons who may find themselves homeless.

- Designated officers in each Health Board (YHLT) should act as an advocate/negotiator for young people who find themselves homeless, regarding their rights to work, education, family matters, religiosity etc.

4.3 Adolescent Refugees and Asylum Seekers

The definition of refugee given in Article 1 of the Geneva Convention is:

"any person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable (or owing to such fear) is unwilling to avail himself of the protection of that country of his formal habitual residence, is unable, or owing to such fear, is unwilling to return to it." [4].

Ireland is a signatory to this Convention, therefore giving those who seek asylum the right to come to Ireland and seek Refugee status. Within Ireland, discourse on Refugees and public policy has only recently evolved. This is mainly due to the fact that, in the past, comparatively few Refugees and Asylum Seekers have sought protection. However, this situation is constantly changing and developing.

Refugees have the same status as Irish citizens and can therefore utilise all services provided within the area of social policy, such as housing, health, social welfare, social services, education, vocational training and they can also receive unemployment benefit [4]. 'Successful integration' into society is extremely important if Refugees are to be able to live meaningful lives [4]. This will

enable the Refugee to participate in their new society, while still retaining their own unique sense of identity. The objectives of social policy are, firstly, to meet the basic needs of the Refugee and, secondly, to aim towards resettlement and, thirdly, to fully integrate them into their new society. In order to achieve these objectives, it will be necessary to develop an ethos of equal opportunity.

4.3.1   Asylum Seekers

Conversely, an 'asylum seeker ' is a person who:

"seeks to be recognised as a refugee, in accordance with the terms of the 1951 Convention relating to the status of Refugees" [4].

Asylum Seekers are more limited in their access to services, compared to those with Refugee status. They are entitled to health care, accommodation and basic income maintenance payments. They are allowed to use the health services on the same basis as Irish nationals and are entitled to hold a Medical Card. On arrival in Ireland, they are assigned a General Practitioner and applications for a Medical Card are processed within one working day. However, they are not permitted to work, participate in vocational training or engage in formal education. Asylum Seekers of school-going age are entitled to primary and secondary education; however, access to third-level education is only offered on receipt of Refugee status.

The numbers of Asylum Seekers in Ireland has greatly increased since 1994. In 1997 there were over 42 times the number of Asylum Seekers in Ireland as there were five years previously. In 1999 there were seven thousand, seven hundred and twenty four (7, 724) applications requesting Refugee status made in Ireland; of these a substantial proportion were dependent children (5). As a percentage of the total population, Ireland was the second highest recipient of applications for asylum within Europe (5). This phenomenon has placed the various processing systems under stress, in terms of applications for Refugee status, and has stimulated controversy and debate within the country.

Number of Individuals Seeking Asylum in Ireland (1992-2000)

Year	1992	1993	1994	1995	1996	1997	1998	1999	2000*
No. of Asylum Seekers	39	91	362	424	1,179	3,883	4,626	7,724	10,938

* Communication with Refugee Applications Commissioner

Despite the increase in attention focused on Refugees and Asylum Seekers in Ireland, very little is known about their actual needs and experiences, especially in relation to young Refugees. There are several hundred children in Ireland today who have experienced the trauma and upheaval associated with having to leave their home country for various reasons. In 1999 there were more than 200 and in a period of just one month, September 2000, 71 children arrived in Ireland, seeking asylum here. The enormous increase in people seeking asylum in this country has prompted the need for Ireland to move towards a more multi-cultural society.

Many children seeking asylum have arrived alone and have been placed in unsuitable accommodation, often sharing bedrooms with adult strangers. This is a violation of the rights of

the children and the state must make every effort to ensure that their needs are met in an appropriate manner. They need special support systems and adequate Counselling services. An approach that recognises the needs of Refugee and children seeing asylum is essential. "This is a moral imperative, never mind a legal and international requirement" (5). The Barnardos' policy document on Refugees and Asylum Seekers highlights the fact that the UN Convention on the Rights of the Child is universal, therefore, the Irish Government is responsible for all children living in Ireland, not just for those of Irish descent.

4.3.2   Health Needs of Refugees in the U.K.

The U.K. Government's White Paper *'Fairer, Faster and Firmer – A Modern Approach to Immigration and Asylum'*, intends to make major changes to the support given to Asylum Seekers. A central Government scheme is in the process of being established, which will direct Asylum Seekers away from major cities, by offering them accommodation elsewhere. This will serve to disperse those seeking asylum and lead to a lack of cohesion between them. It is also intended that services will be provided on a non-cash basis; this will leave Asylum Seekers with no autonomy or financial resources. This situation will inevitably lead to an increase in health problems among Asylum Seekers (7).

In June 1997 the Health Education Authority (HEA) in Ireland commissioned a Report on Refugee Health from an Expert Working Group. The purpose of this initiative was threefold. Firstly, to consider methods of minimising ill-health and maximising health gain amongst Refugees. Secondly, to identify barriers in relation to promoting health within this minority group. Thirdly, the group was commissioned to guide an appropriate research development programme. The expert Working Group report broadened their definition of a Refugee to include Asylum Seekers, as well as those who have had their application refused and are in the process of appealing.

The report revealed that less than 5% of the millions of Refugees world-wide actually make their way to the Western World, however, even this 5% is a substantial number. Approximately 40% of an estimated 50 million Refugees worldwide (20 million), are living outside their own countries, while the remaining 60% (30 million) are thought to be 'displaced' within their own country (5). During 1996, in the U.K. alone, 27,885 asylum applications were made by individuals from various countries of origin (7). It was highlighted in the report that it is of great importance to note that **Refugees themselves are not a homogenous group, although they form a distinct group with specific needs**. They may have experienced very different problems in their native country before being driven into exile and also may have come with different cultural experiences and religious beliefs. Many young people who come to Ireland are not of Christian denomination and may be in need of pastoral or religious support which is currently not available to them. This may further compound the problem of identity formation for these adolescents. **Many adolescent Asylum Seekers may be here for most of their formative years and may become confused regarding their national and cultural identity**. Cultural conflicts may ensue, creating additional stress.

Many Refugees arrive in westernised countries feeling desperate, vulnerable and disorientated. Some may have been tortured, their relatives and friends may have been killed or have disappeared. Many Refugees arrive with no belongings whatsoever, apart from the clothes they stand in. The process of upheaval from their accustomed surroundings, as well as arriving and settling in a new country, is often traumatic. In this situation, many adolescent Asylum Seekers and Refugees may be suffering from post-traumatic stress. There is an absence of Counselling Services for these adolescents. Poor English may further impede access to Counselling or other

services. The Refugees encounter many practical and emotional problems as they try to settle in a society where they may be prone to racial prejudice and discrimination, at both the individual and institutional level. The availability of adequate accommodation for Refugees is limited and is usually of poor standard and of a temporary nature.

In addition to the aforementioned difficulties, most Refugees face unemployment and the health care system is not always in a position to provide services for them. The disintegration of their previous social support network and, consequently, a lack of provision of adequate support mechanisms, inevitably leads to an increase in health problems (7).

4.3.3 Health Needs of Refugees

It is obvious that this group experience many social, cultural and economic difficulties, which place these individuals at risk of encountering various health problems. Research has shown that one in six Refugees in the U.K. was suffering from a physical health problem that affected their daily life and two thirds had suffered from anxiety and/or depression. In addition, Refugees often carry parasitic and nutritional diseases from their country of origin (7). Many Refugees desperately seek treatment for their symptoms through Accident and Emergency Departments or private General Practitioners and this often results in multiple prescriptions that are, in the main part, inappropriate. The U.K. Expert Working Group on Refugee Health has considered promoting the health of this distinct, yet diverse, group who might not view their health as a priority issue needing to be addressed. However, within a health promotion framework, it is becoming of increasing importance to utilise a holistic approach to address the social, economic and cultural determinants of ill-health, which is extremely relevant and should be applied to minority groups, such as Refugees and Asylum Seekers. Evidence exists to suggest that cohesive social structures, per se, serve to promote health (8).

In Ireland, services are provided by the Health Boards, in conjunction with various other agencies. These services include Public Health Nursing, Community Medicine, General Practitioner, Community Welfare, Counselling, Dental Services and (adult) Education Services. The individual and specific needs of Asylum Seekers, in terms of health service provision, requires consideration for inclusion as an area in need of service development. Some Health Boards have included a specific section on Refugee and Asylum Seekers in their Service Plan for 2001. At a national level, an initiative similar to the U.K. Working Group is needed, to investigate ways of maximising health gain and to conduct research into the barriers to promoting health within this minority group.

4.3.4 Adolescent Refugees

In trying to settle into their new society, adolescent Refugees encounter similar problems to their parents, i.e. poverty, low standard and temporary housing, racism and discrimination within society. In adapting to a new culture, these young Refugees invariably have to learn a new language, while trying to 'fit in' to a new school and attempting to make new friends.

Because of the language skills they have attained in their host county, many child and adolescent Regugees take on a lot of responsibility. Their parents frequently cannot cope with the changes in their lifestyles and surroundings and with the psychological distress associated with these changes. As a consequence, young Refugees are often forced into a position which carries too much responsibility and they do not have sufficient parental support. They also miss out on the many experiences that are typical of this age group. These circumstances exert psychological

distress on the young Refugees and often lead to other problems, such as poor school attendance (7).

While young Refugees have similar needs to others in their age group, they also have specific requirements in terms of education and health. Many of these needs may be short term and schools should in particular, ensure that young Refugees are successfully integrated within their system. Certain voluntary groups (e.g. the London Black Women's Group) have initiated community based projects that are culturally sensitive to raise awareness among adolescent Refugees in relation to health issues. These groups organise workshops and activities within the school/college environment and also in community centres to acknowledge the problems that young Refugees encounter while adapting to the culture of their host country. In Ireland, the Irish Refugee Council offers advice, information and referral services and also aims to develop policies and services for Refugees and Asylum Seekers. The Refugee Council initiated 'Access Ireland', which aims to promote greater awareness of Refugees and to integrate them into Irish society. This group has also trained Refugees to teach various professionals about issues pertaining to Refugees. Access Ireland also provides an outreach support programme, which supports both families and community initiatives.

As indicated in the literature review above, the status of an adolescent who falls into the category of Refugee may be in fact quite different to one who is an Asylum Seeker and the services he/she requires vary accordingly. Similarly, a young Irish person whose parentage is mixed or who is of foreign parents born in Ireland, while being an Irish citizen, may still have very specific needs. The issue of racism towards adolescents who are not indigenous to Ireland (no matter what their status) is a real issue that needs to be addressed. Foreign adolescents encounter a range of racist behaviours from other people. This can include verbal abuse through to physical attack. Racism can occur on an individual basis but can also be institutionalised. Children and adolescents are vulnerable in Irish society at the best of times and given the difficulty of being a foreign national trying to live for any period of time in Ireland, this vulnerability is likely to be increased. Cultural reference points will be different and may also create problems at home and in the community where they live. Only voluntary groups provide language teaching to Asylum Seekers/Refugees.

At a more basic level, the income support for a child or adolescent Asylum Seeker is currently £7.50 per week (4). This is a grossly inadequate amount of money for a young person. For example, an adolescent seeking asylum in Ireland will need to support all his or her community and social connection on £7.50 per week. It would be very difficult for them to join any leisure activity requiring a membership fee e.g. a football club or scouts, nor would they be in a position to attend discos or social outings. As a result, the young person is in a weak position as regards developing their language skills and social networks through friendships. Similarly, a clothing allowance is provided to Asylum Seekers in winter but is not repeated in summer; therefore, adolescents are often dressed inappropriately in the summer which may increase their feelings of isolation.

In the context of child protection and welfare, there are a number of specific issues in relation to adolescent Refugee/Asylum Seekers. Specifically, there are instances where adolescents are given parental responsibility for child rearing in the case of younger siblings. In such cases the adolescents (usually girls) may be lacking in parenting skills which are appropriate to an Irish context. In this regard, adolescent Asylum Seekers/Refugees need to be informed of their rights under the Child Care Act, 1991 in the context of what is appropriate under Irish Law in the protection and welfare of children. Accommodation arrangements under the dispersal

programme are in some cases inappropriate, and may be in contravention of Local Government housing regulations. In certain cases, adolescents find themselves in unsuitable accommodation with siblings, parents and in some cases, extended family members, all sharing the same room.

Adolescent Asylum Seekers/Refugees have educational needs, which due to their displacement, may have been deferred or suspended. Access to second-level education and university education is a real issue for Asylum Seekers living in Ireland. However, they are prohibited from receiving third-level education while their status remains as an Asylum Seeker. In this regard, it is essential that a distinction is made between the needs of Asylum Seekers who are in Ireland for a short period, those who are in Ireland for many years while their cases are reviewed and Refugees who will become permanent residents and have the entitlements of citizens. Adolescent Asylum Seekers find themselves idle with too much time on their hands. Constructive activities for occupying such adolescents are completely absent. They are prohibited from employment, which further diminishes the possibility of paying for leisure activities. Finally, in the context of accessing services, particularly health services, there are gender issues for Asylum Seekers/Refugees that needs to be addressed. For example, it may be deemed culturally inappropriate for adolescent Muslim girls to attend a male doctor. These issues should be addressed in the context of planning service provision.

Learning from Good Practice

A potential source of information and advice for developing services for adolescent Refugee and Asylum Seekers is a project known as Vosmosse. Vosmosse is a reception centre for Somalian youth staffed by Danish and Somalian youth workers. The project offers instrumental and emotional support as well as information on services and is situated in a shopping centre of Odense City. Such a model could be assessed for its adaptability to practice in Ireland.

Recommendations

- Every public service should
    - have a declared policy and written protocol to address the issue of racism
    - demonstrate that the service is Asylum Seeker/Refugee friendly. In this regard, every public service/agency should have a designated person to act as an ombudsperson to ensure that protocols and policies are upheld.

- Included in policy and protocol should be issues of access
    - Information provided and displayed in an understandable format
    - Information about existing services disseminated to all interested parties.
    - Cultural background of the young person they are dealing with should be taken into account by front line staff, eg. Issues of gender.

- The practice of fragmenting and dispersing different national groups should be reviewed.

- Models of best practice from other countries should be identified and adapted to an Irish context.

- The appropriate authority should carry out an educational assessment of the adolescent, in consultation with their guardians and representative organisations.

- Appropriately qualified and culturally sensitive Counsellors, Psychologists, Doctors and Care Workers should be made available to assess the adolescent's particular health needs.

- English language training and support in terms of access to school and out of school youth activities should be provided.

- Adolescent Refugees and those seeking asylum should have strategies designed to promote integration from the first day of their arrival.

- Every Health Board area and VEC catchment zone should, as a matter of urgency, allocate at least one existing school and youth project to work with adolescent Asylum Seekers and foreign nationals.

- Isolation, depression and boredom should be addressed by ensuring the appropriate infrastructure is in place. A community or outreach service should be established in each large population area, i.e. city or large town, to offer support and a drop-in facility for Asylum Seekers/Refugees. A mixture of Irish residents and refugees should staff such community reception centres. Such centres should not be seen as a place to deal with all issues, but as part of a model of community integration. Potential hostility from local communities should be averted by providing clear information to the communities and involving them in plans, before the Refugees/Asylum Seekers arrive.

- Front line health care providers, Health Board employees, Civil Servants, Gardaí and other public services should receive training in anti-racism. This training should also extend to community development groups, teachers, media etc. A training module should be developed for this purpose.

- A culturally sensitive, multi-media programme in educating the general population on the experiences of Asylum Seekers/Refugees, including their cultural history, should be developed and made locally appropriate.

- Community based adolescents services, including Neighbourhood Youth Projects, should sensitise all young people who attend the programme to the needs of Asylum Seekers and Refugees.

- All Refugees/Asylum Seekers should have access to information which specifically relates to issues of Asylum Seekers but should also include information on rights which relate to work, education, family issues, religion etc. Asylum Seekers/ Refugees should receive courses on parenting, children's rights and Irish law.

- All unaccompanied minors
  – should be assigned a legal guardian or suitable caregiver directly after entering the State.
  – should be housed in accommodation in a culturally familiar environment, where they have access to support from a suitable caregiver, preferably a guardian.

4.4   Adolescent Travellers

At the 1986 census, there were 15, 888 Travellers in Ireland, 51.9% of whom were under 15 years of age, which is much higher than the number of people aged under 15 years in the general population (28.9%). Literature relating specifically to young Travellers living in Ireland is scarce. Irish Travellers are a minority group with their own ethnic and cultural identity. They are in a unique position in that they are seen as 'Irish', yet at the same time they identify themselves as a distinctly different community, and are also seen as different by others in society. Within this ethnic group, members share certain cultural characteristics, traditions and values, which in turn effect the organisation of family life. Recently, however, Travellers are increasingly adopting features of the settled lifestyle, e.g. many are living in houses instead of trailers. Despite this, great differences remain between the Traveller community and the settled population, in terms of social and cultural identity (9).

Within the Irish population it is common for a negative view of Travellers to be held and, consequently, this group has become marginalised within society. Travellers experience prejudice and discrimination and this has "both a personal and collective impact on the Traveller community" (9). Today, many young Travellers have turned to drug use, as they are often refused admission to leisure facilities used by other adolescents from the settled community (1). In addition, services for Travellers may be inappropriate for addressing their needs and their nomadic lifestyle can limit the quality and availability of these services. This is particularly evident within the education system, as 80% of adolescent Travellers are not in full-time education (9).

4.4.1   Health and the Travelling Community

In 1994, the Department of Health's strategy document *Shaping a Healthier Future* (10) recognised the fact that anyone experiencing social exclusion and disadvantage in society is at risk of poor health. The strategy highlighted that:

"much can still be done to improve health status through tailoring and organising the delivery of health education programmes and community services to take account of the needs of target groups" (1994).

The document contained particular objectives in relation to the health needs of Travellers:

*   Consultation with Traveller groups should take place to aid the development of a health education programme aimed specifically for this target group.

*   Models of Traveller participation in health promotion and prevention need to be developed in order to ensure that the health education programme is delivered to maximum effort.

*   Co-operation is needed between statutory and voluntary organisations working with Travellers, to ensure better targeting of services.

In 1995, the *Health Promotion Strategy: Making the Healthier Choice the Easier Choice* stated that:

"health promotion at an individual level involves educational processes enabling people to acquire information and skills that will help them in making good decisions in relation to their health. At a community, regional and national level, it involves the development of appropriate policies, structures and support systems so that the healthier choice becomes the easier one to make".

A study in the mid-western health board region revealed that travellers had many needs that were not being met. They included the areas of social acceptance, health promotion, employment, education and training and adequate housing and living conditions. The Dublin Traveller Education and Development Group (DTEDG) added the following to the list of issues that need to be addressed - access to healthcare, racism (of healthcare providers) and outreach services.

Statistics show that life expectancy is particularly low for the Travelling community, compared with that for settled people - 11.9 years less for women and 9.9 years less for men. Therefore, young Travellers are faced with a higher risk of experiencing the death of a parent than young people with a settled lifestyle (12). In addition, infant mortality rates (per 1,000 live births) are almost three times higher for Travellers (28.3) than the national average (9.9). Travellers have higher rates of all-cause morbidity and their mortality rates are significantly higher in terms of accidents, metabolic disorders (in the 0-14 age group), respiratory ailments and congenital problems (13).

One proposed solution to the problems outlined above, is the provision of suitable and adequate accommodation. The WHO have stated that safe water and basic sanitation are two of the eight essential elements of primary health care. Having appropriate accommodation is also important in relation to access to services, education and training and has a strong influence on lifestyle, which in turn effects the health of an individual.

In order for any health education programme to be successful with Travellers, they must be consulted and involved in the design of the initiative, to ensure that the project meets their specific needs.

Recommendations

- Every public service should have a policy and a protocol that is Traveller-friendly and specifically addresses the issue of racism.

- All health plans should include a focus on issues affecting Travellers.

- Current anti-racism legislation should be enforced.

- Anti-racism training should be provided for health care providers, Health Board employees, Civil Servants, Gardaí, community groups, teachers, media, etc.

- A designated officer should be assigned in each public service to ensure policies and protocols are upheld, e.g. notices to be written in clear English or with the use of symbols: specific welcoming statements should include Travellers.

- Information about existing services should be disseminated to Travellers through Traveller support and advocacy groups.

- Poverty needs to by recognised as a major cause of ill health: an awareness of the context of the lives of Travellers should inform the planning and delivery of services. Without an understanding of the accomodation and sanitation difficulties faced by Travellers, certain otherwise effective health interventions may be completely ineffective eg. treatment of scabies without access to running water or electricity.

- Learning & social activities for young Travellers need to be specifically targeted as these lead to greater health awareness. Literacy programmes and support systems for adolescents to access schooling should be designed and funded. Youth services and programmes from public bodies such as VEC, Health Boards, and Local Government, should set specific targets for the inclusion of Travellers.

- Programmes of education should be culturally sensitive and include the experience & history of Travellers; rather than the more usual portrayal of Travellers as a problem, Traveller history should be taught as part of Irish History.

- Courses should be funded for young Travellers on parenting, access to education, children's rights, Irish Law etc.

- Health promotion activities should take in to consideration low literacy rates among Travellers; Travellers (or their representative organisations) should become involved in the design of health promotion activities and in the raising of health awareness. The importance of childhood immunisation and appropriate diet need to be stressed.

- Models of best practice should be explored in conjunction with representatives of the Travelling community. It would be useful to draw on the experiences of ethnic minorities and/or nomadic communities in other countries (e.g. The New Zealand Family Group Conference programme for the Maori population).

- All new services for Travellers should be staffed by a quota of Travellers; capacity building among Travellers will have to happen before this can be achieved.

- Traveller Health Units should be monitored in relation to their activities and outcomes.

- The Traveller Community and their representatives should be involved in the development of all new health plans and services; consultation with adolescent Travellers should be given particular priority.

4.5   Gays And Lesbians In Adolescence

The Combat Poverty Agency conducted a study in an attempt to examine discrimination, and fear of anticipating discrimination, and the effect this has on levels of poverty and social exclusion among lesbians and gay men. A further aim was to investigate the needs of those who are most vulnerable in terms of experiencing poverty. The study showed that discrimination effects people's lives in various ways, such as their education, employment, health, service provision, access to resources, harassment and violence (14). Discrimination and prejudice leaves lesbians and gay men at an extreme disadvantage, by excluding them from full

participation in society. Combat Poverty observes strategies applied by lesbians and gay men to avoid or cope with discrimination and proposes policy recommendations to both government and non-governmental organisations.

"Poverty: Lesbians & Gay Men.
The Economic and Social Effects of Discrimination"

Combat Poverty Study (1995)

Profile of the Sample:

- Most of the respondents were young people, with 53% of the sample aged under 30 years of age
- 21% of participants were living in poverty, at the time the survey was carried out
- 57% found it difficult to 'make ends meet'. This figure rose to 91% for those living in poverty.

Family & Other Support Networks:

- 49% of respondents were aware of their sexuality before the age of 15 (which, therefore, makes it relevant to adolescent health issues)
- 66% said that a 'gradual awareness' of their sexuality caused them 'many' or 'some' problems
- Lesbian phone lines, gay switchboards and the 'Gay Community News' (GCN) were important sources of information and advice
- Those on low incomes, who were prone to the poverty situation, felt isolated from meeting other gay people and, consequently, felt it difficult to develop support networks
- 72% of respondents thought that state recognition for same-sex partnership agreements would improve their lives

Employment:

- 64% were working or on FÁS type courses, although only two-fifths said they were completely 'out at work'
- 40% experienced harassment in their current employment
- Fear of discrimination at work was high. Those who were unemployed felt that it would be a problem if they 'came out'.

Services:

- 11% of respondents reported experiences of discrimination because of their sexuality in provision of accommodation
- 31% had left home at some point in their lives, when nowhere else was available to them (therefore high risk of being homeless)
- 39% said that they had experienced discrimination in leisure facilities (pubs/clubs/restaurants/hotels/B&Bs) because they were gay

Health & Well-Being:

- Many respondents showed signs of psychological distress, especially those affected by poverty
- 62% thought that recent law reforms would have a positive effect on their lives

Harassment & Violence:

- 41% had been threatened with violence
- 25% had been punched, beaten, hit or kicked
- 35% had been chased or followed
- 81% said that the possibility of anti-gay harassment had affected their behaviour

"Education: Lesbian and Gay Students – Developing Equal Opportunities"

This publication is seen as a follow-on from the Combat Poverty report (1995), which highlighted the level of educational disadvantage and under-achievement among lesbians and gay men. In relation to education and training it was revealed that:

- 57% of respondents experienced different problems at school, which they believe were due to being gay e.g isolation, depression, low self-esteem, harassment and bullying
- 59% of those who had attended college and 36% of those on training courses experienced similar problems. Those affected didn't feel like they could talk to staff or even to Counsellors. Some people had even left school early (13 respondents) or not completed college (8 respondents) or left training courses, due to problems they believe were caused by their sexual orientation (15).

This reflects a growing body of literature on the experiences of lesbians and gay men, both nationally and internationally. It is hoped that with the increasing interest in research in this area, this will lead to increased awareness, transfer of knowledge and the development of an understanding of the discrimination that lesbians and gay men experience. Gay HIV Strategies commissioned the above report, which examined initiatives already in place within the education system and identified further potential options that might work to alter the current situation. The education system is seen as having a central role in controlling anti-gay prejudice and this is where it is viewed to be most effective. The reason for this is threefold. Firstly, the educational system has an important relationship with individual students. Secondly, it is a tool for transmitting values in society and, therefore, needs to incorporate 'respect for diversity' and 'commitment to equality'. Thirdly, the education system is also a large employer that can lay down important standards, by allowing for differences and challenging discrimination. The education system therefore has great potential in relation to supporting and resourcing the situation in schools for lesbians and gay men.

Challenging Voices: Pathways to Change (9) also outlined the effect of discrimination on marginalised groups, including lesbians and gay men. The gay people interviewed expressed considerable problems in their lives due to the existence of anti-gay prejudice. One interviewee described his situation:

"All elements of your education pre-suppose you're heterosexual. There's never a sense or an element of choice. When it is mentioned, it's in a derogatory way even in religious education. With the books, all the heroes are men, couples are married and heterosexual. The books are gendered anyway but they're also heterosexual. In sex education too, there's nothing or very little, about gays and lesbians" (1999: 83).

A small survey was carried out among young gay people in Derry, Donegal and Tyrone, entitled *The Experiences of Lesbian, Gay and Bisexual People at School in the Northwest of Ireland* (16). This report consolidates the findings of the study by the Combat Poverty Agency in 1995 (14). Out of a total of 31 gay/bisexual males interviewed, one had attempted suicide, two had been admitted to a psychiatric hospital and 11 believed that their school work had suffered. Lesbian respondents described similar experiences and the occurrence of anti-gay bullying was affecting not only their studies, but also their lives. This survey revealed that the acts of bullying were not once off, but forms of ongoing harassment, which was also continuing to happen outside the school boundaries.

"I got verbal, physical and mental torture. I was called names, the other boys spat on my back and in my face. They wrote homophobic graffiti on my property. My brother started getting it too and my mother got abuse shouted at her about me (1999: 16).

A survey of secondary schools in England and Wales (17) established a wide range of problems concerning the needs of lesbian and gay students. 82% of teachers interviewed were aware of cases of homophobic verbal bullying ('name-calling'). 26% realised that physical bullying was occurring and this was usually accompanied by verbal bullying. This bullying had various outcomes, including early school leaving. Reasons why teachers had not intercepted the bullying included parental disapproval, lack of experienced staff and a lack of policy. Although the majority of schools had a general policy on bullying, only 6% had policies that referred to anti-gay bullying. One teacher described the effect these experiences have on young lesbians and gay males at school:

"diminishing or total loss of self-confidence, likewise self-esteem, withdrawing into a shell, no communication, obviously being very unhappy and that affecting friendships, affecting them in terms of motivation towards work, motivation towards school, being off school and feigning illnesses with parents and obviously, at the most severe level, refusing to come to school" (17).

It is in school that lesbians and gay men are particularly vulnerable to anti-gay violence. Monaghan (1997) cites a United States Department of Justice report stated that "gay males and lesbians are the most frequent victims of hate crimes and school is the primary setting for this type of violence" (18). A study by the US National Lesbian and Gay Task Force demonstrated

that 45% of males and 20% of females experienced verbal or physical abuse in secondary school because they were thought to be lesbian or gay. The Report of the Secretary's Task Force on Youth Suicide (19) showed that 30% of completed suicides among young people were among the gay community. Even in schools where there is no documented violence aimed at gay students, the fear of violence can have a marked effect. This was also covered in the Combat Poverty study, as fear of being discriminated against was seen to have a profound effect.

"The ability to behave naturally, disclose one's sexuality and/or seek support becomes controlled by fear" (15).

It is the school's responsibility to ensure the physical safety of its students, but also to provide surroundings that are not detrimental to their students' mental health. Monaghan (1997) stated that constant exposure to verbal harassment "erodes a sense of well being" and "no child or youth should have to fear for his or her physical safety while attending an educational institution and no student should anticipate that attending school will be detrimental to his or her mental health"(18). Students often respond in different ways to these threats to their physical and mental health and their coping mechanisms may not always be positive or adaptive. One obvious coping mechanism is attempting to hide their sexual orientation in the hope of appearing 'normal'. This can have a "significant though unmeasurable cost to their development process, self-esteem and sense of connection" (18).

Research shows high rates of truancy, academic failure, changing schools and ultimately, early school-leaving among young gay people (18). A Study by Combat Poverty in 1995 (14) revealed that 8% of respondents experienced problems at school, which caused them to leave earlier than anticipated.

This chapter has highlighted that there should be an increased focus on the health needs of adolescents who are members of minority groups, with the emphasis being placed on equality and discrimination issues. There should also be greater recognition of diversity in relation to gender, sexuality, socio-economic status and ethnic background. Appropriate and targeted responses need to be developed to meet the specific health needs of adolescents from minority groups.

Recommendations

- Every public service should have a policy and protocol in response to the needs of gay and lesbian adolescents. A designated person should ensure that these protocols are upheld: e.g. that information regarding services is accessible to them.

- Given the high levels of reported health, and in particular mental health problems among gay and lesbian adolescents and their reluctance to disclose their sexual identity to service providers, services should be more proactive in encouraging and facilitating usage by adolescents. Gay and lesbian adolescents should not be precluded from using services due to fear of discrimination or lack of confidentiality.

- Front line health care providers, Health Board employees, Civil Servants, Gardaí and other public services should receive training in gay and lesbian issues. This training should also extend to community development groups, teachers, media etc. Resources should be made available to existing Gay and Lesbian organisations to develop and provide this training.

- The additional pressures faced by gay and lesbian adolescents, who often have to hide their sexual orientation, can have a seriously detrimental effect on their developmental process, self-esteem and participation in school and other activities.

- Support should be offered to the parents of gay and lesbian adolescents

- Equality issues in education as identified in recent reports on the subject need to be addressed, in particular:
  - Awareness of staff and students
  - Parent Support
  - Measures to address bullying

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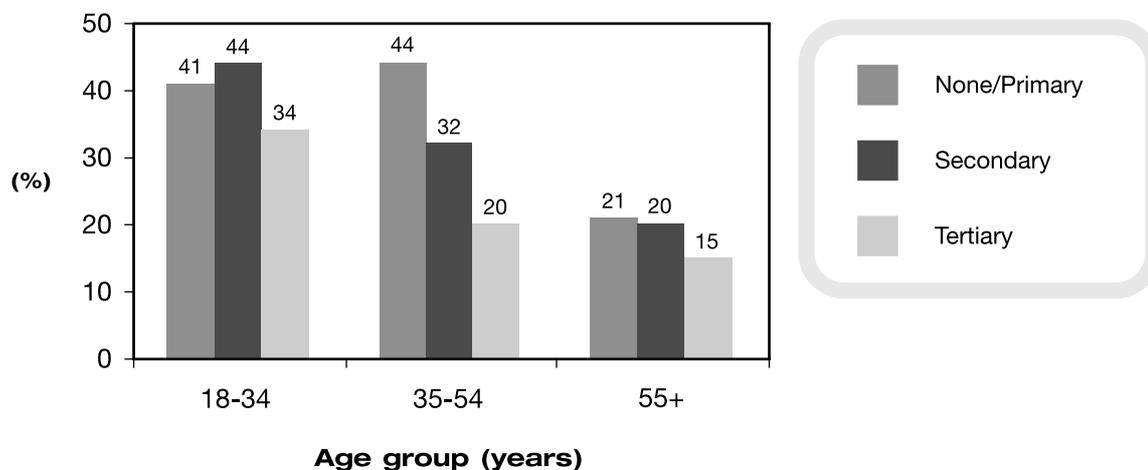
5.0　Educational Disadvantage

5.1　Introduction

5.1.1　Inequalities in Health

Since the publication of the Black Report in the UK in 1980, which highlighted the large differentials in mortality and morbidity between higher and lower social classes, there has been widespread acceptance that health inequalities are primarily a consequence of material differences in living standards. Social and economic factors such as income, unemployment, environment, education, housing, transport, and lifestyle factors all affect health. This document highlights a number of inequalities in health in relation to adolescents and restates the need for action by agencies outside of the health services in tackling health issues facing adolescents. Given the age of the population under consideration, educational disadvantage has been selected for particular attention as an area which impacts on the current and future health of this age group.

- There is strong and consistent evidence for a relationship between health and socio-economic status. Deprivation is associated with poor health.

- Inequalities in health status between socio-economic groups have been demonstrated in this country and these inequalities are persisting.

- Health is determined by a wide range of factors, of which availability and quality of health service are only two.

- To improve the nation's health, a holistic rather than a service-oriented approach is needed across all sectors of government

- Government must take responsibility for the wider influences of its policies on health in order to facilitate the development of a social and economic environment in which health inequalities can be reduced (1).

A key example of inequalities in health can be illustrated by data on smoking. Differences in smoking levels and smoking cessation are important causal factors in the observed mortality differentials between social classes for smoking related diseases. Smoking related diseases make a major contribution to perpetuating health inequalities. The Slán and Irish Health Behaviours in School-Aged Children Survey (HBSC) and the National Lifestyle Survey (2) all highlighted social class differences in relation to smoking. They also linked smoking levels to educational level. This is illustrated in the graph on the following page:

Current Smoking and Education Level

5.1.2   What is educational disadvantage?

Educational disadvantage is a term widely used but it cannot be assumed that everyone using it attributes the same meaning to it. There is no clear and generally accepted definition of educational disadvantage. Neither is there a direct measure of disadvantage. Related features are early school leaving, low-income or poverty, poor educational outcomes linked to unemployment, marginality in the labour force, curtailment of personal development and low self-esteem. The strongest predictors of disadvantage based on school performance measures are 'quality' of the home, level of educational achievement of the mother and measures of relative poverty. Indices of disadvantage and poverty are inter-related. The causes of disadvantage are multiple, suggesting that multiple indicators should be used. It is important to note that many of these indicators are also associated with poor levels of mental health.

Kellaghan (3) proposes "that we may regard a child as being at a disadvantage at school if because of economic, cultural or social factors, the competencies which the child brings to school differ from those valued in school, and which are required to facilitate adaptation to school and school learning."

The report of the National Economic and Social Council (4) says that 'there is a general view that the terms **inequality** and **disadvantage** are most likely to be used interchangeably' (p.131). It also says that 'there is a general view that disadvantage refers to poor performers, low achievers or those who have not attained high grades' (p.134). This highlights only some of the "symptoms" of inequality and consequent disadvantage. According to the Combat Poverty Agency, the concept of educational disadvantage also means that young people from socially and economically deprived backgrounds benefit substantially less from educational expenditure than those from better-off backgrounds.

Students with special needs can often experience disadvantage within the education system. The Special Education Review Committee (5) favoured "as much integration as is appropriate and feasible with as little segregation as is necessary" for students with disabilities or special needs in the mainstream school system. The Minister for Education and Science in November 1998 stressed the concept of "automatic entitlement" to resources in pursuit of this policy, as well as introducing a number of pertinent special initiatives.

Educational Disadvantage

Current Government policy is to encourage the maximum possible level of integration of students with special educational needs in mainstream schools and the establishment of the necessary supports to facilitate this development. It also emphasises equality of participation in mainstream education rather than academic achievement alone. It recognises that increased technological competition is of economic concern and that differential treatment is required in targeting resources to alleviate disadvantage. Intervention to improve performance, most importantly early intervention, is emphasised but identification of potential recipients remains difficult.

5.2   Literature Review

5.2.1   Definition

The Department of Education and Science requested the Combat Poverty Agency in February 1995 to undertake research with a view to the designation of schools as disadvantaged with the consequent allocation of resources to these schools. The Educational Research Centre in Drumcondra was commissioned to undertake the work, with the assistance of an expert advisory group. The resulting work, *Educational Disadvantage in Ireland*, was published in 1995 (3) and is the most comprehensive research available on the area of education disadvantage in this country.

A number of practitioners in Ireland have contributed to recent research in the area including Kelleghan, Boldt, Hannan, Cullen as well as the Conference of Religious in Ireland (CORI) and the Combat Poverty Agency (3, 6-10). There are recent examples of interesting small-scale pieces of qualitative research in the Irish context. However, there is little drawing together of information from these pieces of work and much of what is learned has not been disseminated.

The *Educational Disadvantage in Ireland* report states that "disadvantage in the context of education is considered to result from discontinuities between children's knowledge, skills, and attitudes and the demands of schools. Problems arising from discontinuities in children's out-of-school and in-school experiences are discussed, as well as the contributions of homes and schools to the creation of those discontinuities" (3). The report considers indicators relating to pupils' backgrounds and school performance to identify educational disadvantage. It notes that because disadvantage and associated factors are continuous variables, the designation of disadvantage in quantifiable terms is arbitrary. However, on the basis of evidence relating to the incidence of poverty and of low school achievement, the report considered a figure of 16% of the school-going population to be disadvantaged.

Another indicator of the level of disadvantage is the number of students leaving school without qualification. Most recent figures based on Department of Labour sample surveys indicate the number of students leaving school without qualification (Junior Certificate) as follows:

Year	1990	1991	1992	1993	1994	1995	1996
No. of Asylum	4,500	3,600	5,200	3,400	3,300	2,200	2,700
%	6.7	5.4	7.8	5.3	4.9	3.3	4.0

Hannan (8, 9) also estimates that 1,000 students per annum do not transfer to post-primary schools and 2,000 achieve less than 5 D grades at Junior Certificate level.

The benefits of education range over a continuum, from those who leave school without qualification to those achieving third-level qualifications. Studies since the 1960s have identified a variety of different points on this continuum as important transitions (11-13). A feature of all these studies is that those from poorer backgrounds do significantly less well, almost all who leave without qualification are from poor socio-economic backgrounds; those from poor socio-economic backgrounds who proceed to Leaving Certificate are subsequently much less likely to achieve entry to third-level education.

"Qualification inflation" suggests that employers are now seeking significantly higher qualifications in terms of both certification and grades obtained. Since the Leaving Certificate is used both as an employment selection device and a determinant of entry to third-level courses, this "is one of the reasons why the consequences of educational inequalities are particularly serious in Ireland, although the actual levels of inequality are comparable to those in other countries" (6, 14). Inequality and disadvantage can thus be passed on between generations, as educational qualifications are closely related to socio-economic status and employment prospects are increasingly determined by educational qualifications. **Therefore, depending on the criteria chosen, disadvantage could range from 5% to 20% of the school-going population.**

The Conference of Religious in Ireland (CORI) (6) notes that stratification in our society is such that status and wealth are determined by the nature of paid employment. CORI takes the view that to eliminate poverty and value justice and equality, we must ensure that those who are educationally disadvantaged gain proportionately more from our education system. CORI would argue that the present education system perpetuates poverty.

The Report *Educational Disadvantage* argues that to achieve equality of wider participation or achievement, we cannot treat our children in an identical manner educationally; if we do treat all children equally, those who are better prepared to cope will gain more, leading to unequal participation and achievement for others less well prepared. We must, therefore, view our schools and our education system as having a responsibility to provide sufficient resources to create achievement for students experiencing disadvantage. It concludes that Government policies and school practices must reflect this view (3).

The National Economic and Social Forum (NESF) argues that we should treat as a first priority those young people who are at risk of leaving school before Junior Certificate and this is endorsed by CORI (6, 12). CORI also argues that the present system of certification and assessment needs to be changed as "disadvantaged students realise from an early stage in their schooling that they are involved in a competition in which they are unlikely to do well".

5.2.2   Nature of Educational Disadvantage

Educational disadvantage and associated problems are among the most serious facing our educational system. Their nature is complex, arising from socio-economic conditions within families and communities. Disadvantaged children can experience severe difficulties in school arising from discontinuity of experience between home and school. This can result in inadequate learning, leading to knowledge and skills gaps, which in turn can reduce their future opportunities at a personal and societal level. Labour market and social adaptation problems can result (3).

Kelleghan et al (3), see disadvantage as affecting adjustment to school and consequently leading to reduced educational performance. **Difficulties arise early and due to the cumulative nature**

of the problem, achievement gaps widen through the system. This can lead to early school leaving with poor qualifications and employment opportunities. Time and space usage in the home, the nature of communication with parents, the value system espoused and exposure to stresses can all lead to educational disadvantage.

The school itself may also contribute to disadvantage. Communication and language in the school can be significantly different from that at home (15). Some teachers may have low expectations or set undemanding standards (16, 17). Parents from lower socio-economic groups may be made less welcome than those from higher socio-economic groups (18). Grouping or streaming may also adversely affect disadvantaged students (8,19,20). Learning difficulties may also arise if teachers do not understand the home backgrounds of disadvantaged children and cannot adjust their teaching to take account of it (21, 22).

Research indicates that educational disadvantage is a core element of greater social and economic inequality.

The report on educational disadvantage notes three important implications of educational disadvantage:

1.   Our system is not providing all our students with the opportunity to realise their potential.
2.   This has the effect of diminishing our 'human capital' and reduces our capacity to compete economically.
3.   There is not just loss of benefits but such a failure can create costs in supporting the unemployed and in dealing with disaffected behaviour.

Employment and Education

One of the most visible effects of educational disadvantage is employment following education. The National Economic and Social Forum, "considers that education is a key element in enabling young people to compete for job opportunities and that a weak educational background seriously limits those opportunities. The level of education obtained is also a major determinant of the ability to access training and progression opportunities" (12).

CORI also points out the "dangers of regarding education as simply the preparation of individuals to compete in the points race or in the job market. Such an approach leaves people and communities ill-prepared for many of the major tasks of life such as self-expression, community building, relationships, parenthood and leisure" (6).

It should be stressed that the sole focus of measures to tackle disadvantage must be driven by more than economic concerns and that health should also be a key driver.

5.3   Efforts to tackle disadvantage

The report of the Commission on the Family, *Strengthening Families for Life*, (1998) contends that we must look at preventive measures as a priority, while also combating educational disadvantage at all levels, from pre-school to adulthood. "This approach is essential to break the inter-generational cycle of disadvantage, and it must be accompanied by a national certification framework, with alternative routes of progression to higher levels of training and education" (23).

There is general agreement in the research that we need to identify educationally 'at risk' children at a much earlier age, apply a much more broad ranging strategy to more schools and support this with increased resources. The focus of disadvantage over time has changed from individual children to families and now to the wider communities of these children and their families. Solutions to disadvantage must also be looked for across a range of agencies, even if the primary work takes place mainly in the home or the school. In this respect, the establishment of the National Educational Psychological Service (NEPS) is welcomed because of its direct delivery of services to schools, teachers, children and their parents. This service will eventually become an independent statutory body under the terms of the Education Act, 1998 and will have a staff of 200 Psychologists.

This service is concerned with supporting schools in the development of policies and actions relating directly to educational disadvantage from individual assessment through to consultation and collaboration with staff and parents, particularly in the following areas of concern: literacy, numeracy, language development, social/personal development and vocational choice. The process of development for NEPS will take 4 more years. The role-out plan for the service is available from the NEPS Agency. Although centrally organised, the service will be delivered at regional and local level and as far as possible will parallel the regions of the Health Boards.

Managing this expansion will require ingenuity and great expertise and especially the co-operation of all the agencies concerned. A Liaison Committee between the NEPS and other agencies has recently been established. Examples of good practice already exist between Psychologists in NEPS and health professionals and these models of co-operation must be encouraged and expanded. It is hoped that through consultation with teachers, parents, Health Board and other relevant personnel, identification of needs and recommendations for appropriate provision will be made which will enhance the experience of students and will encourage them to remain in school as long as possible.

"Today's proposed solutions to disadvantage are likely to involve a range of agencies even if the focus is on one institution, such as the home or the school… thus, the supreme confidence of the 60's that educational provision on its own could solve the problem of disadvantage, a view that gave way to a pessimism in the 1970's about what education could achieve, has now been replaced by the view that while education has a necessary role to play, that role is not sufficient in itself to deal with disadvantage" [3].

In line with that thinking, the Department of Education and Science has established a Social Inclusion Unit. This Unit is responsible for all interventions related to Disadvantage. It recognises and accepts the concept of lifelong learning and the importance of the involvement of parents and, in the process, the empowering of communities. The diverse nature of the intervention, their multi-layered approach, the provisions of varied levels of the system, clearly demonstrate the complexity of the issues. The interventions focused on post-primary schools derive from radical changes in curriculum, as well as extra resources.

The Programme for Prosperity and Fairness acknowledges the importance of community dimensions of education when it states: "the community dimension of education and involvement by the community in education will be supported through development of closer linkages between education and area-based partnerships, allied with improved co-operation and integration of education, welfare, health and justice policies, and increased opportunities for involvement of the community and voluntary sector".

5.3.1   Curricular Responses

There have been many positive curricular initiatives at second-level aimed at alleviating disadvantage, with a broadening of the curriculum and the introduction of some flexibility in methods of assessment and certification. These include the Junior Cycle Review, the Transition Year Programme, the Applied Leaving Certificate and the Leaving Certificate Vocational Programmes. Schools with the designated status of "Disadvantage" benefit considerably in the allocation of teaching and financial resources, though there is much concern that a large percentage of students experiencing disadvantage are not served by these designated schools.

In the 1996/97 school year, 501 schools provided Transition Year to approx. 24,000 students. The Commission on the Family particularly welcomed the introduction of the Transition Year Programme. It noted that the development of personal skills, curriculum flexibility, an emphasis on preparation for life, and negotiated, self-directed learning without examination pressures, has the potential to make a significant contribution to young people in equipping them for the world of adulthood.

The tendency of much research in this area, particularly in the past, is to focus on the personal and socio-economic factors of students. Boldt (24,25) argues that all students need support and encouragement in schools. Prevention programmes should be for all but targeted especially at the sub-group most in need. He also argues that students should be listened to for their opinions on prevention programmes and that sometimes a decision to leave school early is an appropriate one for an individual adolescent.

However, Hannan (9) notes that "while at second-level we have devised new curricula, new levels and new exam systems, we have not effectively looked at the 'pacing' of instruction nor the nature or effectiveness of the pedagogy or schooling practice". He sees the need for more flexible timings and curricular connections that are evident in other educational systems. CORI argue that further fundamental changes are required in respect of certification and assessment to confer greater benefit to the disadvantaged.

Stay in School Initiative

Following recommendations of the Kelleghan report, the 'Stay in School Initiative' in post-primary schools was introduced in the 1999/2000 school year. The initiative involves a comprehensive review of the use and deployment of existing and traditional financial and personnel resources in designated schools. It also specifies the use of additional funding at school level to encourage and develop multi-faceted actions in schools in a supportive and preventative manner in meeting students' needs. It sees the need for a collaborative programme in partnership with the community and local agencies. This specifically includes Health Board personnel. This is at present being undertaken in 58 schools nation-wide (3).

The Commission on the Family (23) recommended that special consideration be given to the funding of the further development of the Primary Health Care Project for Travellers. A comprehensive report on Traveller education was presented to the Inspectors' Conference in December 1999. It noted that progress was being made in relation to the overall policy objective that by 2005, all Traveller children of second-level school-going age will complete junior cycle education and that fifty per cent will complete senior cycle. It is hoped that the management and visiting teacher model, as outlined, will be in a position to achieve such targets, servicing some 4,978 families and an overall population of 30,000. This area and the increasing problems associated with the influx of Refugees and other foreign nationals seeking asylum, will need to be considered and planned for, as many of them will also suffer from educational disadvantage (see report on Minority Groups).

5.3.2 Early School Leaving

Sharing in Progress, the National Anti-Poverty Strategy, sets out a target of eliminating early school leaving before the Junior Certificate; reducing early school-leaving so that, by the year 2000, the percentage of young people completing the senior cycle will reach 90% and 98% by the year 2007, and tackling literacy and numeracy problems.

Morgan (20) cites a recent study by McNeal, in 1995, seeking to establish whether certain kinds of extracurricular activities were more influential than others, in the prevention of early school leaving. Working on a data base of 20,000 students, it was found that participation in certain kinds of activities, especially sports and fine arts, significantly reduced the likelihood of a young person dropping out, whereas participation in academic or vocational clubs seemed to have less effect.

The guidelines for Youthstart, a series of EU wide projects, explicitly recognised the need for action to prevent disadvantaged young people from dropping out or leaving school without a qualification. They also advocate the further development and implementation of a comprehensive pathway model, which combines a range of proactive, target group specific strategies and aims to create and to co-ordinate effective links between all the key actors involved. Four recent efforts in the Irish context are outlined and evaluated in a November 1998 publication of Youthstart conference papers (26). All four projects underline the importance of a partnership model.

Family Support and Health Promotion

While much of the research concentrates on the school and mainstream education, there are many examples of good practice in the Irish context where professionals are involved throughout the country in initiatives aimed at combating disadvantage in general, which in turn, can alleviate educational disadvantage.

The Commission on the Family Report (July 1998) states that: "The Child Care Act, 1991, sets out the nature and scope of the powers and duties of Health Boards with regard to the provision of child care services. The term 'family support' is most commonly used to describe the range of initiatives which the Health Board provide in complying with their statutory responsibilities under the Act. An effective, comprehensive and co-ordinated family support service is required to work towards a long-term solution" (23).

Health Boards and the Department of Health and Children are active in health promotion in second-level schools. Programmes such at the Health Promoting Schools Programme, operating with support from some Health Boards, has been shown to have had very positive effects on students' lifestyles. The recent introduction of Social Personal and Health Education (SPHE) as a core subject at Junior Certificate level is highly significant. The Commission on the Family recommended that the Health Promoting School concept be extended to all schools and that the objectives of a Social, Personal and Health Education programme can best be realised within the supportive framework of the Health Promoting School. Support for a Religious and Sexual Education (RSE) programme in all schools was also highly recommended. Opportunities for Health Board personnel to carry out their functions under the Child Care Act, 1991, through schools can be greatly facilitated by a partnership model with schools in all of the above area.

The introduction of Family Support Workers in a number of Health Board regions is designed to provide practical support and guidance to families who are having difficulties in caring for their children. In one Health Board area, support services for adolescents are being developed within a family support strategy. This recognises the importance of the informal support networks provided to young people by the family and the extended family.

Health Boards are also directly involved in running Family Resource Projects and there are many examples of good practices e.g. Geraldstown House in Ballymun and Moyross in Limerick. Neighbourhood Youth Projects work on the basis of building relationships with individual children and group activities. They emphasise maintaining and supporting young people at school, and encouraging participants to remain out of trouble and drug free.

Public Health Nurses are involved in a number of innovative initiatives aimed at alleviating disadvantage, including health education in schools and in the community, parenting skills training, and pregnancy prevention with teenagers.

5.3.2.1 Parent Support

The whole area of parent support is one that is recognised as necessary and in need of expansion. Parenting education has been shown to be an important preventative measure in respect of young offenders. The Commission on the Family considered that a "parenting programme should recognise that there is a need for additional support for families with special requirements and at certain times. Lone parents, Travellers, teenage parents, etc."

The work of the Family and Community Services Resource Centres in community based work with disadvantaged parents is recognised as vitally important in alleviating educational disadvantage, particularly where the work is undertaken in partnership with local schools.

Cullen (27) reiterates the need for a number of levels of measures to tackle educational disadvantage. He cautions against focusing on integration in relation to early school drop-out and educational disadvantage to the point where the need to tackle the deeply rooted institutional and systemic dimensions of these problems is ignored. He also stresses the need to be better informed of lessons that can be learned from developments elsewhere and the need for adequate mechanisms and resources to address key research questions in planning, operating and evaluating initiatives.

A recent review by Murphy (28) of government support for the educationally and socially disadvantaged suggests that current provision emerges as diverse and unco-ordinated. Although

there is evidence of a strong Government commitment to a range of varied initiatives, an overall coherent and strategic plan of action to tackle social and educational disadvantage does not appear to exist. The review emphasises the co-ordination and co-operation of statutory and voluntary provision at a local community level, through a variety of area-based initiatives, as a step towards a more coherent and effective response to tackling the problems associated with socio-economic disadvantage.

In the light of the Strategic Management Initiative, the Department of Health and Children, through the Health Boards and other Government Departments, especially the Department of Education and Science, need to adopt a common policy in respect of a more integrated approach to tackling educational disadvantage. The diagram on page 64 highlights how much activity is happening in relation to educational disadvantage in areas other than education and the obvious need for co-ordination of responses. As a priority, a development of measures that target particularly disadvantaged young persons such as lone parents, Travellers, Asylum Seekers and Refugees, should be investigated by the Department of Education and Science, in conjunction with other relevant agencies.

Recommendations

- Awareness of educational disadvantage, its causes and its long term impact on the health of disadvantaged children and the protective impact on students who remain on longer in school, needs to be highlighted.

- Educational disadvantage requires a co-ordinated response and co-operation at policy level, inter-departmental level, but particularly at regional and local level, to alleviate educational disadvantage. Best practice in this respect should be supported by Health Boards.

- This Report recognises that the networks participating in the Demonstration Programme on Educational Disadvantage initiated by the Combat Poverty Agency in 1996 have demonstrated valuable innovative, collaborative efforts to tackle educational disadvantage. Health Boards should use the lessons learned from these projects to inform Health Board initiatives in this area.

- There should be a review of current practice within the health service to establish best practice in dealing with educational disadvantage. This would include the facilitation of people working with young people, neighbourhood youth projects, information sharing, family support, partnership in addressing educational and consequently the health needs of adolescents.

- Community services to adolescents should review the accessibility of their services to adolescents.

- The National Educational Psychology Service (NEPS) should be provided to all schools. There should be clear systems of communication between the NEPS agency and Health Board Psychology Services

- Present linkages between Health Boards and Educational personnel, e.g. the model of organisation and training for SPHE teachers, should be continued and expanded on a partnership model.

- Health Board Child Health Teams should liaise with existing structures i.e. City and County Development Boards, County Child Care Committees and the Partnership Boards, to ensure that educational disadvantage in adolescence is being dealt with appropriately by these bodies.

- Health Boards, through their partnership organisations, should endeavour to increase awareness of local vocational training options and ensure adequate training in line with needs assessment, in particular to support families at risk.

- There should be enhanced liaison between Guidance Counsellors and local training organisations with appropriate support from Social Work and Psychology services to ensure appropriate and planned transition from school to training/employment programmes.

Diagrammatic Representations of Disadvantage Initiatives of Government Departments Other Than Education

Source: Murphy, 2000

Educational Disadvantage
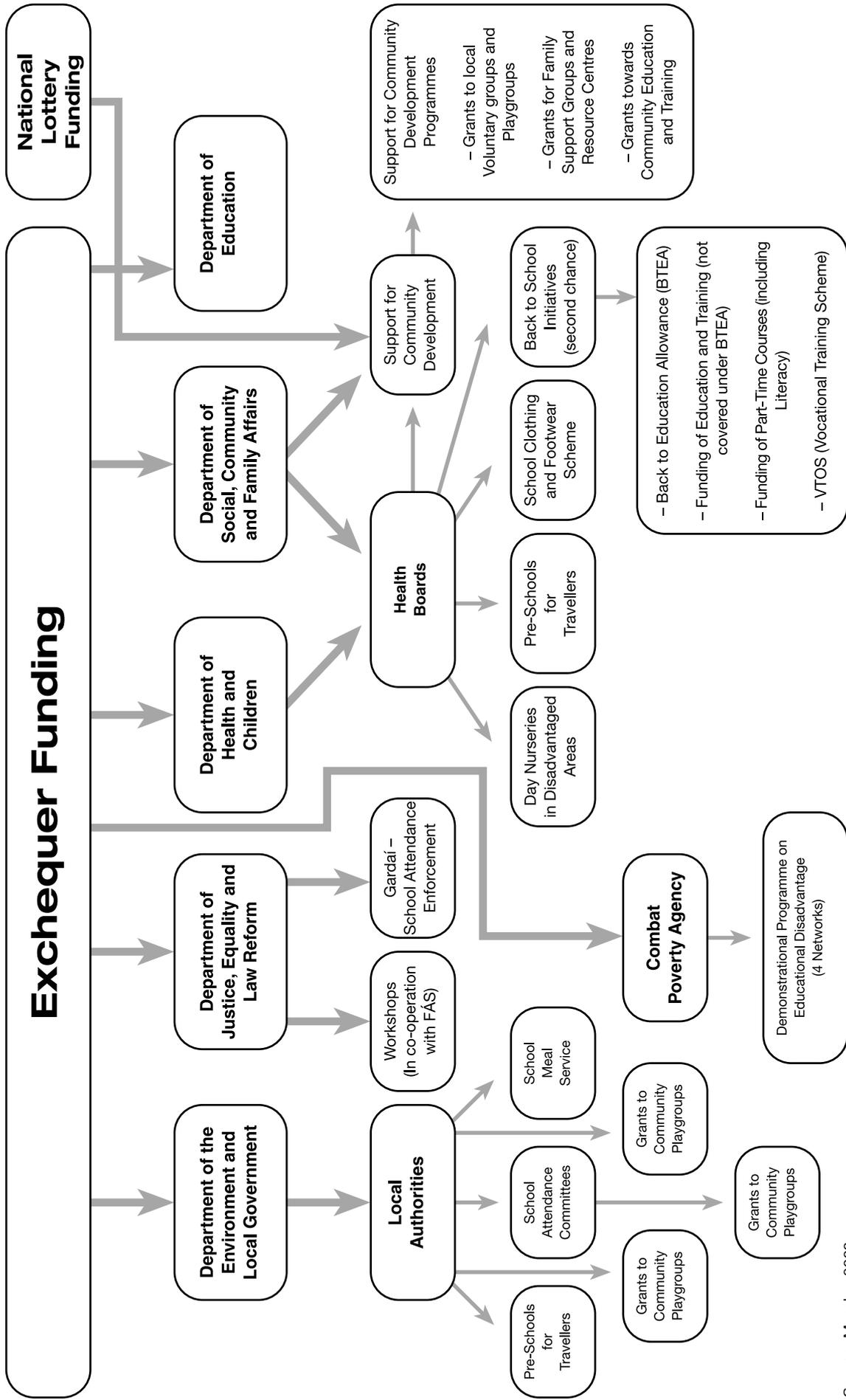
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6.0   Health Behaviours

6.1   Definition of topic

This section focuses on a number of specific health behaviours: substance use, including tobacco use, alcohol consumption and illicit substances, diet, exercise and sexual behaviour. These issues are central topics in a discussion of a balanced lifestyle and are significant for adolescents in relation to their current and future contribution to health related risk and health protection. Adolescence is characterised by relative healthiness. However, the pattern of behaviour established at this stage can have a profound effect on later morbidity and mortality. Equally important is the fact that some behaviours have an effect on current service utilisation.

6.2   Literature review

Policy and strategy relevant to these health behaviours include the National Health Strategies and more specific documents focusing on health promotion, nutrition, alcohol, cancer services, heart health, womens health and youth at risk. These raise a number of specific issues relevant to adolescent health behaviour. Firstly, they document the importance of the specific behaviours being addressed here, and they do so both as behaviours in themselves, while also highlighting the importance of the settings in which behaviours occur. Secondly, the promotion and extension of generic Lifeskills or Social, Personal and Health Education (SPHE) in schools is widely advocated and the appropriateness of collaboration with other settings is highlighted. This is particularly the case for youth at risk and those who are out of school. However, with a few notable exceptions (e.g Building Healthier Hearts), national policy and strategy documents do not give specific targets or timelines. Neither do they provide specific reference to adolescents, teenagers or young people. Most importantly, data on implementation and evaluation are rarely available. Thus, while the issues are highlighted and valuable guidelines on methods of working are provided, more specific material is regularly unavailable.

The Irish Health Behaviour in School-aged Children study (HBSC) covers most of the areas addressed in this section. Data was returned from 8, 497 pupils aged 9-18 in 187 randomly selected schools, which were stratified by Health Board. This reflects an overall response rate of 73%. Respondents compare favourably with the 1996 census data on gender and social class. Data was collected with a self-completion questionnaire - the HBSC survey instrument. Where applicable, data from the HBSC is presented below. This is primarily based on the Irish Survey (1, 2), but international comparisons comprising how the Irish adolescents rank out of the 29 participating countries is also presented (3). To reinforce the direction which responses should take, it is also linked into the relevant strategic aims of the National Health Promotion Strategy (4).

6.3   Avoiding Alcohol Misuse

The rates for lifetime abstinence decline rapidly across adolescence for both boys and girls. Girls are more likely to be abstainers than boys and among girls, a social class effect is evident. Older girls, aged 15-17, from social classes 1 and 2 are less likely to have had an alcoholic drink than those from social classes 5 and 6. In the international HBSC database, Irish 13 year olds rank 18th on abstinence, while the 15 year olds rank 14th.

Current drinking is defined as having had an alcoholic drink in the last month. Overall, 29% of the children report having had a drink in the last month. The gender differences are maintained, with

boys more likely to report current drinking (34%) as compared to girls (24%) and a small but consistent effect of social class among girls from age 12 years on. Irish children at age 13 rank 17th on weekly drinking and at age 15 they rank 14th.

In total, 29% of the children report having been drunk, with higher rates reported among the boys (35%) compared with the girls (24%). Reported drunkeness increases over age and is higher among boys. Among the girls aged 12 and over, a social class effect is evident. 8% of boys and 3% of girls report having been drunk more than 10 times and this increases over age to 3% of 12-14 year olds and 13% of 15-17 year olds. Among girls there is a steady but small social class effect. Having been drunk more than 10 times rises from 1% of 12-14 year olds from social class 1-2 to 2% of those from social classes 3-6. Among 15-17 year old girls, it ranges from 7% from social class 1-2, through 8% of social class 3-4 to 10% of social class 5-6. The same pattern does not emerge among boys whose rates of having been drunk more than 10 times range from 17-19% across the 15-17 year olds. In relation to drunkenness, Irish 13 year olds rank 10th, while the 15 year olds rank 13th.

Percentages of respondents who report drinking alcohol at least monthly
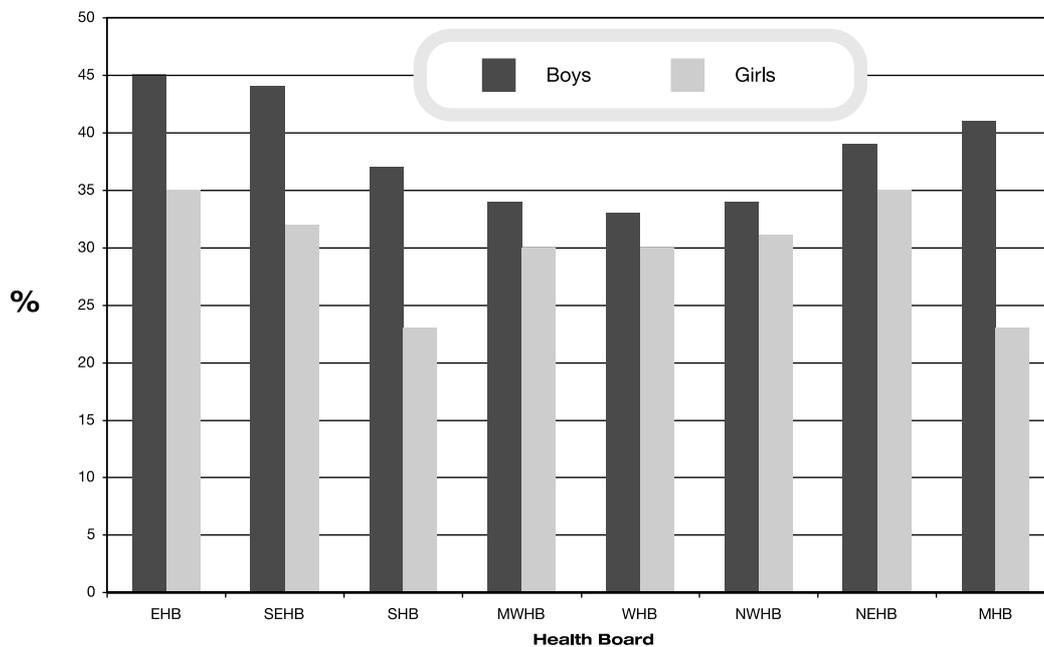
Source: HBSC / SLÁN 1999

Inter Health Board differences in alcohol consumption illustrate that both boys and girls in the Eastern Region report more use of alcohol than in other areas.


National Health Promotion Strategy-Strategic Aim:

to promote moderation in alcohol consumption for those who wish to drink and to reduce the level of alcohol related problems. In relation to young people, the relevant objective is " to delay the onset of alcohol consumption among children and adolescents, especially those in the under 15 year age group.

6.4   Being Smoke Free

Irish 13 year olds rank 4th and 15 year olds 11th of all the HBSC countries on smoking at least weekly. Overall 49% of the children report that they have smoked a cigarette (51% boys and 48% girls), and 21% report that they are current smokers (21% boys and 21% girls). The rates of current smoking increase with age and by age 15-17, both boys and girls of all social classes are exceeding the national targets for those age 15+. Although boys are starting to smoke at an earlier age, by age 15-17, the smoking rates for girls exceed those for boys and among the older girls an effect of social class emerges, with 15-17 year old girls from social classes 5 and 6 reporting current smoking rates of 40%.

Percentages of respondents who report that they currently smoke
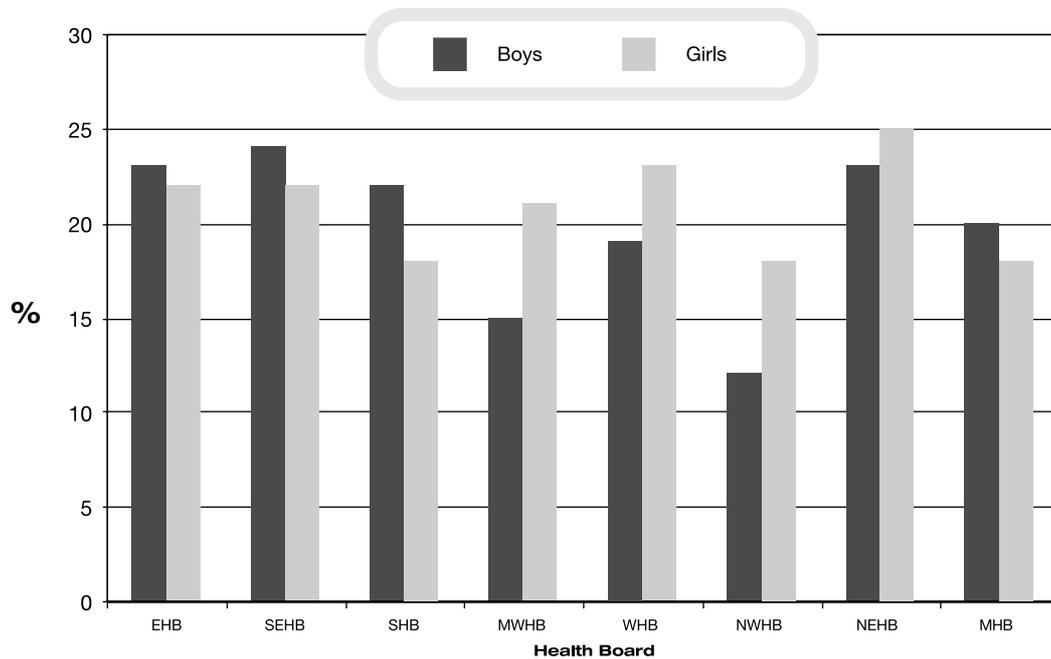
Source: HBSC / SLÁN 1999

The modal number of cigarettes smoked is constant across all Health Boards at one per week. Boys from the Eastern Region are more likely to have experimented with smoking.

The median number of cigarettes smoked per day peaks at 6 among the boys aged 15-17 from social classes 1 and 2. In general, the girls report smoking fewer cigarettes and their median peaked at 3 per day among the 15-17 year olds, irrespective of social class.

National Health Promotion Strategic- Strategic Aim:

to increase the percentage of the population who remain non-smokers with a particular emphasis on narrowing the gap across social classes and to protect non-smokers from passive smoke.

Health Behaviours

6.5   Eating Well

Forty one percent (41%) of children aged 9-11 reported eating fruit more frequently than daily and this decreased to 32% for those aged 15-17. The percentages rarely or never eating fruit was constant at 8% across all age groups. Gender differences are clear with girls more likely to be eating fruit more frequently than boys. Overall 40% of girls report eating fruit more than once a day while 7% report that they rarely or never eat fruit. The corresponding percentages for boys are 31% and 10% respectively. Irish 13 and 15 year olds both rank 8th for eating fruit at least daily.

Eating fruit is more common than eating vegetables. Gender differences are minimal with 19% of boys and 20% of girls reporting that they eat vegetables more than once a day, while 14% of boys and 11% of girls report rarely or never eating vegetables. There are few differences across social classes. There is, however, a reported decrease in vegetable consumption with age. Twenty one percent (21%) of children from 9-14 years reported eating vegetables more than once a day, while this dropped to 16% of those aged 15-17. Ireland is one of only three countries where more than 50% of children report eating cooked vegetables at least daily.

Children were also asked about eating a range of other foods, including cakes and pastries, soft (fizzy) drinks, sweets, chocolate and crisps. Boys in general are eating more high fat and/or high sugar foods, but there are few differences over age group and children from social classes 5 and 6 report eating high fat and sugar foods more frequently. Irish children rank 4th for eating potato crisps and 2nd for eating sweets and chocolate daily (for both 13 and 15 year olds).

No consistent difference between Health Boards in relation to reported eating behaviours were identified.

Percentages of respondents who report eating high fat and/or sugar foods three or more times a day
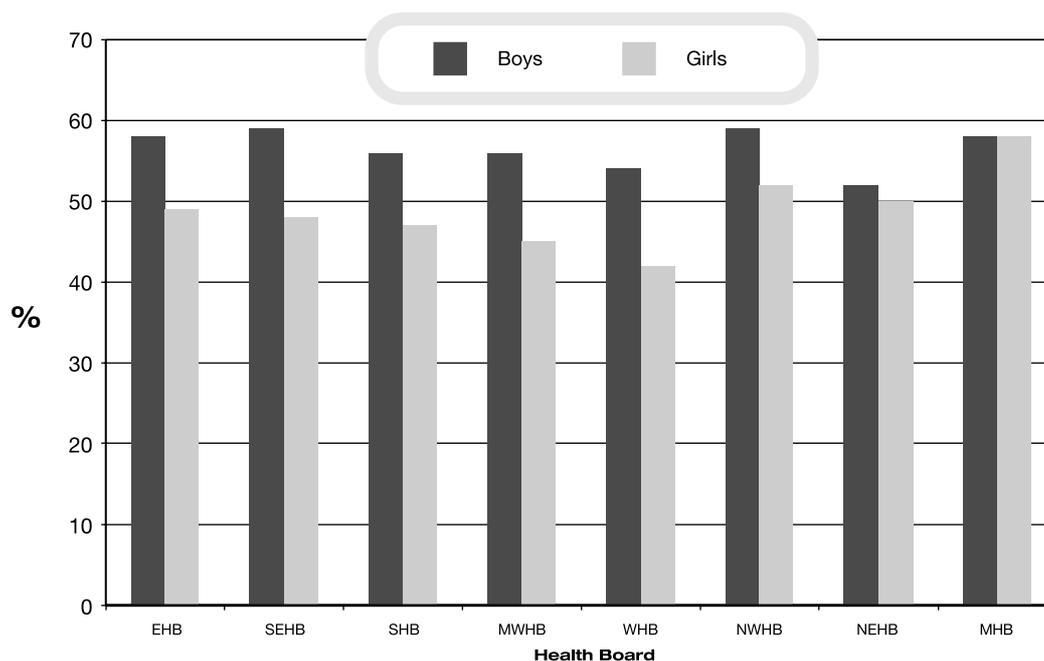
Source: HBSC / SLÁN 1999

National Health Promotion Strategy-Strategic Aim:

> *to increase the percentage of the population who consume the recommended daily servings of food and maintain a healthy weight*

6.6 Good Oral Health

Closely related to healthy eating is good oral health. There are a number of risk factors associated with both general health and oral health. Tobacco, diet and alcohol, are risk factors common to oral diseases, as well as cardiovascular disease and cancers, including oral cancer. Other significant risk factors effecting oral and general health are accidents, injuries and stress.

Oral hygiene practices among some children were found to be inadequate to promote and protect oral health. Irish children, both North and South, are amongst the highest consumers of crisps, sweets, chocolate and soft drinks and amongst the lowest for oral hygiene practices compared to their counterparts in twenty eight countries internationally. Irish children rank way below other EU countries when it comes to dental care. Barely half of all Irish children in each age category brush their teeth more than once a day, more than 75% eat sweets or chocolate at least once in the same period and 63% consume a can of soft drink every 24 hours. The social class differences in relation to healthy food consumption implies that those from lower socio-economic backgrounds suffer a higher risk of oral ill-health.

National Health Promotion Strategy-Strategic Aim:

> *to improve the level of oral health in the general population, with a particular emphasis on people with special needs.*

6.7   Being More Active

Children were asked about their participation in exercise outside of class time with exerciese being defined as physical activitiy, so much that they get out of breath or sweat. Overall, 53% of children report exercising four or more times per week while 6% exercise less than weekly. However, this masks some substantial gender differences. Although only 5% of boys and 7% of girls are exercising less than weekly, 62% of boys and 45% of girls are exercising four times or more times per week. This suggests that the vast majority of children are involved in some exercise outside of school, but that boys are more frequent exercisers than girls.

Percentages of respondents who report that they exercise four or more times per week
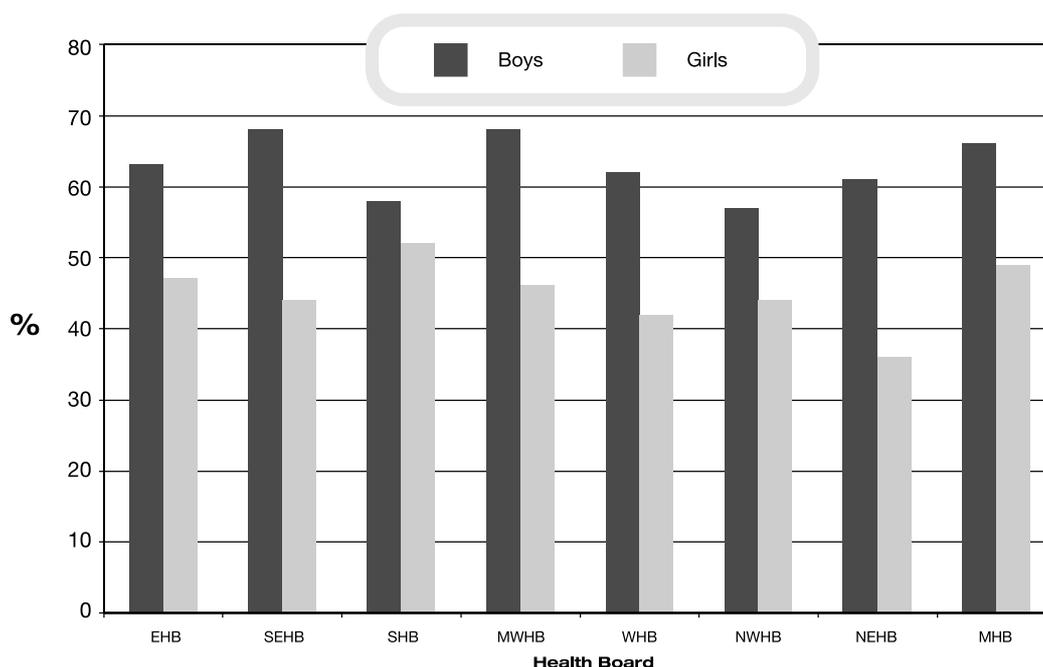
Source: HBSC / SLÁN 1999

Although there are few global differences across social class, exercise participation does decrease with age. Exercising four or more times per week decreases from 63% of 9-11 year olds and 58% of 12-14 year olds to 40% of 15-17 year olds. This decrease is apparent among both genders but is particularly noticeable among girls (dropping from 59% of 9-11 year olds, through 49% of 12-14 year olds to 26% of 15-17 year olds) where it also interacts with social class. There are no consistent differences in reported exercise behaviour across Health Boards. Irish 13 year olds rank 4th for exercising twice or more a week, while the 15 year olds rank 8th out of all the HBSC countries.

National Health Promotion Strategy-Strategic Aim:
   to increase participation in regular, moderate physical activity.

6.8   Sexual Health

While the HBSC did not ask any questions about sexual behaviour, data is available from a number of sources to indicate that a substantial proportion of Irish adolescents is sexually active. Data on Sexually Transmitted Infections STI's among 12 - 18 year olds is not available. However the National Disease Surveillance Centre(NDSC) provided the following information in relation to people under 20 years of age.

Sexually Transmitted Infections Notified to DoHC (0-20 Age Group)

STI	1995	1996	1997	1998	1999
Ano-Genital Warts	88	103	170	181	234
Candidiasis	54	65	99	117	97
Chancroid	0	0	0	0	0
Chlamydia Trachomatis	16	17	34	52	80
Genital Herpes Simplex	10	6	12	16	17
Gonorrhoea	0	0	2	9	8
Granuloma Inguinale	0	0	0	0	1
Infectious Hepatitis B	0	0	0	0	1
Lymphogranuloma	0	0	0	0	0
Molluscum Contagiosum	3	3	7	2	7
Non-Specific Urethritis	32	34	50	51	134
Pediculosis Pubis	3	2	4	9	14
Syphilis	1	0	0	0	1
Trichomoniasis	0	1	2	0	5
Other STIs	33	46	84	102	144
Total	**240**	**277**	**464**	**539**	**743**

Source: NDSC 2001 (5)

While some of the increase documented above can be attributed to better reporting and diagnosing procedures, there seems to be a real increase in STIs among this age group.

In 1998, 20% of registered births were to mothers aged 20 and younger (6) and UK abortion figures report that 738 Irish girls in the 16-19 year age group received abortions (7). Due to the methods of data collection employed, this is likely to be an underestimate.

In 1997, McHale & Newell (8) reported that 21% of 15-18 year olds in Galway city and county (post-primary school pupils) had had sexual intercourse. While in the Midland Health Board, Bonner (9) found that 32% of 16-18 year olds (post primary school pupils) had had sexual intercourse. The Irish Family Planning Association (10) reported on a study of 'vulnerable' 16-18 year olds, among whom they found a sexual activity rate of 70%. Behavioural data reported by IMS (1997) indicated that 50% of those surveyed reported that they had had sexual intercourse by the age of 16. In addition they reported that of those aged 17-20, 52% had had two or more partners in the last 12 months, 43% had sex at least once a week and 19% were not sexually active.

In general, boys report more sexual activity than girls. There are few appropriate analyses for a social class / poverty effect. Activity increases with age group. Although international data suggests that age at first intercourse has been decreasing, the position in Ireland is unknown in relation to trends and recent changes in behaviour. Indeed no data is available on contraceptive usage in adolescents nor on the interval between commencement of sexual activity and the introduction of contraceptives.

Teenage Parenting

The issue of teenage parenting has not been considered in detail in this report but has been recently reported on in depth by a Joint Committee on Family, Community and Social Affairs which has published a report entitled *Teenage Parenting Contemporary Issues* (11). The report highlights that despite perceptions among the general population that teenage prengnancy is increasing, the number of teenagers who give birth has not changed appreciably since the introduction of social welfare payments. The report identifies the significant barriers that teenage mothers in Ireland face in terms of in adequate or inappropriate service provision, lack of awareness of the specific needs of pregnant adolescents and high levels of poverty and exclusion experienced by single teenage parents. The report also draws attention to difficulty in analysing the rate of teenage pregnancy due to the scarcity of research and information about sex and sexuality in Ireland.

National Health Promotion Strategy-Strategic Aim:

to promote sexual health and safer sexual practices amongst the population.

6.9   Avoiding Drug Misuse

Data on drug usage from the Irish Health Behaviour in school-aged children (HBSC) Study drug data is unpublished. However 16% of boys and 9% of girls report having used cannabis on at least one occasion. This increases by age, so that among 12-14 year olds, 8% report having tried cannabis and this rises to 25% of 15-17 year olds. Boys are more likely than girls to report cannabis experimentation. At age 15-17, 30% of boys and 20% of girls have tried cannabis. There are no consistent social class differences. Children in the Eastern Region are more likely to have experimented with cannabis.

Overall 9% of boys and 3% of girls report illicit substance use over the last 30 days. Once again, this is related to gender and age - 12% of all 15-17 year old within that age group, 16% of boys and 7% of girls, have used drugs in the last 30 days. There are no consistent social class differences. Once again, reported use was more frequent in the Eastern Region.

The most frequently used substances were cannabis and solvents. The rates for all other substances were low, 2% or less. Among 15-17 year old boys, 16% reported using cannabis and 7% reported using solvents to get high in the last 30 days. For girls in the same age group the rates were 7% and 4%.

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) extended annual report of 1999 (12) contains Irish data from the last phase of the European School Survey Project on Alcohol and Other Drugs (ESPAD) study (1995) (which should probably be used in preference because it is a more recent study). They report that 37% of Irish 16 year olds have used Cannabis. The rates for other substances are: 9.0% Ecstasy, 3.0% Amphetamines, 2.6% LSD and 2% both Cocaine and Heroin.

National Health Promotion Strategy-Strategic Aim:
to support models of best practice which promote the non-use of drugs and minimise the harm caused by them.

6.10   Health Services Responses

Throughout the country, health and associated services have traditionally had an interest in and promoted preventative activity in a variety of these topic areas. This is still the case. Initiatives exist which aim to tackle one or more of these topics within this age group in all Health Boards. Nevertheless, different approaches have been taken. Some Boards support specialist-led programmes targeted at children at risk in conjunction with broader support for school-based initiatives. Some focus on the behaviours themselves, while others have adopted theoretical approaches, designed to maximise self-esteem and aim to provide or bolster resilience among young people.

Health Boards are currently supporting external initiatives, such as the introduction of Social, Personal and Health Education Programme (SPHE) and the Substance Abuse Prevention Programme in schools, as well as working with local organisations, such as Lions Clubs and the GAA, to support youth initiatives in this area. While all these support initiatives in the area of substance use (alcohol, tobacco and illicit drugs) and most support specific nutritional campaigns, specific initiatives in the areas of exercise and sexual behaviour are less frequent.

It is clear from the review of Health Board Service Plans and Annual Reports that a wide variety of personnel are involved in these initiatives. The programmes are located across a variety of non-hospital settings (Health Promotion, Public Health, Child and Adolescent Services, Psychology, General Practice, etc.), targeting adolescents themselves and also parents, teachers and others who work directly with young people. The breadth and depth of services available illustrate the invaluable position of the regional Health Boards to intervene proactive in this area. In most instances, qualified and experienced personnel are in place and links with communities (including parents and adolescents) are already developed.

However, there are a number of issues that need to be addressed. Although it is clear that a wide variety of initiatives have been designed to promote equity and accessibility to all, their successes are not always clearly documented. The basis on which services or initiatives have been planned is not always clear. The level of collaboration within services, between services within Boards or between Boards and other agencies is not normally well documented. The theoretical principles or models of practice upon which service developments are based are rarely disseminated. Equally importantly, service evaluation is not easily available. Thus, it is difficult to make judgements on issues such as appropriateness, effectiveness or acceptability. A framework for service development is needed to ensure that these issues are addressed and that local or regional services are more easily maintained, replicated or altered for other groups of young people.

Recommendations

- Legislation in relation to young people and alcohol sales needs to be strictly enforced and voluntary codes of practice made statutory.

- Each Inter-agency Drug Misuse Task Force should be asked to produce a plan on adolescent drug and alcohol misuse

- A national media programme should be developed to raise awareness in relation to promoting sensible drinking. It should aim to
  - highlight and deal with the ambivalent attitude of both parents and wider society to alcohol consumption
  - highlight the immediate risks of alcohol intoxication, such as sexual risk taking, accidents and depression / suicide

- Health Boards should establish addiction services targeted at adolescents and employ dedicated staff within addiction teams who would have a role both in direct client work and in supporting health promotion programmes.

- Although prevention activities are the most relevant to this age group, such measures must begin with younger children and be supported across various contexts.

- Smoking cessation activities should be designed and targeted specifically at adolescent smokers and should be introduced by all Health Boards, in partnership with schools and other agencies providing services to young people.

- Research should be commissioned to examine the perceived links between smoking and weight control.

- The enforcement of tobacco legislation should receive appropriate funding and support. The development of the Tobacco Control Board is welcomed in this regard.

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7.0 Adolescent Accidents and Injuries

7.1 Background

7.1.1 Definitions

The World Health Organisation (1) defined accident as:

"an event or sequence of events that results in or could result in an injury" (5).

Although this definition may seem passive or suggest the inevitable, it helps with the inclusion of all events with the potential for injury. Injury invariably means a damage resulting from transfer of energy. There are numerous degrees of injury and the ultimate injury results in death.

Methodology

The research tools used by this Working Group included an extensive literature review and both formal and informal consultations.

7.2 Literature Review

7.2.1 International Experience

In Sweden, North America and Australia, injury surveillance is a vital forerunner of successful injury prevention initiatives. A study in the United States (9) of 87,000 Massuchusetts children and adolescents carried out in 1980/81 indicated that 20% of teenagers had been injured. Results were taken from the 'Childhood Injury Prevention Programme Surveillance System'.

The Centre for Disease Control (CDC) in the U.S.A. established an injury control centre in 1990. In 1991, multidisciplinary university-based injury centres were set up throughout the U.S.A. A national consensus conference was held to set the agenda for injury control activities in the 1990s. A National Centre for Injury Prevention and Control was established in 1992. To date, there are ten injury control research centres in the USA. In Australia and New Zealand, many universities are involved in cross-disciplinary injury research. However, in EU countries, comparative data on injury rates has been extremely limited. The EURORISC project has since been initiated to describe contemporary epidemiology of injury and to identify current injury surveillance and control activities in the EU. In 1996, a review was carried out by the International Society for Child and Adolescent Injury Control (ISCAIC), in which respondents stated that standardisation of injury data collection is a major challenge for injury control in Europe. Injuries to adolescents were a major but neglected challenge, especially in relation to Road Traffic Accidents (R.T.A.s). Injury rates were highest in teenagers; however, a scarcity of high quality research relevant to this age group was evident.

7.2.2 Irish Experience

The Chief Executive Officers (CEOs) of the eight Health Boards in Ireland established the Office for Health Gain (OHG) in 1995. The aim of the OHG is to co-ordinate various agencies, professional bodies and research institutions working together with the Health Boards in an attempt to 'achieve measurable health and social gain' (1). This is to be achieved through the advancement of the aims and objectives of the 1994 National Health Strategy, "Shaping a

Healthier Future" (2). The main objective of the OHG is to facilitate co-operation, firstly between Health Boards themselves and also between Health Boards and other agencies (such as Voluntary and Public Hospitals and other Voluntary Agencies).

Following an initiative by the OHG, a National Accident Forum was established in 1996. The mission of the Forum is to "facilitate a co-ordinated approach to accident prevention at a national and regional level" (1). The Forum aimed to implement a multi-disciplinary approach to enable agencies to work together and share information. Various agencies are represented such as, Cospoir, County Councils, National Roads Authority, National Safety Council, Gardaí, Irish College of General Practitioners, Royal College of Physicians, Faculties of Paediatrics and Public Health, the Department of Health and Children, Dublin Healthy Cities, National Poisons Centre and the Health Boards. One of the areas of major concern is the area of "Unintentional Injuries" as expressed in the report 'Accidental Injury in Ireland – Priorities for Prevention' (3). This report highlighted a number of issues:

1.   In 1993 there were 54,000 admissions to hospital as a direct result of injuries; this is estimated to be about 10% of all injuries as most people will either attend their own GP or not require treatment.

2.   The cost of In-Patient care for injuries was £55 million, for the same year. These costs are an underestimate of the real cost because it does not include the cost of emergency services, GP's or indeed the cost to individuals, families and community.

3.   Nearly 23% of admissions are for the 15 – 24 age group. One third of deaths occur in the under 45's.

4.   Injury prevention must consist of a balance between education, environmental changes and legislation.

5.   The report set objectives for reducing risks and deaths to be achieved by the year 2010.

6.   One of the biggest issues was in relation to information and information systems; it suggests that information on approximately 90% of all injuries is not available.

Given the time-scale of this project, it was not possible for the Working Group to establish the scale of this problem in Ireland. However, information from available sources is outlined below.

It is encouraging to note that since the mid 1990s there has been a notable increase in Irish interest and publications in this area. In 1994, *Shaping a Healthier Future* (2) and, in 1995, the National Strategy for Health Promotion (6) identified accidents as an area for action. The general health of young people, and injuries in particular, were cited as areas that need improving.

The National Health Promotion Strategy 2000 – 2005 (7) also asked school-going children about any injuries they had in the 12 months prior to the survey and also inquired about safety.   Injuries were reported by 58% of boys and 39% of girls. Sport injuries were more common among boys, due to their greater participation in exercise outside school. In relation to safety, 35% of boys and 46% of girls stated that they always wore a seat belt when travelling by car. Cycle helmet usage was extremely low for the younger age groups in all social classes with only 3% of 15-17 year olds reporting that they did so. The sites of injury varied for both age and gender. Young males were most likely to report a sports injury (41% of all sports injuries).

Dr Marie Laffoy and colleagues (3) have indicated that over 1/2 million people are injured each year in Ireland and require treatment for their injuries. Dr A Staines (8) reviewed the scale of injuries in Ireland and indicated a greater excess of male deaths than females, especially in the younger age group of 15-30 years.

7.3   Accident and Injury Information Systems:

High quality, timely information is required to plan, monitor and evaluate accidents and their prevention. The main sources of data are the Central Statistics Office (CSO) and the Hospital In-Patient Enquiry (HIPE). The CSO lists deaths caused by injuries, collects mortality data routinely and publishes them quarterly in the Vital Statistics report. It also produces a summary report each year that includes data on county of residence, sex, cause of accident, and cause of death using the International Classification and Disease Code (ICD) and cause of injury (ICD-E) and this is presented in 5 year age bands. The Public Health Information System (PHIS), provides figures on 'injury and poisoning' for the Irish population and the Hospital In-Patient Enquiry (HIPE) offers a record of those who were injured and admitted overnight as a result of their injury.

Further to a request to the HIPE Unit of the ESRI for HIPE data on the number of admissions for accidents and injuries for the 12 - 18 year age group, the following data was compiled from the HIPE 1999 National File. There were 5,823 discharges from Irish Public Hospitals with a Principal Diagnosis of Injury (ICD-9-CM Code 800-959) and an emergency source of admission for the 12 - 18 year age group for 1999. Note: this total does not include emergency transfers between hospitals.

HIPE had a National coverage rate of approximately 96% in 1998 and only 10% of accidents needed hospital admission for treatment. Hospital discharge data is used as the injuries must be severe to be recorded and are, therefore, important. Data is often computerised, which enables its analysis and it accounts for the majority of medical costs of injuries. ICD coding is also included. Data collected includes county of residence, sex, source of admission, cause of accident ICD-E code, and diagnosis ICD code. The information is presented in five-year age bands and records details on where the accident occurred, length of hospital stay, procedures carried out in hospital and the outcome of the admission. Problems often associated with HIPE include incomplete data, (as private hospitals are excluded), incorrect coding and insufficient information within the charts to enable the assignment of a code. Hence, ICD coding is not always accurate (4). Further drawbacks with HIPE are that it represents only a small percentage of all accidents, social class is not recorded, place of accident and severity of injury are not always recorded.

In addition to these statistics, the National Roads Authority produces an annual report in July of each year, based on data from Gardaí. The National Poisons Centre provides data on poisonings. The European Home and Leisure Accident Surveillance System (EHLASS) is an E.U. project that operates in hospitals in Castlebar and Cork. One drawback of the EHLASS is that this system does not include information relating to Road Traffic Accidents (RTAs). Local Inquiry Surveillance systems are currently being established in a number of Health Board Accident and Emergency Departments.

However, current information systems are not universal, many hospitals (especially Accident and Emergency Departments) are not computerised, and many of those that are computerised, do not collect comparable data. In addition, there are no national information systems at Primary Care level, which can be easily accessed. For this reason, the National Accident Forum has

included the development of good information systems as one of is main priorities. This will ensure that relevant and up-to-date data is available and that prevention strategies can also be evaluated.

The best available data on injuries is related to deaths, but a problem exists in this area in relation to whether the death is unintentional (accidental) or intentional (suicide). The most recent figures available for the 12-18 year old age group from the Central Statistics Office (1999) show that, deaths by injury where the cause is undetermined (i.e. whether it was 'accidental or purposely inflicted') were zero for this age group. It must be noted, however, that there were 47 such cases in those aged over 18 years of age.

Deaths in Young People caused by injury

World-wide, most injuries to adolescents occur at recreation or on the road. These mainly involve falls, being struck with an object, motor vehicle accidents, as an occupant or pedestrian, followed by sports injuries and less so by burns, drowning and violence (10-18). In 1995, in the UK and Ireland, the injury mortality rate per 100,000 for the 15 – 19 year olds were as follows (20)

England and Wales	15.7
Scotland	19.2
Northern Ireland	19.3
Ireland	30.13 *

* CSO figures (1995)

In Ireland, deaths caused by injury registered with the Central Statistics Office (CSO) in 1999 (ICD9-Code E800-E849 & E870-E999) in the 12-18 year old age group totalled 91, out of a total 1,578 deaths by injury in the population as a whole. Adolescents (12 - 18 years) make up 13% of the total Irish population. This seven year age band accounted for 5.8% of total deaths by injury, whereas the under 12 group accounted for only 2.85% (11 year age band). Therefore, the rate of death by injury for adolescents is approximately double that for younger children, even though it represents a smaller age band. Boys are more prone to injury than girls, and this difference becomes more marked with increased age.

The young adolescent (aged 10 – 14 years) has a higher rate of:

- Motor vehicle occupant injury than younger children

- Collision with cars, while riding a bicycle

- Sports injury

- Poisoning is often associated with alcohol or drugs in both sexes. Self-administered poisoning is more common in female teenagers.

The older age group, i.e. 15-24 years of age, accounted for 22.7% of hospital admission for accidents; this statistic comprised mainly of Road Traffic Accidents (RTAs) causing head injury and limb injuries. Poisoning accounted for 17% of the hospital admissions for accidents in this age group.

In the adolescent (12-18 year old age) group:

- 'Motor Vehicle Traffic Accidents' account for the majority of deaths by injury in the adolescent group (46.15%). However, the adolescent group does not yield the highest statistics in relation to the total number of deaths and injuries from road accidents, as they occur most often in the 25-34 age group (22).

- Deaths from 'suicide and self-inflicted injury' rate second highest for deaths from injuries in adolescence (28.57%).

In the summer months, there are more accidents involving teenagers while there are no seasonal variations among adults (3). The most striking observations is the strong association between social class and risk of injury. "Accidental Injury in Ireland" indicates that children and adults in social class 5 and 6 are more likely to be injured, or die as a result of injury, than individuals in social class 1 and 2. In the UK, there is clear evidence that childhood injuries are strongly linked to deprivation (24) and that socio-economic mortality differentials for children are increasing (25).

Organisations Promoting Safety in Ireland

As previously discussed, motor vehicle traffic accidents account for 46% of deaths by injury in the adolescent age group; therefore road safety merits attention in terms of preventing accidents and injuries. 'The Road to Safety' has highlighted that almost 200 fatal accidents and 2,000 accidents leading to injury occur on our national roads every year, leading to a cost of £300 million. Furthermore, it has been estimated that a 'road factor' contributes to approximately one quarter of all accidents. The roads can lead to accidents happening in various ways - signs or road markings may not be clear to both drivers and pedestrians, or the road alignment can give a misleading message to drivers. The National Road's Authority (NRA) offers guidelines in relation to 'safety engineering' and also offers a database, which provides specific accident and traffic flow information. The National Safety Council (NSC) is responsible for promoting awareness and educating the population at large in road, fire and water safety. It is not restricted to road safety only, but does omit occupational safety from its agenda. The Health and Safety Authority (HSA) offers advice on the enforcement of safety in the workplace.

7.4   Consultation Process

Further to the literature search, a questionnaire was sent to all directors of Public Health in Ireland. Responses were received from six DPHs, yielding a response rate of 75%. The results indicate the following:

- No one person in any of the Health Boards has responsibility for data collection relating to accidents and injuries in adolescence.

- There are no units, which cater specifically for adolescents with head injury/brain damage. A meeting with the Director of the National Rehabilitation Hospital indicated the need for a specialist unit for adolescents with a head injury. The largest unmet need is for psychological support for this cohort. The scarcity of qualified psychologists was noted in this regard.

- Policy in relation to assessment, treatment and care of adolescents attending emergency services varies from one Health Board to another.

An attempt was made to elicit policies on injury prevention in the major sports associations in Ireland. The Gaelic Athletic Association (GAA) and Football Association of Ireland (FAI) have clear policy statements and have devised training programmes to reduce the risk of injuries.   These associations also provide extensive training, through development officers, to all their associated clubs. In relation to risk reduction, both associations strongly advise players in relation to protective clothing. As has been reported earlier, most injuries to adolescents occur at recreation or on the road, so therefore, it is important that all sports associations develop explicit safety policies and promote these through training and good practice.

Informal consultation

Informal consultation was carried out with people who have an interest in or collect data in this area. Those consulted included, Dr. Marie Laffoy (Public Health Specialist), the chairman of the sub group of the National Accident Forum (OHG) for children and adolescents, and others who are involved in Information Technology or data collection. In relation to data collection procedures for Accident and Emergency services, the major findings were:

- Data is often incomplete

- Incorrect coding

- Staff did not see the value of collecting data

- Not every Accident and Emergency Department is computerised

- Those that are computerised are not collecting comparable data

Inquires in relation to accidents in schools revealed that there is no system in place to collect such data. Furthermore, injuries are considered to be a responsibility at the local level of each school. There is no regional or national mechanism to capture data regarding injuries at school.

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