

CURRENT TOPIC

Implementing children's rights and health

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Making a commitment to respect the rights of children has profound implications for the status of children in our society. Nowhere is this more evident than in the field of health care where the decisions and actions of professionals impact on children's lives in profound, intimate, and powerful ways. The UN Convention on the Rights of the Child which was ratified by the UK Government in 1991 places a clear obligation on health authorities and practitioners to evolve policy and practice in accordance with the human rights of children.¹ Many of the principles embodied in the Convention are not new. (Many of the rights embodied in the Convention on the Rights of the Child derive from earlier human rights treaties—for example, the UN International Covenants on Civil and Political Rights and on Economic, Social, and Cultural Rights.) They are already implemented as a matter of good practice by some health bodies. What is new is the recognition that children are subjects of rights, that those rights impose obligations on adults to ensure their implementation, and that it is necessary to address the inter-relation between the rights embodied in the Convention in order to promote respect for children. Its principles and standards provide a holistic framework with which to analyse and develop the care and treatment of children in the health services. Examination of two important principles in the Convention highlights the implications of taking a rights based approach to children.

Article 12

Article 12 of the Convention states that all children capable of expressing a view have the right to do so freely in all matters of concern to them and that their view shall be given due weight in accordance with their age and maturity. It has been identified by the Committee on the Rights of the Child, the international body responsible for monitoring governments' implementation of the Convention, as a central underlying principle which must be considered in respect of all other rights.² The case for competent children having the right to give consent to treatment has been well rehearsed, but Article 12 has broader implications. (See *Gillick v West Norfolk and Wisbech AHA*, 3 All ER 402 (1985), *Re W (A Minor: consent to medical treatment)* 1993 1FLR 1 (1993), and the more recent case *RvM*.) It imposes an obligation to respect the right of all children who are able to express their views to be listened to

and taken seriously when decisions affecting them are being made.³

Currently, too many children feel excluded from the process by which information is shared and decisions made in all spheres of their lives.^{4–6} Respecting children's right to be heard does not mean that their views must always prevail. However, it does mean that those views should inform decision making processes on matters which concern them. This has significant implications for practice. It involves giving children the necessary information with which to participate fully in decision making. Research by Priscilla Alderson highlights the extent to which even very young children wish to be given and are capable of absorbing complex and painful information. But she also emphasises the need for such information to be given clearly, sensitively, and at an appropriate pace for the individual child.⁷

Research involving interviews with children in child protection procedures shows that children perceive themselves as capable of dealing with distressing and difficult information often denied them by adults. Common sets of scenarios were presented to groups of children and to groups of professionals working in the child protection field. Consistently, the adults identified a need to withhold information from children in order to protect them. Equally consistently, the children took the view not only that they could cope with the information, but would resent being denied access to it. Indeed, they argued persuasively that exclusion would create more distress and anxiety.⁸ The central message is that the child is a subject of rights, not merely a beneficiary of adult good will and as such must be included as an actor in the decision making process.

However, the right to participate embodied in Article 12, extends beyond obligations to involve children in individual decisions that affect them. It also applies to matters which affect them as a body: the type of services available, the way those services are provided, where they are provided, what times, and by whom (see, for example, the interpretation of Article 12 by the Committee on the Rights of the Child⁹). These are matters on which traditionally children have had no say whatever. Rarely are opportunities provided for them to contribute their experience and views to the development and quality of service provision. In order to comply with this aspect of Article 12, health bodies need to create new

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structures for enabling young people to share their views. For example:

- *Portsmouth and South East Hampshire Health Commission* consulted with 700 children and young people aged 4–16 on their experience of health services. The messages that emerged were that children wanted open, clear, honest explanations about treatment; they wanted to be treated as equals, with time taken to listen to them. They wanted friendliness, respect, honesty, reassurance, and confidentiality.¹⁰
- In *Derby*, architects consulted with children in the design of a new children's hospital. One outcome was a reception desk with a lowered section in order that children could see who was speaking to them.¹¹
- Very small children are capable of providing powerful testimony about their lives and what they would like to change. There are increasing examples of work with small children which illustrates their competence to express views. For example, *Stepney Community Nursing Development Unit* research and development programme undertook a consultation with 4–5 year olds living in East London on their local environment.¹² The children highlighted more effectively than adults could have done, the extent to which their lives were dominated by fear of traffic, drugs, cockroaches, and violence. While anxious for more trees and greenery, they rejected the idea of grass covered play space as this would prevent them seeing abandoned needles and dog excrement.

Promoting children's active participation is important as a matter of principle—children like adults have a right to services which take account of their concerns, experiences, and views. But it is also valuable as a means of improving quality, raising standards, and ensuring the development of relevant and appropriate services.

Article 3

An equally central principle is Article 3 of the Convention which states that in all actions affecting the child, the best interests of the child must be a primary consideration. While the Children Act embodies this principle—indeed it goes further, demanding that the child's interests are the paramount consideration—there is no comparable principle as yet incorporated into health legislation. Nevertheless, ratification of the Convention imposes a clear obligation under international law that governments and public authorities comply with its provisions. Giving primary consideration to the best interests of the child does have significant implications. It applies to decisions that affect the individual children—the nature of treatment, the decision to treat, and how that treatment is applied—but it also requires giving consideration to children's best interests within the services as a whole.¹³

Best interests of children as a body

If children's interests are to be a primary consideration in the broad provision of health services, then explicit consideration must be given to children in the allocation of budgets, the organisation of services, their inclusion in research programmes or indeed, the need to reduce waiting lists at government dictat. The failure to give children adequate priority is evident in the 1997 report of the Health Select Committee on health services for children and young people.¹⁴ It commented that:

- Children are given insufficient priority by policy makers and health service professionals
- Services are too often based on traditional practice or professional self interest
- Services are not always provided by appropriately educated and experienced staff
- Fragmentation between services is common
- Adolescent health needs are given insufficient priority and lack focus with poorly developed services
- Guidance on good practice is often not implemented.

Children do not have access to the powerful lobbies which influence public policy. They cannot vote, they can rarely advocate on their own behalf. It is too easy therefore for children's rights, needs, and interests to be swamped by more vociferous and influential voices. There is ample evidence of the sidelining of children. Despite the fact that we have one of the highest child road accidents rates in Europe, that children suffer disproportionately from the impact of environmental pollution, that rights to play and move freely are restricted by traffic volumes, the interests of the road transport lobby prevail. We appear to value our freedom to drive a car more highly than the health and safety of our children. We know, for example, that the proportion of expenditure on child and adolescent mental health services by health authorities represents on average around 5% of the total NHS mental health budget, although children under 18 represent 25% of the population.¹⁵ It may be, given the heavy call on these services by older people, that this represents an appropriate apportionment, but no attempt to date has been undertaken to analyse whether it does reflect a realistic balance of comparative need. Certainly, we know that child and adolescent mental health services are seriously underfunded in many parts of the country.

Best interests of children as individuals

In respect of actions affecting individual children, the Convention also requires that their best interests are a primary consideration. But how do we determine the best interests of the child? Traditionally, the best interests of the child have been defined in terms of what adults think best, and are too often used, in effect, to "trump" all other rights. In the name of the best interests of children, we have justified decisions, actions, and treatments of children which in retrospect we now consider unaccept-

able. Mothers were denied access to children in hospital, tonsillectomies were performed almost routinely, and disabled children were removed from their families and placed in long term institutional care. At different periods in history, and within different cultures, the perception of a child's best interests varies widely. So a commitment to its application does not provide us with simple answers to problems. Rather it should be a principle brought to bear in helping to ensure that the rights of children are properly respected. It should be applied as an underlying principle to help in the process of implementing the right of a child, or indeed, to help resolve a situation where there is a conflict between rights.¹⁶

Conclusion

The Convention on the Rights of the Child introduces two clear challenges to health professionals.

(1) *Advocating for children within the health service*—The Convention imposes obligations to ensure that its principles and standards are respected and promoted within the health service itself. This will necessitate analysis of the Convention as a holistic framework addressing rights to protection, to provision of high quality services, to active participation by children in matters that affect them. It will necessitate better collaboration with partners in education, housing, and social services to address the social factors impacting on child health. It means looking at the organisation of services, the allocation of budgets, the processes by which decisions are made to assess whether the interests of children have been given proper consideration. It means exploring ways in which children themselves can be enabled to influence decision making. It also means addressing professional practice to ensure that it does not itself violate any of these rights. For example, are there adequate policies on restraint and control of young patients, consistent with the right to respect for physical integrity? Are there adequate complaints mechanisms for children who have concerns over their treatment? Are children in psychiatric units treated without their consent and without the protections afforded by the Mental Health Act 1980? Are small children given appropriate access to pain relief?

(2) *Advocating for children outside the health service*—A significant proportion of the resources of the health service are directed to repairing the damage to children caused by social and economic factors which can only be prevented by decisions and actions well beyond the scope of health professionals. Paediatricians and other health professionals have an enormous body of knowledge pertaining to the impact of public policy on children's lives. It is they who treat the devastating physical consequences of poverty and disadvantage—whether it be the consequences of inadequate diet, poor housing and homelessness, access to drugs and alcohol, early pregnancy, depressed and inad-

equated parenting. It is they who have evidence of inequality of access to services—the difficulties facing homeless families, or those who do not have English as a first language, refugees and asylum seekers, children in prisons in getting the treatment they require. It is they who treat the children whose health is harmed by the priority given to the transport lobby. Paediatricians, then, have a clear responsibility to advocate on behalf of children for the necessary social, economic, and political changes to guarantee them access to the best possible health.

There are competing calls on public priorities. Children are not the only group in society with unmet needs and rights. However, they are deserving of high priority for principled and instrumental reasons. Without the vote and access to the arenas where decisions are made, children's rights have and will consistently be disregarded, unless adults are prepared to advocate on their behalf and create avenues through which children can be heard in their own right. Investment in children now is probably the most effective strategy for ensuring a stable, humane, democratic, and economically sound society of the future. The challenge rests with those who are committed to respecting children's rights and have the information and power to make a difference.

Respect for children's rights cannot be perceived as an option, as a question of favour or kindness to children, or as an expression of charity. Children's rights generate obligations and responsibilities that must be honoured.¹⁷

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- 17 Pais MS. *A human rights conceptual framework*. Florence: UNICEF, 1999.