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Letter from the Editor

Dear Colleague,

Here at last is the third edition of our "JOURNAL OF ADOLESCENT HEALTH AND WELFARE". It is again undersized compared with what we would like and the Winter edition will be the same. Unfortunately production costs continue to plague us. We have reduced these to a minimum in that all the editing, typing, art work and typesetting is done in the YOUTH SUPPORT office. The big cost is the actual printing which works out at £500 per issue for the full sized 24 page journal. This we currently cannot afford. In fact so many people have failed to pay their 1988/89 subscriptions that there may not be a spring 1989 edition unless everyone pays up.

We have a number of articles which have been held over until future issues due to the shortening of this edition, please bear with us. If we can get all the subs in I can assure you some very interesting pieces in the coming year. We are hoping to have a regular book review page and would like feedback from members on suggestions for reviews. Also we would like to print letters in a correspondence section because this will bring the association alive.

One other initiative which we would like to try out is the inclusion of pieces by young people. We frequently in YOUTH SUPPORT have requests by schools and teenagers to provide material for projects etc and It would be nice to include parts of these, also I thought it would be interesting to get the young people's views on how they see matters such as the way they are taught about sex education etc. Perhaps members could think about obtaining such material from young clients?

The Forum had a very succesful meeting at the Royal Society of medicine again in October although the numbers were considerably down. This was partly due to the postal strike but still somewhat disappointing particularly since we were on this occasion sponsored by WYETH and we are very grateful to them for their support. The speakers were excellent and the session was very ably chaired by Audrey LLewellyn. Audrey has been involved with Youth Support since our inception. She has wide experience of the health service in London having worked in both Camberwell and West Lambeth health authorities in the health visiting and school health fields and also has links with education. I very much regretted that illness prevented me from attending the meeting but I passed several fascinating hours listening to the recording of the meeting when I edited the transcript for inclusion in the journal.

We will have annual meetings in GLASGOW on about the 23rd of JUNE and LONDON on about the 20th OCTOBER. Please bear these in mind and make every effort to attend. Exact dates will be circulated nearer the time. Thank you for your support and I hope you enjoy the journal.

Dr Diana Birch MBBS DCH MRCP MD
Director "YOUTH SUPPORT".

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APPLICATION FOR MEMBERSHIP OF THE "YOUTH SUPPORT" "FORUM ON ADOLESCENT HEALTH AND WELFARE"

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Teenage Suicide DR ERIC TAYLOR

(A.L.) Eric Taylor is based at the Institute of Psychiatry and the Maudsley hospital London. He is well known for his work in the department of adolescent psychiatry and has been a supporter of the concept of 'Walk in counselling' for teenagers.

* * * * *

I will be talking about teenagers who kill themselves and who make gestures to harm themselves and injure themselves. Talking about whether we need to think of an epidemic, what kind of problem it is, talking a little bit about the research which has been done which is mostly clinical and descriptive research about the kind of problems which suicidal teenagers show. and to try to say something about that and the characteristics from a series of overdoses that I have seen about how one might go about preventing and reducing the rates.

Suicide is one of the major causes of death in young people, currently I think it is third in this country, following accidents and cancer. In recent years the rates have been slowly but steadily rising. The rate has constantly risen in girls reaching a level in terms of deaths of about one in 20,000 young people actually doing it. This is quite dissapointing because this steady rise has been coming at a time when for most age groups and for most adults the rates of suicide have actually been falling - for boys there was a fall in rates during the early seventies which was probably related to the detoxification of north sea gas, there was quite a marked fall in deaths attributable to gas during this period. So it is probably emphasising one point, which is that as you remove one means of suicide, as you restrict access to it, then you do see corresponding dips in the rates of suicide. So preventive and public health measures which seem very crude and not affecting the adjustment of the individual do show an effect in this way.

It is been at a time as I say that general suicide rates are falling and while not wishing to engender shock and horror, this is an indication that we are not serving our young people adequately.

By contrast we have the rates for attempted suicide, which is largely overdosing - this has been increasing very rapidly and the female /male ratio has been closing due to the increase in male suicide attempts. This is very worrying not only because these are not all medically trivial, we are now talking about something like one in 200 of young people who are actually getting to the point when they are being admitted after a self injuring event. If you come up to the rates of young people who think about suicide who will say when asked in a survey "have you ever felt so low that you thought about ending it all, felt so bad that you seriously thought about killing yourself?" - then thats now about 1 in 20 who have that level of agonising thought.

1	in 20	serious suicidal thoughts
1	in 100	suicidal
1	in 200	self injuring attempts

It is however important to realise that of the 1 in 200 who make attempts in this way about 20% will die by suicide over the next five years. So you are very much at risk, once you have made an atempt both for further self injuring attempts and for completed suicide.

It is not as a matter of fact the first epidemic in history. There have been previous ones. Thomas Chatterton who lived not far from here 200 years ago, died at 17, took arsenic in his garret and bequeathed a kind of legacy of the young man whose genius would be corrupted if he continued to live in the world and that time of the late 1700s was a time of a great epidemic of suicides and suicide of young people particularly. Everyone was worried about it. People were gathering in little groups like this all over Europe discussing what they should do about it and there was a book also, Goete wrote the stories of ..... in which the hero shoots himself and that book became a sort of bible for imitators and all the clergy were blaming it for the suicides.

That epidemic which happened in the seventeen hundreds points up two things, one is the importance of cultural, self reproducing things, so that you get waves of imitative suicides going on, the other is that this was a time when there was a great rise in psychotropic drug use, Laudunum and opium preparations were being very widely used, in the same way that the tranquillisers and antidepressants are very widely used now. So then as now, there was a blurring of the gap between the medicine that treated you and the poison that injured you.

The attempts that have beeen made to research young poples problems and what leads to this, have mainly taken groups of young people who have taken overdoses and compared them with groups of 'normal' young people of the same age. When this has been done it has shown up that in many ways they are not by any means a normal group and I do not expect that I have to labour that point in this audience. But there is sometimes a feeling which is often expressed in medical circles, that

young people who are killing themselves are rather emotionally overindulgent and that they are only under minor stress, that it is a difficulty of lifestyle and communication , within a network of people who do it. I do want to stress that results of research show how common family disturbances are, in comparison with normals, how common it is for children to have been in care of the local authority when they come to poison themselves later, how more of them have ill health and have contacted their family doctors in the weeks before overdose - a survey in Oxford by Thornton showed that this was as high as 50% had seen their doctors in the week before an attempt - I find it very much less in Camberwell but I think that it reflects that Camberwell has lesser helping behaviour towards doctors than Oxford. I mentioned the future for overdoses, in the best long term follow up study, which was Scandinavian, more future suicide and more future marriage problems.

All these things would I suppose characterise most disturbed groups of teenagers, but one could ask "Is there anything specific which characterises groups of suicidal teenagers?" Is THer any specific ways of showing stress. I did a survey of young people still at school who had injured themselvesa dn compared them with a group of Camberwell teenagers who had been referred with other psychiatric problems eg depressed, obsessional, anorexic. Compared with them the overdosing population were in a lot of trouble - even more than psychiatric populations. They come from disturbed families with the striking things being lack of warmth, neglect, disturbed relationships with father, and 20% of them had been on at risk registers in early childhood - there is a strikinh relationship between being hurt as a child and harming yourself. Also children coming out of care in the teenage years are very much prone to be taking this kind of resort. More of them are depressed, more are running away and in the follow up so far more have taken overdoses than the psychiatric cases.

What one also needs to know, is what are the differences between the overdoses and those who actually complete suicide?. One of the important things to know is how seriously do you take this young person, how do you know whether they will make another attempt, who is actually going to kill themselves? Out of those who try it , who is going to complete? One of the alarming things is that when you compare the people who have attempted suicide with those who have completed suicide, then in many respects the profile is similar. There are some differences - those who complete suicide are more likely to be male and that goes with the fact that when boys do it, they are more likely to choose a violent method, they are much more likely to jump out of a window or try hanging themselves, they are much more likely to use those very lethal methods rather than the simple overdoses with a rather better outcome when only 1 in 100 are actually fatal. People who complete suicide tend to be brighter than those who attempt it and do not succeed, they tend to be taller too in some studies, although I don't know quite what to make of that. I think the strong theme that comes through is less determined planning in the people who don't kill themselves but the actual precipitants of the attempts, the actual things which make people try are very similar in both groups. So that when one does psychological post mortems, after inquests, go round and try to find out what it was upsetting that case, how they had done it - whether they had shown problems before hand, the precipitants are very often not gross dreadful things, they are he sort of things that strike an unsympathetic adult observer as being relatively minor stresses the commonest being a disciplinary crisis, a row at home, somtimes about going to school. The same kind of precipitants which tend to precipitate the non fatal overdoses. So while the best guide of who is going to do it is the degree of determination, how strong death is in their mind, and how prepared they are to plan about it; that is a rather tenuous way to predict who is going to do it and I think that in present knowledge one has to reckon that all those who are taking overdoses are at risk for completing suicide, those who are most at risk of completing are those with long standing problems which I guess is not surprising and those who are involved in antisocial behaviour as well as the depression.

So Various bits of research build up a profile of the young person who is going to try it and I want to try and flesh that out by telling you about the motives of a group of teenagers who I have seen. One very common motive was the idea of death of actually wanting to die, so it is not by any means all those who overdose who have the idea of death in their mind. It is only a minority but a substantial minority, this is the group which is most depressed, which is most despairing, in the situation that they are in, so a worryingly high proportion of people will give this as their motive. The largest single category is what I have called manipulating. That is not what the young people would call it but it is trying to get someone else to do something. It is trying to make parents behave in a different way or to make a boyfriend behave in a different way. A lot see this as escaping from problems - something rather like running away, a temporary oblivion. A very few say that they have done it because they want help, really very few, and in some ways it is not a very easy thing for a teenager to say, not a very natural thing to say that they want adult help. It is not the way they think. If you ask a group of teenagers 'what do you do if you are

desperate?' then overwhelmingly the commonest answer is that they would do something practical about it, that they would change the situation; then coming after that there is seeking help from a friend and after that is seeking help from a professional of some sort perhaps a school counsellor or someone that they have known before, and well after that is seeking help from a parent. Bottom of all is seeking help from a doctor or psychiatrist which is salutory. When doctors assess young people after the overdose they often say that the suicide attempt is because they want help from a doctor or want to speak to a doctor, this is not true, this is not the way that young people see it and of course for some people there is a blur between drug abuse and taking a drug for overdose reasons. Another reason for overdosing is when someone else has made them do it, for instance one girl who was made to take an overdose by her mother as a disciplinary procedure!

The precipitants, and that is the immediate thing that comes before it, in the months before an overdose, is often quite substantial, loss of a relative means basically a parent leaving home; either because of the start of a long illness or the start of mental illness or because of a family breakup, family arguments are a common cause and outside the family, rows with boyfriends and so on, but that is a minority. Most is related therefore to a discord within the family in what young people say.

In the long term background there is a high incidence of a parent being psychiatrically ill and then as we have mentioned, there is the previous high rate of physical abuse. There would appear to be a low incidence of sexual abuse in the past history, but this is probably just a matter of not saying it, not reporting it. If one puts together all the factors, physical abuse, family breakdown and poor relationship with the father then all these are also pointers to sexual abuse, so it may also be that the suicide attempt comes out of 'not saying it'. Thus altering the dynamic of taking the overdose in the first place, taking a different route. Young people who do this are a very difficult group to handle they are difficult to engage in treatment.

So how might one prevent overdosing. As I have said, in other parts of the country, other than Camberwell there is the initial contact with the GP, contact with social services is also high, psychiatry you may as well forget. It does not look as if psychiatric services organised ordinarily is going to be very helpful in preventing suicide attempts and in my group it was striking that none of them had ever heard of the Samaritans, although of course the Samaritans are reporting increasing use of their services by young people. That is one possible way of consciousness raising and I think that since my study there has been more publicity with regard to Samaritans.

Still thinking about how one might prevent it, there is the aspect of how do they take the tablets? I did say that if you detoxify Gas you get a fall in gas related suicides and is there anything one could do simply to restrict access to the medications? Almost all of them were taken from the family store, the bathroom cabinet, nearly always something that had been prescribed for a parent, very infrequently was it something prescribed for them so getting at prescribing practices of doctors in the sense of getting them to prescribe less is unlikely to help. Buying from the chemist is a route and it may weell be that if there was less in the bathroom cabinet, more would buy from the chemist but it obviously is very accessible. It is a consideration, perhaps in secondary prevention to go and empty the bathroom cabinet and make sure that the dangerous substances are not kept ready because the impulsiveness of the overdoses is also striking, so that not many of them have thought about it for more than two hours before thay take it. In going back and looking at it, they have often thought about it before, it is not impulsive in that sense. They have very often formed the intention of doing it, but at the actual play, it is acted upon quickly, as of course so many teenage decisions are. This is a problem for prevention but also gives an avenue for prevention because you dont have very much time so anything that slows up the access between forming the impulse and the actual deed would be very helpful in providing an alternative expression of feelings.

In terms of secondary prevention, there is not a lot of evaluation of what you can do. Perhaps the best evaluation is the American attempts to make suicide prevention centres which are basically walk in centres and comparing the states where they do not have prevention centres with those that do. What they have shown over time, in centres where they do have centres is that the rates, especially for young women, have fallen, in the others they have risen. This is fairly good evidence that that sort of easy access centre can play an important contribution. I think myself that it is a mistake to call them suicide centres because theres something unattractive about saying that you can only get help if you are suicidal. It encourages the demonstration of distress in that particular way. I would like to see it much more in terms of easy access services generally walk in services, ones that use the more natural help seeking behaviour of young people which is to contact people of their own age or to contact people who they have known anyway, as for instance would be he case for a centre in a school so that using the kind of services which they would use rather than the tertiary, psychiatrically based

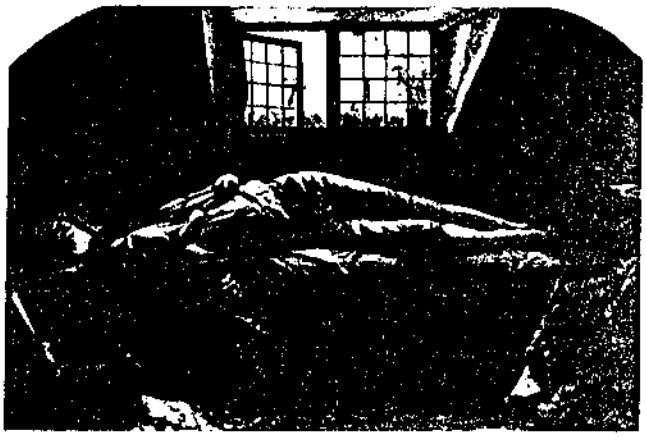
services which do not really meet their needs and are perhaps rather stiff and inflexible. We do have an open access service at the Maudsley but it is not really the right thing because there is a tremendous barrier in walking into a psychiatric hospital.

I have found that of the young people who have been seen on the ward after an overdose, about 50% will come back to keep their follow up appointment. These are often the most depressed, the ones in most despair and those most in need of counselling. The counselling may be conducted by a well trained member of any of the helping disciplines, there are not necessarily definite medical aspects to this although in America there has been a vogue for using antidepressants with young people who have overdosed. This has not been popular here, not even for treating the more depressed suicidal people, let alone those who are less depressed and who are overdosing for different reasons. The cases that I feel best about are those families where I have managed to rally family members around the young person and to impress upon them the seriousness of what has happened. To stress not to let families put up the shutters and forget what has happened, but to emphasise hard the dangerousness and the seriousness of what has happened because I think that for those who improve and for those for whom the overdose is an experience which changes things as it is for quite a lot, they are people for whom there has been successful communication. It has opened up avenues of communicating with people who are close to them, with family members who were not being used before and I think that is something very important to be emphasised in the counselling, to provide not something which competes with the family ties but something which can strengthen communications between the child and the people who would be enduring supports for them.

QUESTIONSand DISCUSSION

FAY HUTCHINSON (Brook advisory) - In my role as an 'agony aunt' for a teenage magazine I looked at 1,000 letters which I had received and about 40% of them were basically depression and what came across very definitely in these letters was their lack of self worth and that is certainly something which one feels powerless to do anything about particularly in the letter writing situation although it is such a common presentation.
ERIC TAYLOR - I agree with that - it is often something which is not really recognised because adults who are near young people ar very slow to realise how depressed young people are. It is something which provides the greatest discrepancy between what the parents say and what the young people say. I have said that 5% have very serious thoughts of suicide to the point of clear determination to do it - that is very much higher than what parents say, if you ask parents about those very same people then only about 1 in 10 of those young people will have those feelings known about by their parents. I found myself in the same position in that with the young people that I was assessing in the study, these in the overdose group were showing symptoms of depression and were much more depressed than the psychiatric group but this was not coming through as my initial diagnosis. So that means that I also, as is common, was defending myself against recognising how distressed young people are. One of the difficulties of a counselling service is to help those delivering the service to perceive the distress of young people and not to use the defence of adults of protecting themselves against it by saying 'It's not that bad", "You are not under that much of a stress', "You are not that seriously distressed". I just think that you can't fool yourself that way.

Dr WALKER (SCMO community child health) - I interview quite a number of children in my work. I wonder how can I recognise depression in these children? I ask this particularly because so many of the symptoms and complaints that they have are very confusing, is there any way that you think you can separate those who may need further help from those who don't?
ERIC TAYLOR - I think that you do pick up young people by asking them. You do have to make it easy for them to answer and you have to introduce it making sure that you use the same language. By making some generalised framing remark that many young people feel very low sometimes, what is it like for you when you get like that? and then to go through with the follow questions on the intensity of it. "Do you feel like running away?','Do you sit and cry?';"Have you ever run away?" "Do you ever feel that life is just not worth living?"."Do you ever feel it would be better if you were dead, have you ever tried to kill yourself?". Those rather blunt direct questions are often very much appreciated and they do have quite a high yield in bringing out the problems in the teenagers. The type of depression that one sees is not the type with marked vegetative symptoms therefore it often does not help to ask the kind of questions that one would ask to adults such as relating to sleep and eating disturbance, often young people sleep more and eat more when depressed. One is looking more for the feelings, the deep feeling of hopelessness and asking "Do you think this can change?, do you think anything can alter it? Could anything help?" because the worrying thing is that combination of being depressed and being hopeless about it. Even more important than depression is that



Wallis The Death of Chatterton

hopelessness that goes with suicidalness.

GEOFF BALL (Youth Support) - Is there any effect of attainment of goals on suicide, in other words, Is there any link between exam failure and suicide or job starting and suicide and does the effect of the young person starting a job mean that they are less likely to attempt suicide than one going on into higher education?
ERIC TAYLOR - In general people who do go on to higher education are less likely to kill themselves than those who do not. I know that this is going against all the stereotypes of young students killing themselves and it is true that at Oxford and Cambridge they do have very high suicide rates but I think that is local to those two Universities I think it is a combination of very high pressure on those young people and rudimentary counselling facilities. So apart from those two Universities, on the whole it is not students at all who are at risk. One of the stresses that push people over the brink and trigger suicide attempts is exam stress, but this is at the end of much longer lasting stress and lack of support and this is only in the minority, it is not as common a trigger as things about personal relationships. In the papers recently there was a big thing about exam stress and how the new GCSE exams would increase the suicide rates but I do not believe that there was an increase, this is not the usual factor, I would have been more concerned that the newspaper campaigns themselves would have increased it. So it is one cause of stress but I would not want to inflate it and in thinking of suicide prevention it is not right to focus on students primarily. They are the groups that get all the services, the student health services, but they are not the groups that need it most.

GEOFF BALL - As regards the Camberwell area, there are marked differences between the more affluent Dulwich end and the poorer Peckham end, does this make a difference?
ERIC TAYLOR - Social class does not go very strongly with it, you can be as neglected in Dulwich as you can be in Peckham.
QUESTION - You mention that overdose was the method of suicide - are the other methods such as hanging very rare?
ERIC TAYLOR - Well the more violent methods are of course more dangerous so they figure more frequently in the deaths from suicide than in the attempts and boys use these more often. 95% of self harming events are overdoses but they are less common in young men who if they are going to use a softer method will use the exhaust of a car, inhaling exhaust. Most commonly however are the tablet overdoses but these can be very dangerous, depending on the drug. If it happens to be that tricyclic antidepressants are in the bathroom cupboard, or paracetamol, then they are in trouble.

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"The Legal Rights of Teenagers" PETER NEWELL

(A.L.) Peter Newell is from the children's legal centre. The children's legal centre opened in 1981. It is an independant organisation concerned with law and policy affecting children and young people in England and Wales. It Aims to promote the recognition of children and young people as individuals participating fully in all the decisions which affect their lives. - This sentiment is precisely what YOUTH SUPPORT is all about - Peter Newell was on the steering committe which produced the Health Advisory Service report on services for adolescents, being responsible for the section on ethical and legal issues. Tonight he is going to speak to us about the complex problem of the legal rights of 'teenagers'

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The idea of covering teenagers legal rights in 20 minutes is probably a fair comment on the extent of their rights but it is fairly inadequate as time to try to cover the issues involved. I am going to deal with general issues first and then go over three issues in rather more detail. It has been I think really quite an exciting summer and indeed autumn for young people's rights. The general emphasis of the Cleveland inquiry report was certainly very much in favour of treating children as people and not objects of concern and in fact the legal centre can claim the copyright on that remark - it was in our own submission to the Cleveland inquiry and was picked up by Lord Justice Butler- Schloss.

It does in a way encapsulate much of what I want to talk about and the further emphasis in that report on always consulting the child, always taking seriously what children say, to respect their rights to consent or withold consent when they have legal rights to do so and also to be consulted not only with regard to consenting to medical examination but also things like video techniques and to treat them properly when we are talking to them and interviewing them and not to subject them to the sort of interrogations which we would not regard as propper or acceptable if they were being used on alleged criminals by the police. It was a very positive document although I would comment on a number of things which are missing if one carries through the logic of its basic philosophy. For instance, when it talks about consulting children and taking their views seriously, it does not say anything about involving them in all the key meetings at which decisions are made about action or in this case child abuse and to me that is a perfectly logical development that children should, as they grow older and have the capacity to understand, to be fully involved in decision making which is going to affect them least as much as anyone else.

Then immediately after the Cleveland report came a report from the Law commission on private children's law and this too was very much about children's rights, that childrens opinions should be reported to thje courts that are making decisions that will affect their lives. The court should always be able to make children parties to the procedure, obviously in some proceedings, such as care proceedings, children are parties but in many other cases such as custody hearings children are not parties and very often their views are not reported to the court at all.

The law commission also proposes that children should be able to make approaches to court themselves if they feel that things are not right and that they feel could be put right by some kind of legal action. Perhaps most significantly it argues that for 16 and 17 year olds at least it is wrong that the courts should make orders about issues like custody and access, that in fact at the age of 16 one should consider that they can make such decisions for themselves about who they live with, who they have access to and so on, while they leave it open for the exceptional circumstance which might arise which may make it appropriate for a court to intervene but the general principle is there that at least from the age of 16 there should be self determination.

I think we really have got to the point that in many services it is accepted that people must consult children and take their views into account if decisions are being made about them. Of course in some areas of law this has been the principle for some time, care authorities duty section 18 of the child care act to ascertain as far as practical young people's wishes and feelings about any decision that the care authority is making and give them due consideration according to age and understanding. That is a very civilised attitude, unfortunately it is quite often completely ignored.

On the other hand it has on occasion led to legal action by young people that has for example stopped the closure of children's homes where the authority had omitted to consult all the children affected by the closure. Unfortunately in both the cases that went to court the authority then consulted the children and then went ahead with the closures. So in the long run it did not make any difference and that is because the principal is just about consultation there is no serious consideration of when self determination for young people should start.

I think in terms of the general things which I want to say is about something which has happened in the last few weeks and that is a positive revolution within the large child welfare agencies. I dont know whethjer you noticed, you can't have missed what happened at Barnardo's last week, but before that the children's society was entirely changing it's image and it's logo. It had a logo which had a protective circle around some silhouetted children and it was removing the protective circle as being an old fashioned image. Then the NSPCC (National Society for the Prevention of Cruelty to Children) brought out their future agenda, they produced an agenda for the coming year called "Children First" which contained really a resume of the Cleveland report including taking children seriously and it was launched, in contrast to the usual images the NSPCC uses to raise money, with a child with a very happy positive smiling face. Of course Barnardo's has decided to drop the doctor (Dr Barnardo's) and they have also changed their logo and their image in a way which I think is very positive and I think it would be true to say that the image projected by these large organisations over the years in order to get money to run services have done an awful lot to cement the image of the child as an object of concern rather than the more positive image of a child as a person with feelings fears and so on. Of course time will tell whether the British public is ready for that image of the child and whether that image will touch and loosen their purse strings in the way that the other sorts of images did.

It will also be interesting to see whether some of the National disability organisations adopt the image and follow suit and drop the to me anyway quite offensive images that they are still using to raise money.

Finally in this context of the establishment of children's and young people's rights, there are two other things happening on an international scale, firstly the drafting of a very detailed United Nations convention of children's rights to replace the rather brief and polemical declaration of the Human rights which was accepted in 1959. That process is almost complete and in fact the group are hoping that the convention will get to the UN and be adopted some time in the next year which will be 30 years from the date of the 1959 convention. It has some important points in it and while I do not have time to go through it in detail, one of them is that children's views should always be ascertained when judicial and administrative moves are being made. The British Government held an interdepartmental meeting a few weeks ago to go through the convention and find out if any of the departments had any concerns about the articles or difficulties in being able to ratify them and apparently several departments noticed, that it is probably the department of education which will have the most difficulty with that article because at the moment educaton law has no principal of consultation of children or young people whatsoever in it an indeed the 86 act removed the possibility of student or pupil governors of schools and of course the national curriculum will do a great deal to remove choice for pupils at all levels. So unless our education law changes to be able to insist on consulting children an young people when educational decisions are made, there are going to be difficulties in ratifying that particular article.

Nevertheless the idea of a detailed international standard in children's rights is I think a very important and exciting one. Also the first steps are being taken at the moment towards the drafting of a european convention on children's rights and that , if it ever comes off is more likely to be an enforceable convention like the human rights convention, which applies to everyone whatever their age, has allready of course, had quite a significant effect on the rights of people and children in this country. Corporal punishment in school certainly would not have been abolished in schools had there not been cases before the european commission and the court suggested that at least parents wishes must be obeyed - well that is not really a children's rights principle but they were beginning to get to the point of saying that at school corporal punishment is actually an inhuman or degrading punishment.

We at the legal centre have threatened to take cases to Europe in two particular areas and in both cases it had a useful effect. I am not claiming that it was the only thing that led to changes but it certainly helped. First of all in persuading the government that they must introduce a fair hearing for children and people who are locked up in secure accomodation in the child care system, as you probably know, until 1983, young people could be locked up if they were in care by anadministrative decision without any sort of judicial test of that whatsoever and that was a very obvious breach of one of the articles of the human rights convention. It is still the case unfortunately that wards of court can be locked up in secure accomodation without any sort of hearing at which they are directly represented, there are quite a number of wards of court held in this way and we have made it clear to the government that if a case comes to us we would take that to Europe immediately.

The other area was over the right to education, to any education rights at all for children with severe learning difficulties in Northern Ireland. While in this country children with severe learning difficulties gained a right to education back in 1971 and in Scotland in 1975, in Northern

Ireland the law has only just changed and until extremely recently, parents of children with severe learning difficulties were getting letters, as they came up for school age saying that they had been assessed as unsuitable for education. So there again threatening a case, and we actually drafted that one and put it in, persuaded the government that they really must act.

Now I am going to mention just three areas of particular concern to me. The first is the need of children who find themselves in residential settings to have much more detailed and consistent legal safeguards. Including ready access to well publicised complaints procedures, and some sort of way of enforcing their rights to basic protection and basic standards of care for them. I am sure you all know that there is a remarkable veriety of categories of institutions for children and young people which particularly those who are described as being to some extent disturbed, can find themselves in by run by health, care, voluntary organisations and private organisations for profit. They have different sets of regulations applying to some of them. A lot of them are currently under review by the DHSS. Private childrens homes, homes run for profit, are completely unregulated still, in fact the law exists to enable them to be regulated but has not been brought into effect. To take one topic of interest to us, corporal punishment again, there is only one category of accomodation where the DHSS has moved to prohibit use of corporal punishment and that is residential care homes, which are mainly used for elderly people but do contain quite a lot of children with disabilities. They have promised regulations to cover the various categories of childrens homes but so far they have been very resistant to the idea of including detailed protection against corporal punishment and othef forms of undesirable punishment in mental homes and nursing mental homes. I think that this is because the health side of the DHSS are very resistant to any sort of limitations and there are no regulations, as you know that apply to care within NHS provision.

The category of nursing home and mental nursing home covers some private hospitals some of which have a great number of young people in them and there are also places run by multinational private companies, one particularly for teenagers and I think there are plans for more. They come under the category of nursing home although obviously they are providing not only nursing care but other services. It seems to us particularly important, as some of them are providing 'security', restriction of liberty, that they should be fully regulated very frequently inspected and so on.

Restriction of liberty is now controlled quite carefully for children in care but again we are concerned about patients described as informal patients and the vast majority are children and young people who are in effect detained in hospitals and units are there in fact as informal patients. The number of young people who are sectioned under the mental health act is tiny but there are very many informal patients who have none of the protections afforded to sectioned patients in units and hospitals throughout he country. On that issue there is an interesting case before the human rights commissioners at the moment, a 12 year old boy in Denmark has taken his case to Europe. He was placed in a psychiatric hospital by his mother, his parents split up, he wanted to live with his father, his mother got custody and did not want him to live with his father, he ran away a few times, she placed him in a psychiatric hospital. He made an application to the European commission alleging wrongful detention. It has got past the major hurdle - it was declared admissible by the commission some time ago, they then go through a process of trying to reach a friendly settlement beteen he boy and the country, Denmark. That failed and it is now going to the court for judgement. I think the result of that case may have a lot of implications for the sort of placement of young people that parents can make without it becoming a serous intrusion on the right of the child or young person. Obviously the child goes into hospital on the parents say so for treatment all the time, but if a child is being placed in what amounts to detention in a psychiatric unit solely because their parent has asked and a medical practitioner has agreed then I think that raises fundamental civil liberty issues.

The second issue I would like to say something about is consent. The here the legal position is that from their sixteenth birthdays young people have adult rights to consent or to withold consent under the family law format. Under 16, the situation is as I am sure you all know, as stated in the judgement of the Gillick case in the house of Lords. This briefly stated that if a child has the understanding and the intelligence to make the decision then they have an independant right to consent for themselves. THat right has been confirmed very positively in the Cleveland report and also in the guidance from the home office to the police on the investigation of child sexual abuse and I think it is becoming fairly widely accepted. We still have had cases over the last few months of young people who clearly had the intelligence and understanding but were still being examined with no question of consent being raised at all.

Finally and perhaps most controversially, the concept of confidentiality. The rights of the young person to their own confidentiality, to have their confidences respected when they go to a professional or indeed anyone else to talk about

something that is concerning them. Here Cleveland and the report has not been at all helpful. Cleveland reports that there is no easy solution to this problem and there is no recommendation there.

The General Medical Council has I think gone overboard in advising doctors in one of their annual reports that if a doctor hears any suggestion or allegation of child abuse physical or sexual tha they have a duty to pass that information on to other agencies. That is a matter for concern and we have raised this with the GMC who are considering what we have said. The guidelines for doctors dealing with child abuse contains a section prepared by the defence organisations which includes a section on confidentiality, it says that from the age of 16 young people have rights to consent and would also have rights to confidentiality like adult patients. but unfortunately the advice says nothing about htat substantial group of young people under tha age of 16 who would, under the Gillick ruling, be regarded as having rights to control their own treatment - but do they or don't they have the right to confidentiality?

Outside the medical profession I think that because of the growth of concern about child abuse in particular there seems to be a misinformed belief that there is a duty to simply pass on information about child abuse and other things that children may tell one, you can see it reflected in the circular to teachers.

While obviously there are extreme circumstance in which I believe all of us would decide to breach the confidentiality of a young person or adult, there are agencies that very strictly adhere to confidentiality even if this places the client in immediate danger, that is not a policy which I personally could work with but I think it important that anyone who works with young people should think about this issue and decide what their position is and they should let the young people they work with know what their policy is.

If we want professional services to be useful and utilised by young people and if we want them to come to us when things are difficult or when they are hurting, then it is vital that we should, whenever possible offer them confidentiality. I use the phrase 'whenever possible' and I think that let out must be very carefully and precisely defined if it is going to be useful. Yes there may be exceptional circumstances and yes there are difficulties about ascertaining the degree of understanding and maturity of the young person but it is better that one should confront those complications than that one should go overboard on a policy of sharing information that is going to make many professional services even less acceptable to children and young people than they are at the moment.

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Notes from letters

Exploring Parenthood Carolyn Douglas, family therapist, wrote to us earlier this year. I reproduce here parts of her letter.. "I recall your organisation being established and thinking what an important service you were to provide .... Exploring parenthood is a practice based organisation serving arents, whoever they are, wherever they are in the country. We are very much committed to providing a service to parents of adolescents and indeed offer a small group in our workshops frequently for such parents. However our experience is that, just as other services for adolescents are demanded and then undersubscribed, we often have difficulty getting a quorum for such a group...".

Dr John McEwan of the Brook Advisory Board has joined the forum and wrote "I think this is an exciting new development and once again congratulate you on oyur enterprise".

We also continue to receive encouragement from our colleagues in Australia, particularly Dr Murray Williams who writes "I wish you well with your search for members - I have the same problems!. I don't know what the answer is on an international level. Clearly the IAAH (International Association of Adolescent Health) needs to establish itself as an organisation representing national organisations, with provision for individual members - we are moving that way, now that national bodies are beginning to declare themselves but I don't know that there are yet enough to ensure support and viability".

Benefits? In April 1988 the government introduced major changes to the social security benefits system which profoundly affected children and young people. Many of the benefit changes have been poorly publicised and difficult to fathom. The result being that benefit clerks in some areas have been reported as denying money to young people on the basis that nobody was really sure what their entitlements were.
These matters are of concern to the 'Child Poverty Action Group' (CPAG) which is pressing for reform. To quote from their fact sheet "CPAG is a national charity which was founded in 1965 to promote action for the relief of poverty among children and families with children. CPAG has been in existence for over two decades. Yet today, with millions of people living below the poverty line, we believe that our work is more powerful than ever" (CPAG 1 Bath Street, London EC1 9PY). YOUTH SUPPORT has joined CPAG in order to be better informed of benefit changes affecting our young clients.
Figures released in July this year showed that in 1985 74% of children (1,090,000) in one parent families and 23% of children (2,460,000) in two parent families were living in poverty (Hansard, house of Commons 15.7.88 column 384). Despite this shameful situation, social security payments were cut and the way of allocating state aid changed with detrimental affect on the young. It is now much more difficult to obtain free meals in schools, some state aid has been replaced by loans and benefits to young people are paid at a lower rate. For instance young unemployed people under the age of 25 are paid at a lower rate than older unemployed people and young mothers under the age of 18 are forced to raise their children on less state aid than older mothers.

Youth unemployment (under 25) now stands at 32% of the total level of unemployment but the manner in which unemployment is calculated has been altered 24 times between 1979 and 1988! (Department of Employment Gazette march 1988) Since September it has become technically impossible to be an unemployed school leaver. The government has stated that a YTS "Youth training scheme" place will be available to all school leavers, hence there is no need for any 16 or 17 year old to be unemployed. It should be noted that the "pay" for the first year of YTS is £29.50 per week rising to the dizzy heights of £35 for the second year.

Recruitment Drive Any ideas? So far we have recruited members mainly on a word of mouth basis. Advertisements in professional journals have so far had a poor response, particularly from the medical profession. Our drive to recruit paediatricians was disappointing with only four replies to 2,200 leaflets! Hopefully this will improve. Teachers and social workers seem keen to join us but we are in need of ideas as to how to reach them and how to publicise the forum. Please write in with ideas. We are just producing a new leaflet, would members please let us know if they are willing to circulate leaflets to their colleagues? Handing out leaflets is much more effective than sending them by post when there is a danger of them being dumped with the mountain of junk mail which arrives every day.

Self Esteem This is a subject which is coming up over and over again in our discussions as to whether teenagers with low self esteem are more likely to be getting into difficulties with sexuality etc. YOUTH SUPPORT are currently conducting a piece of research into self esteem in teenagers who have early pregnancies or early sexual experiences. We will probably have to limit our survey to girls at first but may then extend to boys. If anyone would like to cooperate with this survey we would be very pleased to hear from you. It involves asking teenagers to complete a very simple one page questionnaire by ticking yes or no answers. This is then returned to us anonymously accompanied by a short history sheet completed by the professional involved. In this the referrer will be asked the age of the teenager and will then tick which of a list of factors (eg lack of parent, in care, history of abuse, early pregnancy etc) are known to have occurred in this young person's life. Of course not all teenagers in the survey will be those perceived to have a problem of some nature, we need comparable data on happy, untroubled adolescents too for control purposes (even our own children!). We will accept referrals from any professional group, social worker, teacher, midwife, GP, hospital or community doctor or midwife etc. Age limits are 10 - 18yrs. If you wish to participate please write soon to the YOUTH SUPPORT office or leave a message on 01- 659 3309. We look forward to hearing from you.