



**THE VOICE of THE CHILD MUST  
PERMEATE  
INFORM & INSPIRE OUR  
COLLECTIVE  
ENDEAVOURS**



**THE CHILDREN of 2030 ARE BEING  
BORN TODAY.  
THEY ARE the FUTURE LEADERS  
of TOMORROW**

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**In collaboration with members of the NHS Youth Forum**

**Illustrated by Beci Ward**

**Edited by Haris Sultan and Sonia Beard**

## INTRODUCTION

The NHS Youth Forum is part of NHS England (NHSE) and the British Youth Council (BYC). The forum consists of 25 young people between the ages of 14-25 from across England, providing young people with the opportunity to express their thoughts on the health issues that matter most to them. The forum works directly with NHS England, Public Health England and the Department of Health and Social Care, thus enabling the forum to have a real impact on the health services that young people use by using their voices to shape these services.



After being consulted by the National Network of Designated Healthcare Professionals for Children (NNDHP) on their report: ‘Health thematic for consideration prior to the review of the UK by the UN committee for the rights of a child’, we decided to write our own report for consideration by the UN committee for the rights of a child that addressed the concerns and views of the NHS Youth Forum. For accessibility, the report is accompanied by illustrations throughout.



throughout.

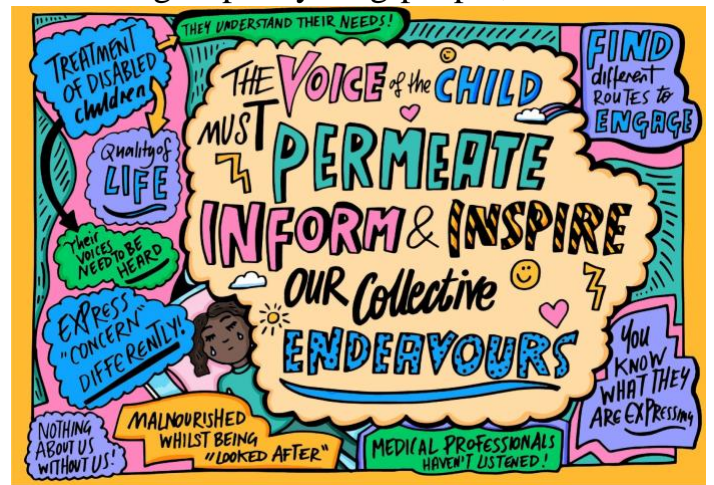
This report will look at the five issues outlined in the NNDHP report, as well as a further issue young people thought to be prevalent. These issues are:

- Infant mortality, Maternal death in childbirth and Adolescent Mortality
- Malnutrition
- Looked after children
- Child poverty + UN sustainable development goals
- Promotion of health and wellbeing
- Gender identity

We are aware that transgender and gender variant children are not mentioned in any UNCRC article, so we aligned articles 2, 3, 6, 12 and 13 to the section on gender identity. We hope that by discussing the issues faced by transgender and gender variant children, the UN will consider implementing an article that addresses these rights, or, considers adding the topic to other articles to explicitly address the adversity faced by this community.

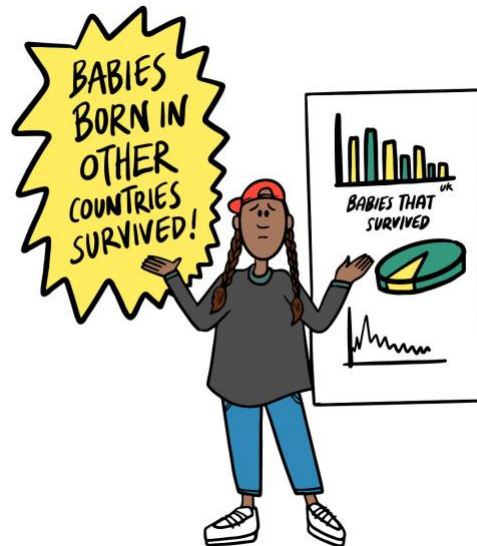
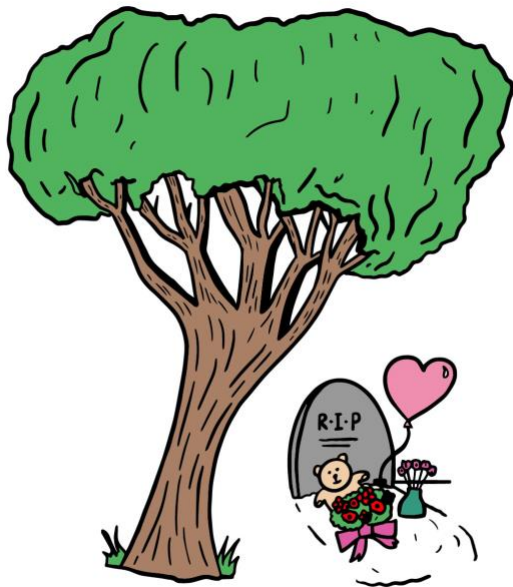
The gravitas of these issues is of gravest importance to children across the UK. We understand that these issues are dark and difficult, but they are topics that need to be addressed. As young people, we want to contribute to the issues that affect us and our peers directly.

We acknowledge that we are not an entirely representative group of young people, and we are already very engaged in the discussions concerning the rights of children, especially within health and social care. However, with Article 42 starting that, ‘States Parties undertake to make the principles and provisions of the Convention widely known, by appropriate and active means, to adults and children alike’, overall, meaning that everyone should know about the UNCRC, we are driven to ensure that Children and Young People and those who advocate for them are aware of their rights. Not only those who have the opportunity to be engaged, or can engage on behalf of others, should know the rights that themselves or others are entitled to. We know that some of the articles within the UNCRC are not being implemented correctly at present. Therefore, in this report we will use the voices of young people to highlight that.



We believe that the UNCRC is a means to an end, but not an end in itself. The end is children and young people having a good childhood and we are not there yet. As the leaders of tomorrow, we want to use our voices and experiences within the health and social care system to ensure that the leaders of tomorrow are raised with their rights to health and wellbeing at the centre of the government’s collective endeavours.

# INFANT MORTALITY, MATERNAL DEATH IN CHILDBIRTH & ADOLESCENT MORTALITY



Section written by Emma Beeden

## INFANT MORTALITY, MATERNAL DEATH IN CHILDBIRTH AND ADOLESCENT MORTALITY (ARTICLE 6 AND 24)

Infant mortality is a taboo topic in the UK. When we think of childbirth and infancy we automatically think of the joy of a new life being brought into the world. However, this is not always the case and sometimes it does go wrong. For some in society, the tragedy of infant mortality is more likely.

Infant mortality is a topic that needs to be spoken about and then acted on. Not only within our government, but across society. Figures indicate that over a thousand infants in the UK die a year who would have survived had they been born elsewhere in the developed world<sup>1</sup>. Why is it that as one of the most developed countries in the world, the UK has infant mortality rates (IMR) of 3.593 per 1000 births<sup>2</sup> which is much higher than other similarly developed countries?



One of the key factors that contributes to high IMR is social deprivation. The rates of infant mortality are higher in the 10% most deprived areas of the country.<sup>1</sup> In order to improve this, the government needs to put more attention into social factors such as housing, food and education in order to reduce the unacceptable levels of infant mortality.

When discussing infant mortality and creating a plan to improve to IMR in the UK, ethnicity is a factor that must be considered. Per 1000 births, 7.3 babies of a Pakistani ethnicity die compared with 2.6 white babies.<sup>2</sup> This must change. Ethnicity must not affect how likely you are to grow up and survive. An increase in deaths due to race also extends to the mother. Black women are 5 times more likely to die in childbirth and 2 times more likely to experience stillbirth than white women.<sup>3</sup> In a diversified nation like the United Kingdom, statistics like this should come as a shock, but prior to the Black Lives Matter Movement, statistics such as these were not common knowledge. Moving forward, the voices of ethnic minority women, mothers and children need to be heard and acted upon.

Maternal death in childbirth is a tragic bereavement for any surviving infant or child. Whilst it does not correlate directly to an article within the UNCRC, Article 9 which stipulates that a child should not be separated from their parents can be used here. Maternal death is a tragic bereavement for the new born infant as well as any children that they had previously had, although Article 9 does not specifically mention maternal death, at the grassroots you are separating a child

<sup>1</sup> Child and Infant mortality in England and Wales: (2018)

[www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2018](http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2018)

<sup>2</sup>[www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2018](http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2018)

<sup>3</sup> <https://www.rcog.org.uk/en/news/rcog-calls-for-government-action-to-tackle-racial-inequalities-in-womens-healthcare/>

from its parent(s). The inequalities in maternal death in childbirth rates for black women is something that should be considered to have huge effect on the surviving child.

Over the years, mortality rates for adolescents have continued to rise and the Coronavirus pandemic has rapidly increased the numbers of youth suicides. In the 82 days before lockdown there were likely to have been 26 child suicides and during the lockdown there were a further 25.<sup>4</sup> Children's lives should not be cut short by the inability for them to access services that may prevent such a tragic outcome. Young people need more mental health support. The mental health of young people was at breaking point before the lockdown and the pandemic has only exacerbated it. More services, support and trained professionals are needed to help the tomorrow's leaders thrive and grow up with positive mental health.

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<sup>4</sup> Child Suicide Rates during the COVID-19 Pandemic in England: National Child Mortality Database (2020)  
<https://www.ncmd.info/wp-content/uploads/2020/07/REF253-2020-NCMD-Summary-Report-on-Child-Suicide-July-2020.pdf>

# MALNUTRITION & IMPACTING FACTORS



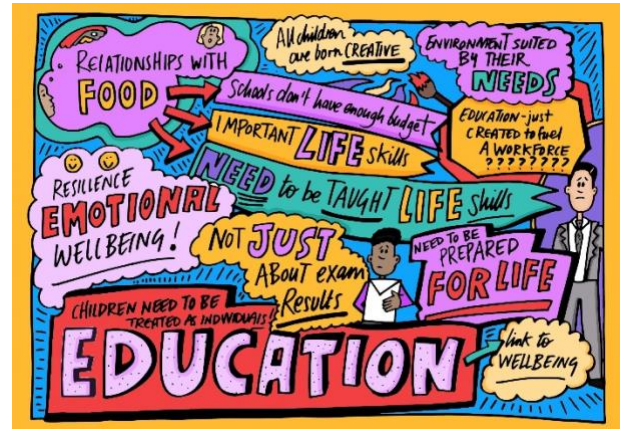
**WE MUST LOOK AT ROOT CAUSES  
DON'T LET THE PROBLEM TRAVEL DOWNSTREAM  
TO A POINT WHERE WE ARE TAKING ACTION  
RATHER THAN PREVENTION**

## MALNUTRITION (ARTICLE 24 AND 31)

Figures show 1 in 5 primary school children are overweight or obese. This statistic increases to 1 in 3 secondary school children. BAME children and those who live in deprived areas of society are also particularly affected<sup>5</sup>.

As young people, we believe that the way in which the UK is dealing with obesity could be improved. We need a focus on prevention rather than trying to cure once the issue has already occurred. By going upstream and preventing the issues by addressing the root causes, children are less likely to become one of the aforementioned statistics.

Throughout our education, we are not taught about our relationship with food. The lack of awareness many children and young people possess about the food they consume impacts their health and wellbeing. Not only does education not teach children about how to maintain a healthy relationship with food, many are not supported with the triggers that develop from this lack of awareness, such as food triggers, coping strategies for unhealthy food behaviors or stress eating.



Healthy food is not accessible to some with an unhealthy meal frequently being far cheaper and more accessible than the ability to create a notorious homecooked meal. We need to ensure every child has access to nutritious food all year round. Access to healthy/ affordable provision is key - social and economic inequality needs to be recognised.



We also believe that we need to get the balance right around the language and actions we use for obesity. We understand that we need to be realistic and focus on the truths that obesity is not good for our overall health and wellbeing. However, by using phrases such as ‘the war on obesity’, we create a discourse that is negative rather than supportive<sup>6</sup>. Therefore, we risk not encouraging children to make healthier choices and shaming them instead of supporting them. Discourses such as this create a barrier and

prevent meaningful changes to be made. Children and young people need more support to make healthier choices and approaching this in the “blame and shame” manner accomplishes nothing.

<sup>5</sup> <https://www.rcpch.ac.uk/key-topics/nutrition-obesity/about-childhood-obesity>

<sup>6</sup> [https://www.huffingtonpost.co.uk/entry/why-the-government-needs-to-acknowledge-he-risk-of-uk\\_5b45a59ee4b0c3d90ede031b?guccounter=1&guce\\_referrer=aHR0cHM6Ly93d3cuZ29vZ2xlLnVlLnVrLw&guce\\_referrer\\_sig=AQAAAHpNq3bwdf7KnH6Hwmn8dhkvZs51RTOr2SAGiHo-C-xrbING6hDGjdxXgEKmRkoF10GPgpnJpS6\\_CjVfzRuRwF2uoNk5Fdinc-7FAhDvQJHwRVFLTodFr48SQpF\\_Nj7YHzNUVfH5tuYqz\\_3lxaN61J2qNF6zcaSAOICKgMSKxl\\_-](https://www.huffingtonpost.co.uk/entry/why-the-government-needs-to-acknowledge-he-risk-of-uk_5b45a59ee4b0c3d90ede031b?guccounter=1&guce_referrer=aHR0cHM6Ly93d3cuZ29vZ2xlLnVlLnVrLw&guce_referrer_sig=AQAAAHpNq3bwdf7KnH6Hwmn8dhkvZs51RTOr2SAGiHo-C-xrbING6hDGjdxXgEKmRkoF10GPgpnJpS6_CjVfzRuRwF2uoNk5Fdinc-7FAhDvQJHwRVFLTodFr48SQpF_Nj7YHzNUVfH5tuYqz_3lxaN61J2qNF6zcaSAOICKgMSKxl_-)



We need to have a more holistic approach when tackling obesity and eating disorders. Mental health needs to be looked at to help address the barriers to support. As well as this, mental health support should be provided for the family of the patient in order to help them understand the young person's issues to allow for a successful support network. The impact of a young person's eating disorder(s) on siblings and close family members is often overlooked. Providing support for those who are having to offer firsthand support is beneficial for all.



When approaching a topic such as this, we must also consider the cultural environment; what is a healthy body differs depending on where you are from. Different communities may have a different perception of obesity.

Eating disorders are incredibly complex and often, they are not clear cut - which I think not enough people realise. It's important to keep a balance between tackling obesity whilst also looking at underweight children. At present, with the current push around obesity, we are potentially instead, enforcing eating disorders instead of tackling them.

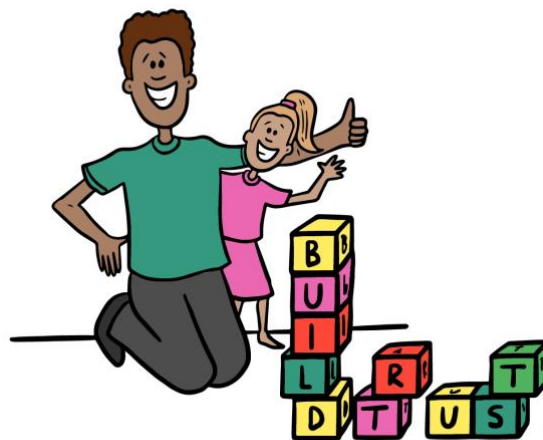
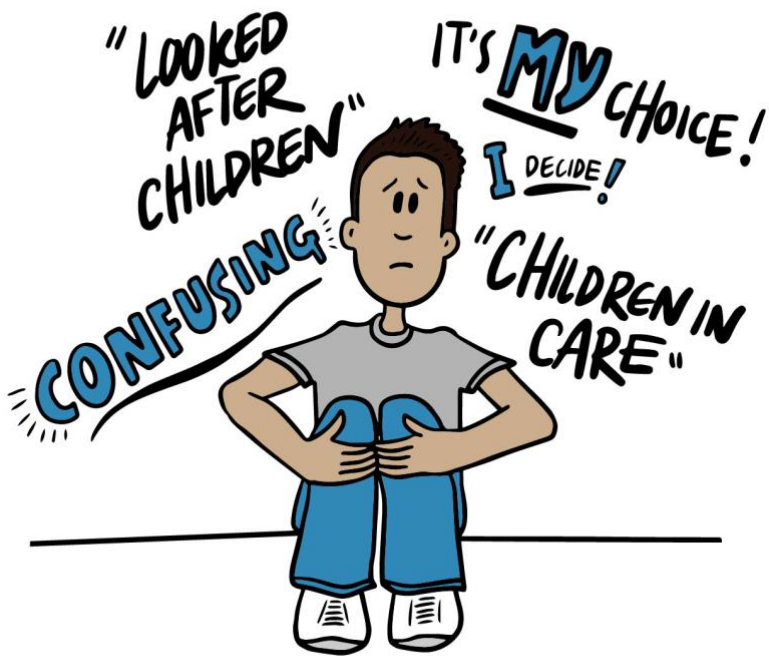
We currently use a one size fits all model for obesity but what we have to remember is that every young person is different. The promotion of healthy diets should include diets which are healthy for different cultures; we now live in a country that has a plethora of different cultures. We also need to emphasise to young people that all bodies are different. Using an ideal body type does not work when, even if we all had the same diet, we would all have different body types. The 'ideal body type' is influenced by social media. Although, such idealism is subjective and influenced by what we see on our individual social media platforms. Therefore, how do we communicate and influence young people when the images of this ideal are rife across social media? How do we mitigate against this? We need a more personalised approach to obesity.



With regards to the term obesity and overweight, we use BMI to define these terms. People/healthcare professionals need to realise that BMI does not work if you have certain disabilities/chronic illnesses example of these are young people with dwarfism. Also, depending on where your fat is located, the chance of developing health conditions changes. BMI also does not take into account bone mass or muscle mass<sup>7</sup>. Should we still be using this archaic system or is it time for change? We need to change the way we define obese to ensure that each young person is supported in the best way for them to live a long and healthy life.

<sup>7</sup> <https://www.webmd.com/diet/features/bmi-drawbacks-and-other-measurements#2>

# LOOKED After CHILDREN



Section written by Sonia Beard and Haris Sultan

## LOOKED AFTER CHILDREN (ARTICLE 24 AND 25)

The NSPCC defines a looked after child (LAC) as one who, ‘has been in the care of their local authority for more than 24 hours’.<sup>8</sup> Children or young people themselves, however, often prefer to be referred to as somebody in care. This report will continue to refer to LAC as a ‘child in care’ as this is the discourse often preferred by children and young people. However there are multiple ways in which young people like to refer to themselves, this should be personalised when engaging with them.

The Department for Education (DfE) is responsible for child protection in England, but local safeguarding partners, including the police and clinical commissioning groups are responsible for child protection policy, procedure and guidance at a local level. Due to the children in care being more frequently exposed to traumatic experience and neglect as they process through the safeguarding system, they require more support to gain access to health and social care services, or support at a



local level. Children in care are more vulnerable to health inequalities, and exhibit significantly higher rates of mental health issues, emotional disorders (anxiety and depression), hyperactivity and autistic spectrum disorder conditions.<sup>9</sup> Therefore, support and provisions should be provided to ensure that practitioners are able to tackle issues such as these that arise within children in care and know how to work proactively alongside them.

According to the Statutory guidance for local authorities, clinical commissioning groups and NHS England published by DHSC and DfE in their 2015 ‘Promoting the health and well-being



of looked-after children’ report, ‘The local authority that looks after the child must ensure that every child it looks after has an up-to-date individual health plan, the development of which should be based on the written report of the health assessment.’<sup>10</sup> However, we are aware that the voice of the child does not often permeate plans for individual healthcare planning. Whilst we must ensure that we do not re-traumatise children and young people by not respecting their privacy or

<sup>8</sup> <https://learning.nspcc.org.uk/children-and-families-at-risk/looked-after-children>

<sup>9</sup> <https://www.rcpch.ac.uk/resources/looked-after-children-lac>

<sup>10</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/413368/Promoting\\_the\\_health\\_and\\_well-being\\_of\\_looked-after\\_children.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/413368/Promoting_the_health_and_well-being_of_looked-after_children.pdf)

offering support, healthcare providers must strive to deliver an individualised healthcare plan that works for each child.

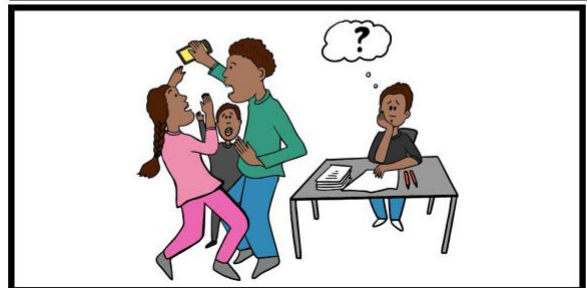
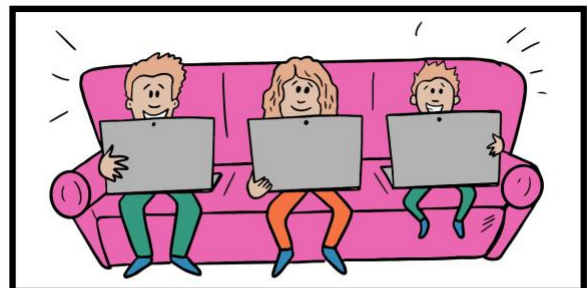
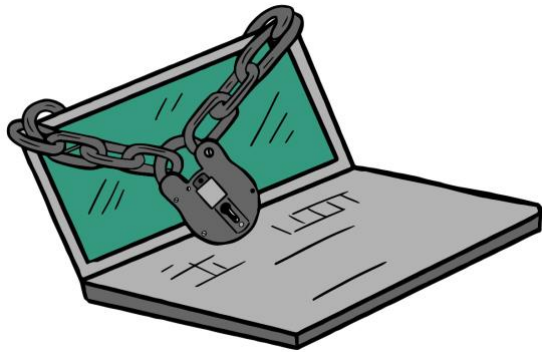
The UK needs to invest, resource and implement trauma informed practice for all health and social care providers that treat children in care. Across the country, different children will receive varying experiences of care due to their locality. Why do some staff deliver a great service whilst others continually fail children in care? By identifying the key ingredient to success, we will be able to prevent negative experiences in our health and social care system for children in care. Therefore, professional, universal training and practice standards are vital and urgent to establish this cultural change to reduce variation in experiences and outcomes of poor health and wellbeing.

We must also recognise the need of children in care, or children who are arguably, without care, who choose to seek asylum unaccompanied. Refugee children should receive the same level of care as those looked after by local authorities. No child, regardless of their level of support network should go without help when it comes to managing their health and wellbeing after any traumatic experience. The Government states however that they have, ‘a strong and proud record of helping vulnerable children and this will not change’<sup>11</sup>. What is not clear to refugee children is their rights when arriving in the UK. They do not know what will happen and what they can do; no idea whether they can access healthcare or shelter. What these children need is an accessible resource to help them understand what is going on, deal with the trauma and provide healthcare without adding any further turbulence.

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<sup>11</sup> <https://homeofficemedia.blog.gov.uk/2020/01/15/factsheet-unaccompanied-asylum-seeking-children/>

# CHILD POVERTY & UN Sustainable DEVELOPMENT GOALS



A CHILD DOES NOT **CHOOSE**  
TO BE BORN INTO **POVERTY**

Section written by Sonia Beard

## CHILD POVERTY (ARTICLE 4,24,27 AND 31)AND UN SUSTAINABLE DEVELOPMENT GOALS

In 2010, the Government pledged to end child poverty by 2020 in the Child Poverty Act. With the abandonment of this pledge in the Welfare Reform Act of 2016, rates of child poverty were as high as 30% in 2017-18. We know that poverty is a major determinant of health, and with today's children experiencing more poverty types than those before them, with a significant rise in digital poverty amongst food and material poverty, children and young people lack the ability to make the healthy choices needed to avoid ill-health and wellbeing.

Food insecurity was an issue that existed long before the Coronavirus pandemic, but this has been catalysed during the lockdown and following months. In May 2020, the Food Foundation commented that more than 200,000 children have had to skip meals because their family couldn't access sufficient food during lockdown and around half a million children who normally rely on free school meals had received no substitutes to support them during the lockdown<sup>12</sup>. This continued into the October half term when a parliamentary vote against backing Marcus Rashford's campaign to extend free school meals over the holidays occurred.



It is incomprehensible that any child living in the fifth largest economy in the world should rely on donations from local cafes and restaurants to not go hungry during the ongoing Coronavirus pandemic or October half term<sup>13</sup>. Leaving children to be fed by charity donations is not consistent with the UNCRC Articles 24 and 27. However, the government have since offered a U-turn on the decision to leave school children without support during holidays with a £170m Covid winter grant scheme. This would support vulnerable families in England and an



extension of the holiday activities and food programme to the Easter, summer and Christmas breaks next year<sup>14</sup>. Despite this, there is still a long way to go before children and young people are entirely free from food poverty.

With Food Banks becoming a new normal, but still having huge amounts of stigma attached to accessing them, we cannot combat child food poverty with such stigmatisation still present. Food insecurity is a major issue for low-income families who are also more

likely to live in unhealthy environments that perpetuate risks to health further. Not only through

<sup>12</sup> <https://foodfoundation.org.uk/wp-content/uploads/2020/05/New-COVID-19-childrens-food-insecurity-data-FINAL.pdf>

<sup>13</sup> <https://www.bbc.co.uk/news/uk-england-54660387>

<sup>14</sup> <https://www.theguardian.com/education/2020/nov/08/marcus-rashford-forces-boris-johnson-into-second-u-turn-on-child-food-poverty>

their inability to make healthy food choices, but also in their inability to play safely, live in damp free housing, and at present, 'lockdown' in a home environment that is supportive and safe.

The children of today are not only faced with food poverty but experience the growing issue of digital poverty. Unequal access to appropriate WIFI, digital equipment and digital support has been accelerated, and unearthed by Covid-19. With education, learning and other forms of support for children (such as Youth Activities or Therapy) changing into an online format, many children were left without access to education. Thus, deepening the social divide between low and high-income families further.

OFCOM estimate that up to 1.18m children across the UK have no home access to a device to complete schoolwork on. Whilst the government provided a £100m package to fund laptops and 4G wireless routers to vulnerable pupils, care leavers and disadvantaged penultimate year students (Aged 14-15) the package only targeted and thus supported, roughly a third of children who are experiencing digital poverty in the wake of Covid-19<sup>15</sup>.



As Covid-19 comes with a severe amount of uncertainty for disadvantaged children experiencing all levels of poverty, access to appropriate nutrition and education is paramount in aiming to reduce the divide that has been finally highlighted and acknowledged in light of the Coronavirus pandemic.

<sup>15</sup> <https://www.childrenscommissioner.gov.uk/2020/08/18/children-without-internet-access-during-lockdown/>

# PROMOTION of HEALTH & WELLBEING



ISOLATED



Section written by Ray Everall



## PROMOTION OF HEALTH AND WELL-BEING (Article 24,26,27,29)

The promotion of children's health and wellbeing involves every topic and theme present in this report. It is the foundation upon which the quality of our health, and consequently our lives, is built. In order for children to develop into healthy, well-adjusted adults, their health and wellbeing must be prioritised in every aspect: physical, developmental, social, emotional. Adolescence involves huge developmental difficulties, so it is crucial that young people are supported throughout this time.

One essential component of children and young people's health and wellbeing is access to youth services, which help take young people out of negative situations, supports their wellbeing and ability to develop skills. However, according to the YMCA's report on local authority expenditure on youth services in England and Wales<sup>16</sup>, funding for these services have been reduced by 6% since 2010/11. The YMCA report goes on to state that local



authorities do not recognise the long-term benefits that youth services offer. Overlooking the importance of youth services only causes more harm to the health and wellbeing of children and young people.

We found that one of the most pressing issues for children and young people regarding the promotion of health and wellbeing was not addressed in NNDHP's UNCRC report. This refers to the academic pressure placed on children and young people. A fundamental part of children's wellbeing is their ability to be creative, which is severely limited by our education system. It is essential that every child has the equal opportunity to pursue what they want in their educational interests, and for those options to be available to them.



Furthermore, the sexual and reproductive health education that children and young people receive is inadequate. Every child deserves to receive an intersectional education on these topics. Although LGBTQ+ sexual health education is now mandatory, not enough schools provide this. Trigger warnings within sex and relationship education are vital, specifically regarding sexual assault and domestic violence to avoid re-traumatisation. Often, it is the

most vulnerable CYP who do not receive the sexual health education that they need as it not compulsory for parents to allow their children to take part.

<sup>16</sup> <https://www.ymca.org.uk/wp-content/uploads/2020/01/YMCA-Out-of-Service-report.pdf>

Another pressing topic is the lack of assistance for families with disabled children, who are too often unable to receive the support they need due to lack of funding for appropriate interventions and resources. According to the National Education Union (NEU)<sup>17</sup>, the number of children with an education healthcare plan has increased by a third to 320,000 since 2015, but the government has failed to meet this growing demand. As a direct result, local authorities are unable to provide adequate resources for SEND provision in schools. The Local Government Association warned that as a result of this loss of funding, many children with SEND would not be able to participate in mainstream education<sup>18</sup>.



As noted in NNDHP’s report, many young people with complex disabilities or mental health needs are placed on adult wards, but it does not discuss the impact this has on the young person. Positive and Active Behavior Support Scotland (PABSS) and the Challenging Behavior Foundation reported that, out of the 566 families of SEND children surveyed, 88% said that their child had been forcibly restrained. 58% of children had been injured after being restrained, including bruises, carpet burns and even broken bones.<sup>19</sup> There is no justifiable reason for disabled children to be brutalised and mistreated by adults, especially in environments which are meant to help them. The systematic violence that exists in the UK that targets disabled children and young people cannot and should not be ignored.

The Future in Mind (2012) report, conducted by the Department of Health and Social Care and NHS England, stated that:

*‘If we are to have the greatest chance of influencing the determinants of health and wellbeing, we should focus efforts on actions to improve the quality of care for children and families.’<sup>20</sup>*

Our health outcomes should not be a postcode lottery, and the ways in which our health and wellbeing are promoted cannot exclude any group or community. A ‘one size fits all’ approach to the promotion of health and wellbeing will never work. Reaching out to children and young people directly to ask what they need is vital. It is especially important that the voices of children from marginalised groups are elevated, as their needs can differ.

<sup>17</sup> <https://www.independent.co.uk/news/education/education-news/special-educational-needs-sen-school-funding-children-parents-a8867581.html>

<sup>18</sup> <https://www.independent.co.uk/news/education/education-news/special-education-needs-children-funding-cuts-government-association-a8634041.html>

<sup>19</sup> <https://www.challengingbehaviour.org.uk/learning-disabilityassets/reducingrestrictiveinterventionofchildrenandyoungpeople.pdf>

<sup>20</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/414024/Childrens\\_Mental\\_Health.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf)

The VSCE Health and Wellbeing Alliance and Young People's Health Partnership stated that young people have different wellbeing concerns to that of healthcare professionals.<sup>21</sup> Whilst healthcare professionals were most concerned about behaviors such as substance abuse and exercise, young people stated that their wellbeing was more to do with having a sense of community and equal opportunities. Therefore, the voices of children and young people must permeate the care they receive and inform the approach of healthcare professionals.

When you surpass a certain age, you lose the ability to relate to your younger self; therefore, how can you possibly determine the best way to promote our health and wellbeing unless you speak to us?

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<sup>21</sup> <http://www.youngpeopleshealth.org.uk/wp-content/uploads/2019/10/Scoping-paper-CYP-views-on-wellbeing-FINAL.pdf>

# GENDER IDENTITY



Section written by Ray Overall

## **GENDER IDENTITY (ARTICLES 2,3,6,12 AND 13)**

In the last five years, transgender and gender variant children have become the central target of attack by many who believe that children are being rushed into medical treatment that is detrimental to their health and wellbeing. Certain media outlets have become increasingly hostile towards transgender people, and as a result hate crime motivated by transphobia rose by 81% between 2018- 2019<sup>22</sup>. Whilst gender identity does not correlate directly to an article in the UNCRC, we believe that it is essential that the issues transgender, gender variant children and young people endure are highlighted, and that the UNCRC and the UK Government commit to protecting this group.

In January 2020, the British High Court confirmed that a judicial review of the Tavistock and Portman NHS Foundation Trust, which is the sole provider of gender identity development services (GIDS) for under 18s, would go ahead<sup>23</sup>. The argument behind this case is that children are unable to give informed consent to receive pubertal blocker medication, known as gonadotropin-releasing hormone (GnRH) analogues, because they lack Gillick competence. They believe that this treatment should be illegal. It is their belief that GIDS does not properly review transgender and gender variant children, and that they are ‘rushed into’ treatment.

Gillick competence means that anyone under the age of 18 is legally allowed to consent to their own medical treatment as long as they understand the nature of the treatment, options, and the risks and benefits<sup>24</sup>. Medical professionals must act in the best interests of the child, and the parents cannot overrule their child’s decision once they are proven to be Gillick competent. There is no rational, scientifically proven argument against transgender healthcare, just like there is none against contraceptive care and abortion. Under 18s cannot get gender affirming surgery; treatment is limited to hormone blockers.

Despite the NHS service specification for GIDS stating that the service must see people within eight weeks<sup>25</sup>, and under the NHS England Constitution the maximum waiting time for an initial appointment after referral is 18 weeks, current waiting times have no estimate from GIDS themselves, with patients and/or parents of patients reporting that the waiting time is over two years. Transgender and gender variant children, as well as their parents, receive little to no support during this time. This goes against the claim that children are ‘rushed into’ treatment. This year, it was reported that over 5,000 children and young people were on the waiting list, but only 267 children under the age of 15 began using blockers between 2012-2018<sup>26</sup>.

Puberty blockers have been used for the management of precocious puberty from the age of six onwards for many years. The role of this treatment for transgender and gender variant children is to provide them with more time to figure out their identity and think about whether transition is the right step for them. Part of the argument that puberty blockers harm children is that they

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<sup>22</sup> <https://www.bbc.co.uk/news/uk-48756370>

<sup>23</sup> <https://www.theguardian.com/society/2020/mar/01/families-divided-tavistock-nhs-gender-clinic-judicial-review-goes-ahead>

<sup>24</sup> <https://www.nhs.uk/conditions/consent-to-treatment/children/>

<sup>25</sup> <https://www.england.nhs.uk/wp-content/uploads/2017/04/gender-development-service-children-adolescents.pdf>

<sup>26</sup> <https://www.bbc.co.uk/news/health-49036145>

will eventually detransition, but a research analysis by the European Professional Association for Transgender Health found that less than 1% of people had detransitioned, and that this was not just due to no longer identifying as transgender<sup>27</sup>.

Multiple studies have shown that access to puberty blockers can be lifesaving. A study in the US found that those who were able to access this treatment were less likely to be suicidal or to have severe psychological distress, compared to those who were unable to access puberty blockers<sup>28</sup>. Other studies have illustrated that those who underwent puberty-blocking treatment early and also received psychological support were much more likely to have better mental health throughout the rest of their life.

“[Gender Dysphoria] can be more distressing in adolescence due to the pubertal development of secondary sex characteristics and increasing social divisions between genders. As a result, adolescents can be at risk of self-harm, despair and can become vulnerable to relationship difficulties, social isolation and stigma.”<sup>29</sup>

Transgender and gender variant children and young people are much more likely to self-harm or to attempt to take their lives due to multiple factors, such as bullying or unsupportive family members. A study by the LGBT Foundation found that 84% of transgender young people aged 11-19 have self-harmed at some point, and 92% have thought about committing suicide<sup>30</sup>. There are also many concerns for transgender and gender variant children at school – the same study found that 51% of transgender students have been bullied for being openly transgender at school, with another study finding that 89% of people who have experienced transphobic bullying stated that it had a negative impact on their attainment<sup>31</sup>. Children and young people also face difficulty regarding changing their name and gender on records due to lack of understanding on how to do so, as well as teachers refusing to use the correct pronouns and name for them. Transphobic bullying and harassment has a lasting impact into adulthood, resulting in increased risks of poor mental health, homelessness, and economic hardship – which are already increased risk factors for transgender people in general.

It is crucial that transgender and gender variant children are aware of the benefits and risks that these treatments have, and that they are provided up-to-date, accessible information on this – but that does not mean that puberty blockers or HRT should be made illegal where it is impossible to obtain. If we want to reduce the self-harm and suicide rates in these children, what they truly need is better support so that they have the opportunity to grow into confident, fulfilled adults.

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<sup>27</sup> <https://epath.eu/wp-content/uploads/2019/04/Boof-of-abstracts-EPATH2019.pdf>

<sup>28</sup> <https://www.cnn.com/2020/01/23/health/transgender-puberty-blockers-suicide-study/index.html>

<sup>29</sup> <https://www.england.nhs.uk/wp-content/uploads/2017/04/gender-development-service-children-adolescents.pdf>

<sup>30</sup> <https://s3-eu-west-1.amazonaws.com/lgbt-website-media/Files/b9398153-0cca-40ea-abe-bf7d7c54d43af/Hidden%2520Figures%2520FULL%2520REPORT%2520Web%2520Version%2520Smaller.pdf>

<sup>31</sup> <https://s3-eu-west-1.amazonaws.com/lgbt-website-media/Files/acd2bcc5-a2d4-4203-8e22-aed9f4843921/TransformingOutcomesLGBTfDn.pdf>

To date, there is no mention of transgender and gender variant children under the UNCRC's articles that set out the political, economic, social and culturally rights that all children are entitled to. It is vital that these children are explicitly protected under these articles, specifically articles 2, 3, 6, 12, and 13. Transgender and gender variant children have the same rights to non-discrimination; being treated in their best interests; life, survival and development; respect for their views; and freedom and expression, as any other child. This is an incredibly vulnerable group who have been at the forefront of debate around the rights of transgender people in the UK, and as a result, children are being driven to self-harm and suicide. We face an extraordinarily violent climate, and more needs to be done to protect transgender and gender variant children and young people. We are capable of making our own choices, and we deserve to be safe and to be protected under the law. The UNCRC and the UK Government must ensure that transgender and gender variant children and young people are explicitly protected in every capacity so that we are able to live their lives freely without fear.

# QUESTIONS FOR THE GOVERNMENT

## **INFANT MORTALITY, MATERNAL DEATH and ADOLESCENT MORTALITY**

By what strategic approach does the government plan to reduce infant mortality rates in this country?  
How does the government plan on supporting families, before, during and after pregnancy with mental health issues?

Does the government plan on offering support to families of disabled children, and how will support be individualised for different families?

Inequalities between different ethnicities in infant mortality section?

## **MALNUTRITION**

Does the government acknowledge that BMI and other weight determiners are not an approachable way of tackling ?

Does the government plan on tackling the communications around obesity to tailor to the discourse used by children and young people?

What strategic approach does the government intend to have to reducing eating disorders and offering support for this?

## **LOOKED AFTER CHILDREN**

What is the government doing about reducing the inequalities between looked after children?

What is the government going to do to ensure that looked after children have support during the transition to adult services?

How is the government going to ensure that migrant children have appropriate access to health provisions and support?

## **CHILD POVERTY AND UN SUSTIANABLE DEVELOPMENT GOALS**

By what child rights-based approach does the Government intend to restore the pledge to end child poverty?

How does the government plan to incorporate child and youth voice at each stage of strategic decision making when planning to reduce child poverty?

What processes are the government taking to ensure that all children have access to appropriate equipment in order to receive the education that is lawfully provided to them?

## **PROMOTION OF HEALTH AND WELLBEING**

How will you connect to the most vulnerable is society?

How can out health outcomes be improved when there is not enough funding for essential services such as youth centres or child care?

What will be done to better promote health and wellbeing of CYP and to safeguard them from discrimination and abuse?

How will the government develop a systematic cross-governmental approach to hear the voice of a child?

## **GENDER IDENTITY**

What measures will be put in place to ensure that transgender and gender variant children are protected from harassment and abuse in all aspects of their lives?

How will the Government commit to reducing the waiting times for transgender and gender variant children?

What will the Government do to ensure that they receive adequate treatment locally, so that they do not have to travel excessive amounts of distance for appointments?