

YOUTH AS A RESOURCE

Promoting the health of young people at risk

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A report of the National Consultative Committee on Health Promotion, 1999

Written and compiled by Sara Burke
edited by Owen Metcalfe

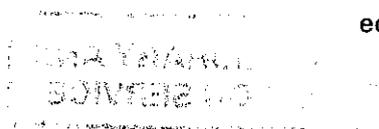


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Foreword

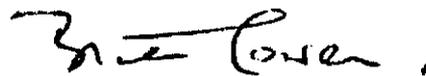
This document comes at an important time in the development of health promotion in Ireland. In the past decade, we have witnessed the development of appropriate structures at regional and national level which have allowed health promotion to take its place as an important and vital aspect of the Irish health services. There has been significant investment at departmental and regional level in developing this function and reports like this bear witness to the progress that has taken place.

This report on the health needs of young people at risk comes about as a result of the work of the National Consultative Committee on Health Promotion. In 1997, this committee produced a report which detailed the issues and set out priorities to facilitate the development of the health and well-being of all our young people. The more specific work detailed in this report has been a natural follow on to the 1997 Young People's report and the Department of Health and Children Statement of Strategy, 1998. Additionally, current government policy places an emphasis on tackling social exclusion and again this is particularly relevant and fitting given our current prosperity which obliges us to focus on, tackle and reduce inequities in our society.

'Youth as a Resource' gives an overview of the relationship between socio-economic status, educational disadvantage, youth at risk, health status and behaviour. It also documents a consultative process on the health needs of young people at risk, details some examples of good practice and makes specific recommendations. These recommendations will be implemented by working with the health and other relevant

sectors whose policies and initiatives impact upon the health status of this particular population. The challenge of this report is to do this in a meaningful way so as to effectively meet the health needs of young people at risk.

I would like to congratulate all involved and I look forward to this report making a positive contribution to the ongoing challenge and process of reducing inequity.



Brian Cowen, T.D.

Minister for Health and Children.

Acknowledgments

I would like to take this opportunity to thank all those who have been involved in the development of this report. As hundreds were involved, you are too many to mention by name.

First of all there are the young people, with whom I worked before I started in this position with the Department of Health and Children, who are really the inspiration for the work in which I am currently involved. Then, there are the young people from around the country who participated in the focus groups, who gave their time and honest perceptions of their own health needs, knowing this task was of no benefit to themselves, but hopefully will be to other young people in the future. I hope for the best for the futures of these young people. Without their views and information, the rest of this work could not have happened. Special thanks also to the young people from Neighbourhood Youth Project (NYP), Sean McDermott Street, whose drawings and sketches appear in the report.

Thank-you to those who assisted in the arrangement of the focus groups, who helped to organise and who participated in the Regional Health Fora : youth and community workers, staff and volunteers from youth organisations, communities and clubs, youth trainers from Youthreach centres, Early School Leaving projects and Community Training Workshops, health board personnel including social workers, childcare workers, residential care workers, drugs/AIDS education workers, outreach workers, psychologists, addiction counsellors, health promotion officers and their team members, drugs co-ordinators and project workers, public health nurses, public health specialists, Garda Juvenile Liaison Officers (JLOs), probation officers, school staff including teachers, guidance counsellors, school nurses and home-school liaison officers, voluntary organisations, Partnerships and Local

Area Task Force representatives, Prison and Special Schools staff, representation from Government Departments, religious and academics. I thank you all for your time, energy, commitment, challenges and ideas without which this process could not have continued. Special thanks must be paid to Linda Moloney for her endless typing of mail merges, to Paula Monks who was my administrative back up and support during the Regional Health Fora, to Siobhan McGrory who planned, co-facilitated and travelled the country with me during the winter of 1997/1998 and to Caroline Cullen for her continuous professional and moral support. I must also thank those in regional and national management and policy making positions from the relevant sectors who gave me their time, helped obstacles to be hurdled and shared their ideas for the future. Most of all I thank the Young People's Sub-Committee of the National Consultative Committee on Health Promotion who identified the need for this important work to be done, instigated this whole process and have supported it throughout. Those from government departments on the Sub-Committee, thanks for your different perspectives. Saoirse Nic Gabhainn, thanks for your guidance and direction in research methodologies and theoretical frameworks. Maura McNally, I must give special thanks to you for your absolute encouragement and support, for showing me the bigger picture and for keeping my ideas close to the ground. My greatest thanks is to Owen Metcalfe who has guided me throughout, listened to me, taught me, inspired me, kept me on the right track, edited, re-edited and assisted me in rewriting draft after draft.

It is my wish that all those who have been involved so far and many more of you can play a part in implementing the recommendations of this report so as to address more effectively the health needs of young people at risk.

Sara Burke

Youth Health Promotion Project Officer

Introduction

This document is a report of a process undertaken to identify the health needs of young people at risk. It also includes a strategic dimension in that it considers what steps can be undertaken to address these needs and concludes by making specific reference to recommendations which would aid this process.

The introduction briefly details the background to the process and outlines the rationale upon which this work is based.

Chapter 1 explains the rationale for the document's development, makes the link between educational disadvantage, poverty, youth at risk and their health behaviour. It also defines risk and resilience factors.

Chapters 2 and 3 detail the outcomes of the consultative process from the focus groups and the regional health fora.

Chapter 4 gives examples of good practice which are currently in place to address the health needs of young people at risk.

Chapter 5 makes recommendations as to how these issues can be addressed more effectively in the future.

Background

In 1994, the Government launched a National Health Strategy called 'Shaping a Healthier Future'. Subsequently in 1995 a Health Promotion Strategy was launched. To support this strategy a National Consultative Committee on Health Promotion was established. One of the priorities of this committee was the health of young people and therefore a specific Sub-Committee on Young People was established. Young people were prioritised as a target audience as the habits and patterns of behaviour established early in life have an ongoing impact on lifelong behaviour and health status.

Arising out of discussions of the Sub-Committee and work conducted with young people a report was produced. The Report on Young People of the Sub-Committee of the National Consultative Committee on Health Promotion, 1996, states that "at the outset it is important to acknowledge that young people are an integral part of family, community and environmental settings, so, in efforts to directly impact upon young people, consideration must be given to the wider influences that exert enormous pressure on a young person's life. People's physical, social and economic situations - their broader environment i.e. where they live, work and relax, greatly influence their prospects for better health. This is why Health Promotion, if it is to be successful, must rely on inter-sectoral activity that seeks to harness the potential contribution of many disciplines and sectors in effecting the introduction of healthy lifestyles in the widest possible arenas. It is also essential that the appropriate structures to facilitate the delivery of health promotion for this target audience be in place." (Dept. of Health, 1996a, p.5).

The report concluded by making a number of recommendations. One of these recommendations was to conduct research which would give greater insight into the health needs of young people, as expressed by young people themselves. As a result of this, a national consultative process on the health needs of young people at risk took place.

Young people at risk

What 'at risk' refers to in the context of this report is at risk in terms of behaviours that influence health status. While acknowledging that most people are at risk to a greater or lesser extent with regard to these behaviours, particularly young people, the focus of this

report is on young people who leave school early or are at risk of early school leaving because

1. there is a general perception that young people who leave school early are more at risk in terms of their health behaviour than their school going contemporaries. Particular examples which give credence to this perception are "58% of those who present for drug treatment had left school before the official school leaving age of 15" (Moran, R et al., 1996, p.13) and "50% of out of school girls aged 17 and over smoke compared to 22% of those in school, while the corresponding figure for boys is 57% and 24%" (Dept. of Health, 1996b p.47).
2. whilst the Department of Health and Children, together with the Department of Education and Science, have developed a number of initiatives to address the school going population and the non-formal education sector, relatively little has been done in a health promotion context to address the specific needs of young people who leave school early.

CONSULTATIVE PROCESS

In order to clarify the health needs of these young people, a national consultative process was carried out between May 1997 and April 1998. There were three stages to this process.

Stage 1

The first stage of the work was to do research with groups of young people, aged 13 to 17, who were not in school, on their perceptions of their own health needs.

Stage 2

The next stage was to regionally meet with the people who are working with these young people. Those responsible for service provision for young people at risk such as teachers, youth and community workers, Juvenile Liaison Officers (JLOs), Youthreach, FAS and Community Training Workshop (CTWs) trainers, health board personnel including health promotion staff, social workers, child and family support workers, addiction counsellors, probation and home-school liaison officers, local area partnership and crisis service personnel, were brought together in order to :

- a. gain an increased awareness of the health needs of young people at risk ;
- b. provide an opportunity to share information and learn from each other in terms of addressing the health needs of young people at risk ;
- c. identify the circumstances and structures influencing the health status of young people;
- d. make recommendations as to how the health needs of this group could be addressed more effectively at local, regional and national levels.

Stage 3

The final stage of the consultative process was to assemble those in national and regional policy making and management positions from the relevant sectors, to present to them the issues that had been raised at the focus groups by young people out of school and by the regional health fora in order to enable them to formulate recommendations as to how these issues could be addressed in the future.

Outcome

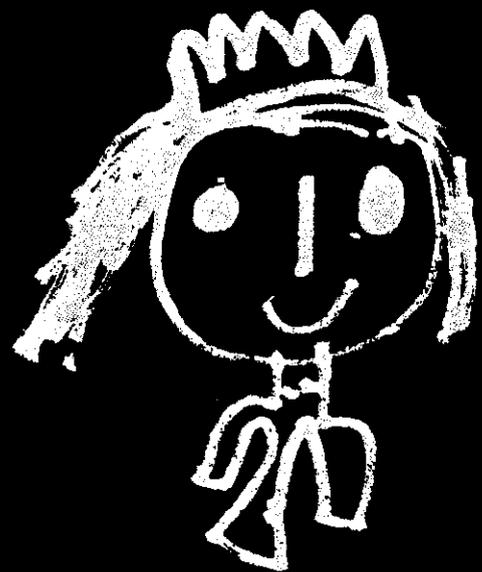
Resulting from this process this document specific to the health needs of young people at risk with a particular focus on early school leavers has been developed by the National Consultative Committee on Health Promotion.

The production of this document would not have been possible without the involvement

of about 400 people, including young people, professionals and volunteers who work with the target audience and management and policy makers from the relevant sectors. Those involved in the production of this report would like to express deep gratitude and heartfelt thanks to all those who participated in this process for giving their time, energy and commitment to this task.

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Young people at risk, health status, poverty & educational disadvantage



Defining young people 'at risk' for this report

This is a report on the health needs of young people at risk. As outlined in the introduction, what 'at risk' refers to in the context of this report is at risk in terms of behaviours that influence health status. While acknowledging that everybody is at risk to a greater or lesser extent with regard to such behaviours, particularly young people, the focus of this report is on young people who leave school early or are at risk of early school leaving as they are considered to be more at risk. This premise is based upon the general perception and growing body of knowledge that young people who leave school early are more at risk than their school going contemporaries in many lifestyle behaviours. Early school leaving has been shown to be a common denominator of those who become the long term unemployed and the prison population (Ireland, 1997b, Ireland, 1998b). Recent research shows that this higher risk status is also true in terms of their health behaviour. "Education attainment is an important determinant of both occupation and income, it may however have an impact on health through a variety of mechanisms; health knowledge and behaviour, accessing health care, ability to cope with life stressors" (Ben-Sholomo Y, et al. 1997). The Department of Health and Children, together with the Department of Education and Science, continue to develop initiatives to address the school going population and the non-formal education sector. However, up to the production of this report, relatively little has been done in a health promotion context to address the needs of some young people who may be more at risk.

Definition of health

The World Health Organisation (WHO) definition of health as being a "state of complete physical, mental and social well-being, not merely the absence of disease or infirmity" is used in this report (WHO, 1985).

It must be acknowledged that health has many components and whilst frequently referred to in the context of disease and illness it is in fact much more than the absence of disease or illness. It is a resource for everyday life, it is a positive concept emphasising social and personal resources as well as physical capacities.

General definitions of 'at risk'

The term at risk has many meanings and is not easily defined. In *Risk, Health and Welfare*, edited by Alaszewski, Harrison and Manthorpe (1998), the issues in relation to risk management within health and welfare services are discussed. They define risk as "the possibility that a given course of action will not achieve its desired and intended outcome but instead some undesired and undesirable situation will develop." What is referred to below are life situations or characteristics that render a young person particularly at risk. These characteristics or life situations include

- being involved in criminal behaviour
- being 'in care'
- living in poverty and/or poor quality housing
- having a history of family problems or abuse
- having learning or physical disabilities
- having psychological or behavioural problems
- working in prostitution

- having academic problems and/or a bad experience of school
- having mental health problems
- being out of home
- having a crisis pregnancy at an early age
- experiencing discrimination due to sexual orientation, race or ethnicity e.g. travellers, gay, bisexual and lesbian young people, refugees and asylum seekers
- being from families with a history of substance misuse
- living in geographically isolated areas.

What is also understood is that by virtue of being included in one or more of the above circumstances the health status of the individual is placed at particular risk.

Obviously all young people may place themselves or be placed 'at risk' at various times in their lives, and risk taking may be a healthy activity for some young people, but what this document traces is the particular experiences of young people who are early school leavers or at risk of it and belong to one or more of the categories referred to above. When young people are exposed to these multiple risk factors they can be considered more at risk. This said some young people can be exposed to one or multiple risk factors and still manage to live a very healthy life. One of the explanations for this are resilience or protective factors.

Resilience factors

These are the factors in a young person's life which protect them or enable them to overcome the risk factors. These resilience factors include

- a supportive family environment
- a positive caring relationship with an adult, e.g. a youth worker, teacher, sports coach
- good educational achievement
- positive experiences through involvement in sports, arts, or the community.

Young people at risk and Health Promotion

Such resilience factors are closely related to some of the corner stones of health promotion, such as developing personal skills, creating supportive environments and inter-sectoral co-operation. When looking at ways that health promotion can positively influence young people's lives, it is these resilience factors that should be built upon. In chapter 5, some of the recommendations outlined are those which can positively enhance the experiences, environment and relationships of young people at risk.

Definition of the term young people

There is often a lack of agreement concerning a definition of the terms 'youth' and 'young people'. For the purpose of this report the WHO definition is used, and this defines young people as being between the ages of 10 and 24 years. Within that youth are defined as 15 to 24 years and adolescents as 10 to 19 years. The 1996 census shows 42% of the Irish population are under the age of 25 and 24% are under the age of 15, giving Ireland the highest proportion of young people per head of population in Western Europe. WHO give the following reasons as to why adolescence is a particularly appropriate time to target young people. They state that it is a period when there is

- rapid physical growth and development
- physical, social and psychological maturation occurring at different times for different individuals
- sexual maturation and the start of sexual activity
- a trying out of experiences for the first time

- a frequent lack of knowledge and skills to make healthy choices
- the start of behaviours that may become lifetime habits that result in diseases many years later.

It is generally recognised that one of the virtues of being young is that it is a time in life when one is most likely to be healthy and therefore, it is the challenge for health promotion to build on this natural advantage. In order to capitalise on this process in a manner that seeks to ensure that health is not just linked to this natural advantage, but that during this period skills and attitudes will be acquired which attempt to support and maintain this state of well-being into later years.

Contributing factors to health status

As outlined in the Health Promotion Strategy (Dept. of Health, 1995a), the main causes of morbidity and mortality in Ireland are from illness in which lifestyle and /or environmental factors play a role. Such risk factors include smoking, substance misuse, overweight, high blood pressure and poverty. In relation to young people, accidents and suicide must also be considered as they are the two highest causes of death among young people. These risk factors are now considered in some detail.

1. Substance use

YOUNG PEOPLE AND SMOKING

The most recent national research on health and lifestyle behaviour of school going young people, aged 9 to 17, (Health Behaviour in School Aged Children Survey (HBSC, 1999)), shows a life time prevalence rate of 49% with 21% being current smokers (HBSC, 1999). In 'Smoking and Drinking among Young People

in Ireland 'the results show a life time prevalence of 55%, 29% being current smokers, while 16% are regular smokers (Dept. of Health, 1996b). When compared to the two previous studies (Grube and Morgan, 1984 and 1990) of the same aged pupils, there would appear to be an overall decline in smoking among young people. However caution should be taken when drawing this conclusion as the previous studies were done solely with young people from the Dublin area. In the 1996 research it is stated that "there is no clear association between smoking and social class except that smoking prevalence tended to be highest in the group for whom social class is unknown and in the unskilled manual group. Social class was unknown for 10% of the total sample" (Dept. of Health, 1996b, p.8). Ninety percent (90%) of the young people believed that "smoking is dangerous to your health" with no difference between smokers and non-smokers (Dept. of Health, 1996b, p.15).

HBSC is the first national survey on health and lifestyle behaviours of school aged children and is the first comprehensive youth and health specific data which is analysed according to age and social class in relation to health and lifestyle behaviours. This survey shows that "although boys are starting to smoke earlier, by age 15 to 17 the smoking rates for girls exceed those for boys and in older girls an effect of social class emerges, with 40% of 15 to 17 year old girls from social class 5 and 6 reporting current rates of 40%" (HBSC, 1999). In the most recent European study, the 1995 European School Survey Project on Alcohol and Other Drugs (ESPAD, 1995) report, which is a comparative study of 16 year old students, Ireland comes out top or close to it in most of the smoking categories when compared to our European counterparts. The 30 day prevalence rate, which is the best indicator of regular smokers,

shows Ireland second to the top of the European league with 41% having smoked in the last 30 days and with 18% of students smoking daily. The 1996 study mentioned earlier carried out the research amongst a sample of out-of-school young people. Due to the size and age of this cohort, caution is urged when making comparisons with the school going population. However the findings that did emerge are relevant with 50% of out of school girls being regular smokers compared to 22% in school, the corresponding figure for boys being 57% and 24% (Dept of Health, 1996b).

Kiernan, who carried out research in the Western Health Board with young people aged 13 to 18, included a sample of young people out of school and from the travelling community. She reports that these young people are at high risk of becoming regular smokers (Kiernan, 1995). This difference indicates the importance of doing further research at regional and national levels to establish in a more definitive manner the health behaviours of out of school young people in order to have more accurate information and to be able to draw comparisons with their school going counterparts.

The National Health and Lifestyle study (SLÁN, 1999) makes the link between lower socio-economic status and poorer health status. This connection is also made in International Studies, e.g. the Black Report. However few of them do so specifically in relation to young people.

A study was done in 1991 by the Health Information Unit in the Eastern Health Board that "compared the prevalence of certain behavioural risk factors for premature mortality in high mortality black spots with the prevalence in low mortality areas" (Johnson,Z, et al,1991, (20(4) p.989-996). This study shows a strong association

between smoking prevalence rates and social class. "57% of people in black spots were smokers as against 48% in low mortality areas but significantly more people in black spot areas were current smokers (50.9 % as against 28.5 % in low mortality areas)." Smoking commenced at a younger age for people from the black spot areas. The Southern Health Boards research on smoking, alcohol and drug use in the region found that current smoking was 14% higher in social class 4-6 (43%) than in social class 1-3 (29%) supporting the connection between higher smoking rates and lower socio-economic status (Jackson, 1998).

<p>Social class 1: professional workers Social class 2: managerial and technical Social class 3: non manual workers Social class 4: skilled manual workers Social class 5: semi-skilled workers Social class 6: unskilled workers</p>
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YOUNG PEOPLE AND ALCOHOL

Traditionally, for most Irish people their drug of choice is alcohol. This is also true of young people. Yet, in the HBSC, "substantially fewer children report having had an alcoholic drink than had a cigarette." 29% report having had a drink in the last month (current drinkers). This sample although larger than any previous studies in this area, with the sample size being 8,497, is of a younger age and therefore caution must be used when making comparisons. Of the current drinkers, boys are more likely to report current drinking compared to girls and a small but consistent effect of social class emerges among girls from the age of 12, showing not only increased use with age, but also small variations between social classes i.e. 49% of girls aged 15 to 17 in social class 1 and 2, 50% among social class 3 and 4, and 52% among social class 5 and 6 (HBSC, 1999). This pattern is further confirmed by those

who report being 'really drunk', with the percentages also increasing with age and according to social class. This is particularly true among the girls sample, ranging from 12% (social class 1&2) to 28% (social class 5&6) aged 12 to 14, and 44% to 52% respectively, aged 15 to 17. The life time prevalence of alcohol use among 12 to 18 year olds in the 1996 survey does show a decreased use compared to the previous studies, with 63% having ever drunk an alcoholic drink in 1996, compared to 65% in 1984 and 78% in 1991. This study shows 42% are current drinkers (those who reported having one type of beverage on not more than three occasions in the last 30 days) and 29% are regular drinkers (those who drank more than one type of beverage or drank on more than three occasions in the last 30 days). The difference in alcohol use between young people in school and out of school is not so marked. "58% of males aged 17 and over out of school are regular drinkers compared to 56% in school, while the corresponding figure for females of the same age is 58% and 45%" (Dept. of Health, 1996b, p. 41).

When Irish young people's drinking habits are compared to their European counterparts, the issue of our 'culture' of drinking is highlighted, with 32% of 16 year old students having consumed an alcoholic beverage 20 times or more in the last 12 months (ESPAD, 1995, p. 56). This is the second highest percentage in answer to this question in the ESPAD study. "The proportion of Irish students who had been drinking alcohol during the last 12 months is somewhat higher (87%) than the average in all countries (80%). The proportion who answered they had been drunk during the same period is also larger (66%) compared to all countries (48%)" (ESPAD, 1995, p. 104). These national figures (ESPAD and Dept of Health, 1996b) appear an

underestimation of young people's alcohol consumption when compared to regional studies carried out with young people. Overall comparisons are difficult to make due to different definitions of terms such as current drinkers.

The Midland Health Board's School Survey shows 88% of those surveyed have consumed a drink in the last month, with 45% of males and 28% of females having consumed 6 or more drinks (Midland Health Board, 1997, unpublished). The North Eastern Health Board's report on 'Illicit drug Use among Adolescents in the North Eastern region' shows 57% of school going students and 81% of 17 year olds consuming one or more drinks per week. In recent regional research carried out by the Southern Health Board in the Cork and Kerry region, 44% of the under 18 age group were current drinkers and 72% of these had experience of being drunk (Southern Health Board, 1998, p.21).

The link between use of alcohol and social class is not evident in the Johnson's study of high and low mortality areas in Dublin, showing the proportion of the population which consumed 'excess' alcohol was virtually identical in the black spot and low mortality areas (Johnson, Z et al., 1991). However a greater number of respondents in black spot areas were non-drinkers. Jackson's study showed a greater proportion of current drinkers in the higher social classes. Kiernan's study in the West found that the early school leavers were at high risk of increased drinking levels and possibly problem drinking (Keirnan, 1995). All these figures are of great concern as alcohol is one of the key risk factors which contribute to the three main causes of premature death in Ireland i.e. heart disease, cancer and accidents (Ireland, 1996a). However when considering young people, their current health behaviour also needs to

be taken into consideration. The two main causes of death in Ireland among young people are accidents and suicide. Accidents are the greatest cause of death among young people and alcohol is a factor in 20% of these (Ireland, 1996a). The figures on admissions to psychiatric hospitals show that in 1996, 304 (11%) of a total of 2683 admissions in the 15 to 24 year old age group were for alcohol related problems (Keogh,F, Walsh,D, 1996). Given Irish young people's drinking patterns and our high rating compared to our European counterparts, use of alcohol among young people should not be viewed with complacency especially when considering the short and long term effects on the health of the population.

ILLEGAL SUBSTANCES AND YOUNG PEOPLE

In the last thirty years the issue of illegal drug use and misuse has changed from being one of occasional recreational use to one of the most serious challenges facing communities and society at large. Drug use is generally associated with young people and with the increased availability of drugs, there is a growing concern about young people and their drug misuse. In 1980 there was 33.5 kg of cannabis resin seized compared to 1,646.5 kg in 1981 and 1,280 kg in 1997. In 1996, 19,244 tablets and 13.5 kg of ecstasy were seized alongside 7.6 kg of amphetamines and 642 kg of cocaine. Seizure statistics are more of a reflection of law enforcement than drug use per se, however they do portray the availability of drugs, particularly 'dance' drugs in Ireland. This is also evident in the numbers charged with drug offences. In 1979, 594 people were charged compared to a figure of 1,822 in 1983, 3,953 in 1996 and 7,927 in 1997 (Dept. of Health,1986, p.18, Dept. of Justice, 1997). These figures cannot reflect the overall situation of the total quantity of drugs available in Ireland as seizure statistics are understood to reflect the tip of the iceberg

and the extent of law enforcement. However they are one of many indicators of the growth in the availability of drugs.

Up to the 1980s, the problem largely speaking was one of occasional use of drugs like marijuana and LSD among 'fringe' elements of society with more serious use of drugs, most notably heroin, among certain working class areas of Dublin.

It is only in the past ten to fifteen years that all types of illegal drugs have become more widely available and that their general use has crossed all social classes. In the 'Second Ministerial Task Force Report to Reduce the Demand for Drugs', it was stated that ecstasy and cannabis are now available in every town in Ireland. Apart from the Department of Health(1996b) and ESPAD studies, already quoted, few national studies have been carried out on young people's drug use, therefore it is very difficult to detail trends with accurate and reliable data. The most recent national survey published, carried out as part of the ESPAD research shows "drug use as common among Irish 16 year old students, with 37% of them having used cannabis, 16% having used an illicit drug other than cannabis and 7% having used tranquillisers or sedatives without a doctor's prescription" (ESPAD,1995, p.104). In a recent survey done for the National Youth Council of Ireland on 1400 people between the ages of 15 and 24, 53% said they had taken illegal drugs, with 12% currently using them once or twice a week, 22% taking drugs once or twice a month and 34% taking them three to four times a year (National Youth Council of Ireland, 1998). Among those working directly with young people there is a common belief that drugs are one of the main recreational options for Irish young people in the late 1990s and indeed young people themselves see drugs as second only to unemployment as the most serious issue/ problem facing young people today (NYCI, 1998, p.4).

There are also regional studies as mentioned above which carried out research in young people's drug taking behaviour. These vary according to the age of those surveyed and the most recent published from the Mid-West shows a lifetime prevalence for cannabis varying between 5.3% at the age of 13 to 33.1% at the age of 17 (Mid-Western Health Board, 1998).

Another main way of gauging drug use patterns is through statistics of those who present for drug treatment. Again caution must be used with these figures as they are only those who present for drug treatment and therefore do not reflect the growing population whose drug use has not become problematic, at least to the extent that it requires treatment. The available statistics give information on age and social class, however up to 1995 they only pertain to the Dublin area, so it is therefore impossible to give an overall national picture prior to this. Moran et al show there is a marked difference between the drugs misused by those under 15 and older treated drug misusers. For those under 15, cannabis is the primary drug of misuse(58%), followed by volatile inhalents(20%), which is closely followed by opiates(17%). The figure for volatile inhalants is particular worrying given the knowledge that use can cause death even on the first occasion. After the age of 15 however, the primary drug of misuse for all groups are the more problematic opiates. When asked the age at which they first used any drug, 42% indicated that they were under 15, while 49% said they were between 15 and 19 years of age. Thus 91% of the total treatment group had commenced drug use while in their teens. 68% were using their primary drug on a daily basis and nearly a quarter were misusing their primary drug for over 5 years. Over 58% of this study had left school before the official school leaving age of 15 and 83% were

unemployed. An overview of the trends of those who presented for treatment for drug misuse for the Dublin area between 1990 and 1996 shows that there "has been a steady increase in those presenting for treatment for drug misuse, with the scale of the increase being particularly remarkable in the north inner city. Clients are getting younger, however the percentage of teenagers who present for drug treatment has remained constant. Levels of unemployment range between 88% and 90%, the proportion of those treated for heroin misuse has doubled and intravenous use has become less common while smoking (heroin) is increasing"(Moran,R et al., 1996, p.8, 11, 28).

2. Diet, overweight and high blood pressure

While being overweight and having high blood pressure are generally not health concerns of young people, the patterns and behaviours that young people establish early in life will be reflected in their health status in later years. Thus the importance of establishing healthy eating and exercise patterns among young people is apparent. In recent years there has been concern around the dietary habits of young women with eating disorders being a cause for particular concern among a minority of young people. The HBSC Study found that overall, 8% (4% of boys and 12% of girls) reported being on a weight reducing diet and an additional 23% (18% of boys and 28% of girls) reported that they needed to lose weight (HBSC, 1999, p.36).

Concern is often cited in relation to the diet of lower socio-economic classes. In 1992, Murphy-Lawless compared the living standards of an 'average' family and a 'welfare' family and found that "the 'average'

family have better quality food, larger portions and greater variety. Fruit consumption is a regular for most 'average' families whereas fresh fruit and vegetables are severely limited for the 'welfare' family. The welfare family relies heavily on cheap filler foods like potatoes and white bread in order to stretch spending on food which is 25% less than that of the average family. It is interesting to note that the mother of a welfare family makes do with smaller portions and compromises her own nutritional status" (Murphy-Lawless, J, 1992, p. 55). The HBSC survey shows that there is minimal variability between socio-economic groups in relation to diet and exercise patterns (HBSC, 1999).

3. Stress, mental health and suicide

For young people, family circumstances, economic situation, home environment, support networks, exams and educational achievements, all can be contributing factors to the levels of stress in their lives. Obviously, there is a great deal of variation in these influences from time to time and from individual to individual. Statistically, the only measure of young people's mental health status is when they present for help through the psychiatric services or figures kept on those attempting (para-suicide) and committing suicide. Again, these must be viewed with caution as they only represent those who end up in crisis situations. The admissions to psychiatric hospitals for 1996 show a total of 859 admissions for those 19 years and under. This research does detail social class which shows that admissions are considerably higher in the unskilled manual group than in other socio-economic groups. (962.8 per 100,000 in the unskilled manual groups compared to 214.7 per 100,000 in the employers and managers group) (Keogh,F, et al., 1996).

The greatest manifestation of depression and mental illness are para-suicide and suicide. "Suicide is the second most common cause of death among young men in Ireland, however among young women, only one in thirteen deaths are due to suicide" (Ireland, 1996b, p. 29). The interim report of the Task Force on Suicide states that "psychological illness and access to alcohol and drugs become increasingly important factors in late teenage suicides and thereafter" (Ireland, 1996b, p.29). This marked gender difference does not hold for para-suicide. The National Suicide Foundation has shown that for the age group 15 to 24, para-suicide is as common among females as males. This Foundation has been carrying out research in the Cork area for 15 years and it's findings correspond with similar research being done in Helsinki (NYCI, 1997). Their work has found that while suicide is more common in rural areas, para-suicide is more common in urban areas. The Cork study also found that some areas of Cork had much higher para-suicide rates than others and that these were characterised by the following social factors

- domestic units were mainly rented from local authority
- high density of people per room and per hectare
- the majority having a minimum education and most are unemployed (NYCI, 1997,p. 50).

Thus, it follows that there is a strong association linking higher rates of para-suicide with lower socio-economic status. "Of those who deliberately end their lives, over 90% of them are mentally ill of which the commonest illness is depression" (NYCI, 1997, p.38). Research carried out in other countries shows that depression is frequently an undiagnosed illness. One of the findings in the psychological autopsy study carried out by the above mentioned National Suicide

Foundation was that only one in four young people who ended their lives were known to be in contact with the health services in the year before they died. Had they been in touch it is possible that at least some of these suicides could have been prevented (NYCI, 1997).

4. Young people and injuries

In 1993, 40% of childhood (aged 1 - 14) deaths were from injuries. Of these 48.6% were from road traffic accidents. In a review of 'Accidental Injury in Ireland, priorities for prevention', Laffoy et al outline how there is a strong association between social class and risk of injury. The socially disadvantaged have consistently higher risk of injury and death from injury. The gradient is steeper for death from injury than any other cause of death in children. They make reference to a Canadian study where the increased risk from traffic injury was four to five times that of children in more affluent areas (Dougherty, G. 1990). This finding has been reproduced in many similar studies for injury type (Lafoy, M. et al, 1995).

5. Young people and sexual health

Young people's sexual health and behaviour can directly impact on their current and long term health status. Societal norms and attitudes in the area of sexual behaviour have changed considerably in recent years and today for example young people grow up in society where Relationships and Sexuality Education (RSE) is part of schools curriculum, issues of sexuality are discussed more openly, homosexuality is legal and contraception is widely available. While there remains no national data on young people's sexual health behaviour, some data is available on teenage pregnancies which shows us that the number

of pregnancies has not greatly increased. There were 2,109 teenage births in 1970, 3,580 in 1980 and 2,700 in 1996. Thus showing no major difference in the rate of births to women under 20 during this time span. What has changed is the marital status of these women, with 50% of births to women under 20 in 1982 being to married women compared to 5% in 1997 (Vital Statistics, 1998).

International research in Europe, Australia and the USA show that the age of engagement in sexual activity is lowering (McHale, 1994). Additionally some regional studies have been carried out in Ireland which show patterns of young people's sexual health behaviour. McHale, in her research carried out in Galway city and county, with school going teenagers, reported 21% of teenagers had had sexual intercourse, 29% of these were male and 15% female. Their average age of first sexual intercourse was 15.45 years. The Alliance's research (1998) carried out in Cork with 800 15 - 24 year olds, found that 22% of females and 32% of males had had sexual intercourse by the age of 16. These figures are higher than the McHale research and the Cork study suggests that this could be because their cohort consisted of young people in and out of school. Of the 15 to 17 year olds questioned in Cork, 70% of the females and 55% of the males had not had sexual intercourse. These figures are important as they contradict the common perception that all young people are engaging in sexual activity. Of those engaging in sexual activity in the Cork study, 59% of men and 55% of women reported using a condom at last intercourse, thus showing large numbers not practising safer sex. These figures are backed up by anecdotal evidence from STD and GUM clinics around the country which are reporting increased testing and reporting of Sexually Transmissible Infections (STIs).

All of these issues, smoking, substance use, diet, mental health status, injuries and sexual health behaviour are ones which can be positively influenced through health promotion and lifestyle initiatives. In all the above mentioned areas apart from alcohol consumption, there is a direct link between lower socio-economic status and poorer health status or more risky health behaviour, hence the importance of looking at the issue of poverty when addressing the health needs of young people. It also demonstrates how important health promotion interventions can be in order to positively influence healthy lifestyles among young people, particularly young people at risk.

6. Young people and poverty

In the National Anti-Poverty Strategy (NAPS) people are defined as living in poverty, if their income and resources are so inadequate as to preclude them from having a standard of living which is regarded as acceptable by Irish society generally. This report also states that "as a result of inadequate income and resources people may be excluded and marginalised from participating in activities which are considered the norm for other people in society" (Ireland, 1997a, p.30). Children are specified in the NAPS as being particularly at risk of poverty, especially those living in large families, as poor children do less well academically, are more likely to suffer ill health, are vulnerable to homelessness and delinquent behaviour and have fewer opportunities in life (Ireland, 1997a). This strategy specifies unemployment as the main factor causing poverty in Ireland, therefore households with an unemployed head have the highest risk of poverty (Callan, T. et al, 1996). The strategy outlines the three areas where poverty is most concentrated as being decaying inner city

areas, large public housing estates at the edge of cities and towns and isolated and underdeveloped rural areas (Ireland, 1997a). It also outlines how those living in poverty find it hard to break the cycle and therefore find it difficult to escape. Factors associated with long term poverty seem to be related to class origins, childhood economic circumstances and erosion of resources over time. This can be reproduced inter-generationally where children of those living in poverty are also at high risk of poverty, so that a cycle of poverty is created which deepens the extent of poverty among certain communities (Ireland, 1997a).

7. Educational disadvantage

Educational disadvantage is defined in the National Economic and Social Forum (NESF) report as "a complex phenomenon which results from the interaction of deep-seated economic, social and educational factors" and it stressed that its roots were to be found in the social and economic disadvantage of communities and families (Ireland, 1997b, p.39). Unemployment is cited as the main cause of poverty and access to employment is strongly related to educational experience (Ireland, 1997a, Ireland, 1997b).

Young people who leave school early or fall outside of the formal education system are identified by the National Anti-Poverty Strategy as one of the three most important categories, linking educational disadvantage and poverty. These young people are at high risk of unemployment and poverty. This, when combined with the finding that educational achievement influences life chances more generally, enhances the transition from youth to adulthood and the establishment of independent households further puts young people who leave school early at a severe disadvantage compared to their school going

counterparts. This is supported by Clancy's study on access to higher education which shows huge disparities according to economic status, socio-economic group and social class. The admission rate to higher education for the Dublin 1 postal district was 4.8% compared to the national average of 35.9% (Clancy,P, 1995).

In a study commissioned by the Clondalkin Partnership on school absenteeism in the area, McSorley found that "as with other marginalised areas of Dublin, levels of educational qualifications are disproportionately low, with 54% of the labour force having only primary or lower secondary education. The population of Clondalkin tends to leave school earlier than the national average. This is particularly true of North and South-west Clondalkin, where as many as 58% have left school at 15 years or younger" (McSorley,C, 1997). This report also comments that "the unemployment rates amongst heads of households in local authority areas is as high as 73%." The ESRI report on the 'Economic Status of School Leavers 1994-1996' shows an absolute correlation between standard of education and employment prospects. The OECD Economic Survey of Ireland also shows the direct relationship between poor educational achievement and low earnings (OECD, 1995).

The NESF report outlined that 88% of those who left school early were from working class origins or with unemployed parents while the average proportion of all school leavers from such backgrounds is only 50%. A comparative European study found that 8% of Irish students left school without any qualification and 18% left without any qualification beyond compulsory education (Ireland, 1997b). The NESF report made it's own estimations which show that 7.5% of the total school going population were early school leavers, defined as young people who do not enter second

level, leave without any qualifications, or who did not achieve 5 passes in the Junior Certificate. It also estimated that 21% are potentially educationally disadvantaged leaving school with fewer than 5 passes in the Leaving Certificate or having achieved 5 passes in the Junior Certificate (Ireland, 1997b). Traveller children are even more likely to leave school early with only 5% of traveller children between the age 12 and 15 attending mainstream education (Ireland, 1997b).

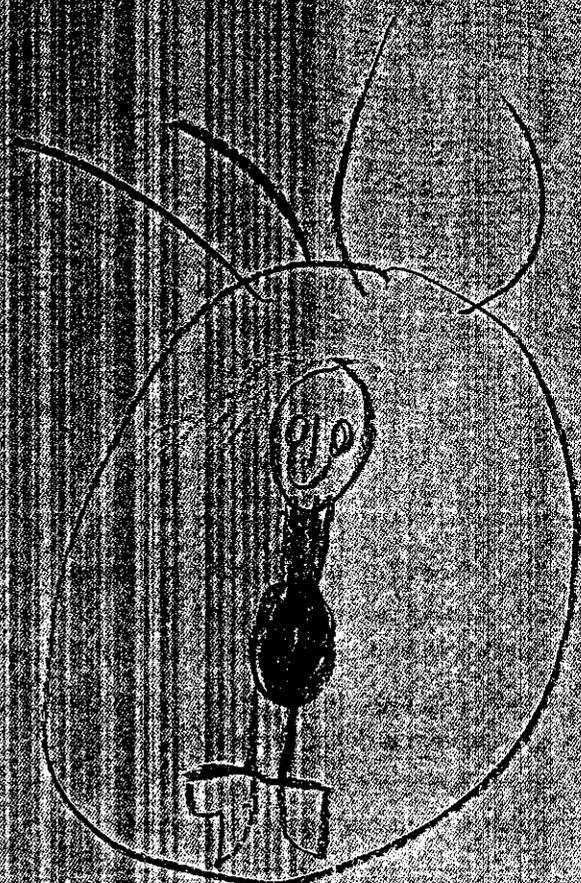
Young people at risk in terms of their health behaviour

The effect on physical health, the increase in psychological stress and the alienation of young people are three of the six consequences of poverty outlined in the NAPS report (Ireland, 1997a). This NAPS explains the complex relationship where the consequences of poverty can become the causes of it. Poverty has been found to manifest itself in psychological distress, physical ill-health and reduced life expectancy as detailed above in relation to smoking, substance use, diet, exercise, stress and mental illness. The above relevant data show that there are clear links between educational disadvantage, unemployment and poverty, (particularly child poverty) and the high risk factors that negatively influence health status and behaviour.

Thus the focus of this report is on young people at risk, as young people who experience these factors are more at risk in terms of their health related behaviour than those who do not. The definition of at risk used in this report is in terms of their health behaviour, but the inter-connectedness of the various factors discussed above must be acknowledged and taken into account when considering the health needs of this particular target audience.

CHAPTER TWO

Young people out of school -
perceptions of their own health needs



Researching young people's perceptions of their own health needs

The first stage of the national consultative process was to carry out research on young people's perceptions of their own health needs. For the purpose of this work, young people were divided into three categories but as the focus of this process is on young people at risk, who have left school early or are at risk of leaving school early, this report concentrates on young people in category two.

<p>Category 1</p> <p>Young people aged 13 to 17 in school</p>
<p>Category 2</p> <p>Young people aged 13 to 17 not in school, but attending youth training programmes, early school leaving projects or in touch with youth or community organisations</p>
<p>Category 3</p> <p>Young people aged 17 and under, not in school or any form of training, but in contact with crisis and treatment services or detention centres</p>

The reasons for this have been detailed in the introduction and in chapter 1. As the focus of this report is on young people at risk, focus groups were carried out with young people in category two. These categories were devised in the knowledge that many young people move from one

category to another, but in order to prevent so many young people reaching the third category, those most at risk in category one and those in category two must be targeted.

Research process

Focus testing is a research method designed to elicit the maximum understanding of a groups attitudes and perceptions. Six focus groups were carried out, between April and June 1997, comprising of 53 young people [26 were male, 27 were female] between 13 and 17 years old. In order to obtain an overall national picture, six groups were contacted, two in Dublin city, two in a large town and two in a rural area.

The aim of the focus testing was to establish what issues young people viewed as important to themselves and how these related to their health. These outcomes are not considered representative of all Irish young people, but rather as a sample of the perceptions of some young people who are out of school.

Accessing young people out of school

It was very difficult to access these young people for the focus groups as the very nature of such a target audience is that they are the young people who are not being worked with by mainstream services, thus making it extremely difficult to convene them as a group. Allied to this is the fact that most of the community and youth organisations contacted expressed a degree of reluctance to allow someone from a government authority i.e. a 'government official' to make contact with 'their' young people. They held the view that because the young people with whom they are working are sceptical about

'government authority figures', their participation in such a process could endanger the relationships that they, as workers, have established and they did not want to jeopardise this.

Focus groups

Five of the six groups that were focus tested were accessed through youth and community groups who have specifically targeted early school leavers and the final group was contacted through a home-school liaison officer working in the north-western region. Some of the young people were on youth training programmes e.g. Youthreach or Community Training Workshop (CTWs) or had returned to school in the recent past, having spent a period of time out of school.

The size of the focus groups varied from 5 to 14 participants and the proceedings of each group were taped. All of the groups were of mixed gender except one which was all male. The time spent with each group ranged from 35 to 90 minutes depending on their concentration and how much the young people had to say. The group that lasted 90 minutes was from a rural area, had never met as a group before and were very keen to talk about their health.

The first pilot focus test which was planned had to be postponed as one of the group overdosed on heroin the weekend before and therefore it would have been inappropriate to proceed. An alternative pilot was carried out in a different area. The vast majority of the young people who took part in the focus tests were from lower socio-economic backgrounds and came from areas either designated or considered disadvantaged in both the rural and urban settings.

Overall, the groups, once they got going, were keen to talk and seemed somewhat surprised that the researcher was interested in what they had to say.

Questions asked in focus groups

- Q.1 What is important to you ?
- Q.2 What is most important ?
- Q.3 Are these the same for other young people (in the country, in a town, in a rural area)?
- Q.4 Are any of these (the things that are important to you) related to your health?
- Q.5 What could other people do to make your life healthier ?
- Q.6 What could you do to make your life healthier ?

Young people's health issues

In response to these questions, the main issues emerging for the young people can fit into the following categories. Each of these are discussed in turn with quotations used as appropriate to highlight the young people's views.

- A. Relationships
- B. Sexual health
- C. Substances
- D. Poverty and their lack of opportunities
- E. Personal responsibility for their health
- F. The feeling of not being listened to and the issue of role-modelling
- G. The commonality of their issues.

A. RELATIONSHIPS

All the groups mentioned their relationships with their family, friends and partners in response to question 1 and it was the only issue named unanimously in response to question 2. All the young people interviewed believed that their relationships were the most important part of their lives. Four of the groups identified their relationships as being related to their health and these were mentioned in both a positive and negative sense. There was general recognition from

these four groups of how life is easier if you get on well with your family and how difficult it could be if relationships were poor. "If you don't get on with them it wrecks your head." It was also perceived that being abused, either physically, mentally or sexually, was very damaging to your health. These groups put a lot of emphasis on the importance of friends and how life is better if you have good friends. It is interesting that while a lot of emphasis was placed on relationships and friendships as being very important to them and related to their health, these issues were not identified as a way in which they themselves or others could make their lives healthier, in response to questions 5 and 6.

B. SEXUAL HEALTH

The term sexual health is being used in this context when the young people referred to sex, sexuality, contraception and sexual health related issues. The issue of sexual health was not mentioned in response to question 1, yet it was named as one of the most important things in their lives in response to question 2. Initially, there was some bravado, particularly from the boys in the groups in relation to sexual issues. However, when pushed to answer question 2, what emerged from the girls was the issue of not getting pregnant and for the boys the importance of information on sexual issues. Two of the groups acknowledged that while not all young people were sexually active, there is a big importance attached to having accurate knowledge of sexual health issues. All the groups made the connection between sexual health issues and their health. Again, the issue of pregnancy came up but of equal importance was the issue of sexually transmitted diseases, with particular reference to AIDS.

Of the groups that responded to the fifth question, all of them spoke about the need for

making contraception more readily available in places where young people congregate. Here there was particular reference to condoms with demands being expressed that "condoms should be free and everywhere" or at least cheaper and that there should also be more accessible information on contraception in their language for all young people, "They should speak to us in our language." In response to what they themselves could do to make their lives healthier, all groups identified practising safe sex, by either going on the pill and using and/or carrying condoms. One young person proposed abstaining from sex in order to be healthier, a suggestion that was met with disdain by others in that group. However, it is an important point that must be taken into consideration when dealing with young people on sexual health matters as young people become sexually active at different times in their lives and to become sexually active at a very early stage may not be the healthiest option for that young person.

There was also reference to the importance of the anonymity of sexual health services where young people can access information, contraception or health care. One young person referred to the only place where one could go for a pregnancy test in that town as being a doctor's surgery on a particular afternoon and if you were seen entering then the word would immediately travel around the town that you were 'up the pole'. These responses show that there is clearly a demand for providing young people with anonymous, accessible, youth friendly information and services on sexual health issues.

C. SUBSTANCES

All the groups mentioned cigarettes, alcohol and drugs as being important to them [Q.1] and issues that are related to their health

[Q.4]. These issues will be dealt with separately here as follows :

Smoking

While smoking was immediately stated by all groups as being important, only one group named it as being most important. All of the groups made the connection about smoking being a health related issue, "smokes are bad for you", "it gives you lung cancer", "stops you breathing" [this was said in relation to asthma]. However, they also spoke about how "they calm you down", "are good for your nerves", "stop you eating" [this was said by a young woman].

Only two groups mentioned responses to what other people could do to make their life healthier in connection to smoking. The first was on the topic of advertising, with one young person suggesting that they should "scare the hell out of us". Another young person responded by saying that everyone knows that smoking kills, but nobody cares. The second was in relation to the sale of cigarettes to under 16's. This group suggested not selling cigarettes to under 16's as "everyone starts smoking before they are 16 and if you could get to 16 not smoking then you mightn't start."

When asked what they could do to make their lives healthier, all of the young people suggested giving up smoking. When asked to apply this to their personal situation, they found this more difficult and suggested "smoke lighter cigarettes", "go on the patches" and "chew gum". Two young women in two different groups, spoke about not giving up as it would affect their figure.

The vast majority of the young people in all the focus groups were smokers, and in three

of the focus groups the young people smoked throughout. The other groups were situated in non-smoking rooms and with two of these groups, the session paused for 'smoke breaks', a familiar term and experience for all the young people involved. The sixth group managed to last the 45 minute session without smoking!

Alcohol

Like cigarettes, all the groups mentioned alcohol as important [Q.1], but not most important [Q.2] Five of the groups talked about alcohol in relation to their health. There was a general consensus that it was good for them, but bad for others. For most of the young people, it was apparent that drinking is an important part of their social lives and they do not view it as a drug. There was general conversation in most groups on the benefits of alcohol, "you can do anything", "it gives you courage", "it's something to do". There was a tendency to view alcohol as being unhealthy only in relation to adults and they talked about how alcoholism and heavy drinking can ruin people's lives, especially families.

Again, like cigarettes, the only suggestion as to what other people could do to make their lives healthier was not to sell alcohol to under 18's. When it was pointed out to them this was in fact the law, this was met by general hilarity as none of the young people seemed to have any difficulty when purchasing alcohol.

Moderation seemed the general response to what they themselves could do to make their lives healthier in relation to alcohol, "don't get too drunk". Again the point of the enjoyment they got from alcohol came up with discussion centred around how it enabled them to have a good time and provided them with an escape from everyday life.

Illegal Drugs

Two of the groups considered illegal drugs as most important [Q.2], one of these was from a rural area and one from Dublin city. Initially, drugs were mentioned usually in the context of being a threat around them rather than something they use. However, once the groups became more engaged, it was apparent that recreational drug use was part of their or other young people's regular social activity. There seemed to be a general consensus that cannabis is OK, is much less damaging than alcohol and in some groups agreement that it is good for you, "it gives you something to do", "calms you down", "chills you out", "hash is harmless" and ecstasy was seen as being 'alright' if it was a good one.

Two of the groups spoke about how cannabis should be legalised. The other illegal drugs mentioned were acid and heroin. In relation to ecstasy and acid it seemed that if young people were doing them recreationally and or regularly, they spoke positively about them, "they give you a good buzz", "make you feel brand new and bopping". Two groups, one from a rural area and one from the city, did differentiate between a good trip and a bad one, but also agreed there was no way of knowing until you were on it. They spoke about rat poisoning in ecstasy and if you are on a 'love buzz', you are more likely to have unsafe sex. The two groups which appeared to be made up of young people who were not doing any type of drugs were obvious as they spoke about them with fear and anxiety and used a different language to the rest of the young people.

There was also a general consensus about heroin which was the only drug that everyone agreed was dangerous and damaging. Heroin was viewed with fear and was considered

only a Dublin phenomenon. For the two Dublin groups, heroin was clearly very near to them in that most of them came from communities where many are affected by addiction. In both of the Dublin groups they mentioned not wanting to end up on 'gear', nevertheless there seemed a sort of inevitability that some of them would end up 'strung out'. The need for more access to and effective treatment services was named as one of the things other people could do to make their lives healthier. These two groups also talked about the rave scene and how dance music can affect your health.

Half the groups suggested that by giving young people something to do they were less likely to end up 'using' drugs, "give us a decent future and jobs", "if there was some hope". Only one group was totally negative about drugs and even in that, it seemed that the recreational drug users were staying quiet. This group suggested staying away from people who use and sell drugs in order to stay healthy and "not to do them and if you do to talk to someone and get off them".

The above are insights into these young people's views on substances and show what they identified as ways of effectively addressing these issues. In relation to smoking, they recommended that prevention must be targeted at children and legislation should be enforced. They believed that moderate drinking could be promoted with young people as a way of influencing healthier drinking habits. Clearly on the drugs issue, the young people said they are looking for non-judgemental information but they are not interested in being lectured to. Some of their comments were inaccurate e.g. rat poisoning has never been found in any ecstasy tablets in Ireland. In general it was identified by the young people that providing

them with alternatives and educational opportunities is a way of preventing their alcohol and drug use becoming problematic.

D. POVERTY AND LACK OF OPPORTUNITIES

As mentioned above, the majority of young people who participated in the focus groups were from areas either designated or considered disadvantaged. With the exception of one of them, all the groups convened in a community centre in their own area. This was a conscious decision to meet with them in their own environment, in order for them to be in familiar territory. These centres are located in areas of high unemployment and poverty.

Half the groups mentioned money as being one of the most important things in their lives and it was mentioned in the context of not having it and how that inhibits opportunities and choices. Two thirds of the groups identified money as being related to their health and having more money as critical to living a healthier life.

Two of the groups, one from a rural area and one from Dublin, could not come up with any ideas as to what other people could do to make their lives healthier [Q.5]. Both these groups came across as hopeless and despondent. They seemed reconciled to the fact that their circumstances would not change and nothing anyone could do would make their lives healthier. A third group found this question also very difficult to answer and the only one they came up with was "to find a cure for AIDS".

There was a general consensus from the other four groups that young people drink and do drugs as they have nothing else to do and if young people were given a "chance", "alternatives", "more things to do", more

"clubs" and "activities", "better chances in school" and "a job", then their lives would be healthier.

What is interesting here is these quotes clearly indicate that these young people believe that their environment, socio-economic status and lack of opportunities directly relate to their health behaviour and status.

E. EDUCATIONAL OPPORTUNITIES

While no questions were asked about their education experience, the issue did arise with most groups. *There were varying opinions on school, with some young people wanting to get back into it and others very clearly having no intention or desire to return. All the groups also commented on the lack of health education in schools or when they did get it, it was too late, in a language incomprehensible to them and by teachers whose opinions they would not trust anyway. There was quite a lot of anger coming from the young people in relation to this issue.*

In the four groups from the town and the rural areas the fact that they have no alternatives to school was named as an obstacle to further education. The age requirement of being over 21 in order to access the Vocational Training and Opportunities Scheme (VTOS) i.e. returning to school while still getting your dole was named by young people as a barrier to re-entering the education system.

These concerns voiced by the young people highlight the importance of maintaining young people within the school system whenever possible, of a holistic health education module in all schools and the provision of incentives and alternative education for those young people who do not remain within the formal education system.

F. PERSONAL RESPONSIBILITY

The issue of young people taking on personal responsibility for their health was highlighted when two of the six groups could not think of anything anyone else could do to make their lives healthier. "There is nothing anyone can do to make my life healthier." Yet they were able to articulate many answers to what they themselves could do to make their lives healthier. This demonstrates the importance of social health promotion as well as individual health education in addressing the health needs of young people at risk.

However, when asked to apply these answers, "don't drink", "don't do drugs", "don't have sex", "don't smoke", to their own personal situation, their answers changed to "smoke lighter cigarettes", "go on the patches", "don't drink too much", "use condoms".

This indicates that while these groups have a comprehensive understanding of what is and is not healthy, it does not correspond to their behaviour, thus the challenge for health promotion initiatives is to impact not just on their knowledge base, but also upon their behaviour.

G. HAVING A VOICE AND ROLE-MODELLING

While not being a direct answer to any of the questions, the issues of having a voice and role modelling did arise again and again as persistent themes throughout the focus groups. The young people felt very strongly that they were not being listened to and their views were not being taken into consideration even on subjects directly related to them. They participated very constructively in the focus groups which could indicate the fact that they felt they were being listened to. There was a strong consensus among all the groups that young people should be

consulted with on all issues relating to them.

The other consistent theme was in relation to adult role-modeling and the inconsistency between adults messages and behaviours. This was explained very clearly by one of the young people from a Dublin group who talked about her ma telling her not to do drugs in the same minute as heading out to the pub. The inconsistency in adults 'instructions' and 'examples' seem to render any advice given to them in this vein as lacking credibility and therefore unlikely to be adhered to simply on the basis of the instruction.

H. COMMONALITY

The extent of commonality between the groups is demonstrated through the lack of diversity between their responses. As all except one of the groups were mixed it is not possible to estimate the gender differences, however it is apparent from the responses that there was not a rural/urban divide, except on the drugs issue as outlined above.

Question three was the only question where there were very apparent differences and yet the consistency of the differences show a commonality in that they all believed that they were very different to young people in the same circumstances i.e. the young people out of school in Dublin felt that they were very different to young people in any other environment i.e., in a town, in a rural setting.

Their answers to this question were disturbingly stereotypical with young people in the city viewing young people from the country as only interested in "sheep and sex and muck", while their rural counterparts envisioned the city young people as "into crime and drugs and prostitution."

Summary

Arising from the focus groups the main issues are summarised below and are solely those of the young people out of school who participated in the focus groups. They do not reflect the policies and views of the Department of Health and Children. However, many of their views have been taken into account in the formulation of the recommendations as outlined in chapter 5.

THE MAIN ISSUES THAT THESE YOUNG PEOPLE OUTLINED WERE

- the importance of their relationships in their lives
- the need for provision of anonymous, accessible and youth friendly information and services on sexual health issues with particular reference to greater accessibility to contraception
- smoking prevention should be targeted at children and current legislation enforced
- moderate drinking habits should be promoted among young people
- non-judgemental, accessible and youth friendly information should be provided on illegal substances
- there should be a greater provision of recreational facilities and alternative educational opportunities
- the identification of links between poverty and poorer health status
- the need for more accessible re-entry into the education system
- the importance of health promotion impacting upon their behaviour as well as their knowledge
- that young people should be consulted on issues related to them
- there is a need for consistency between adults' messages and behaviours if adults are to be credible
- the commonality of the issues that emerged from the young people from the city, a large town and rural areas.

CHAPTER THREE

Issues arising from Regional Youth Health Fora

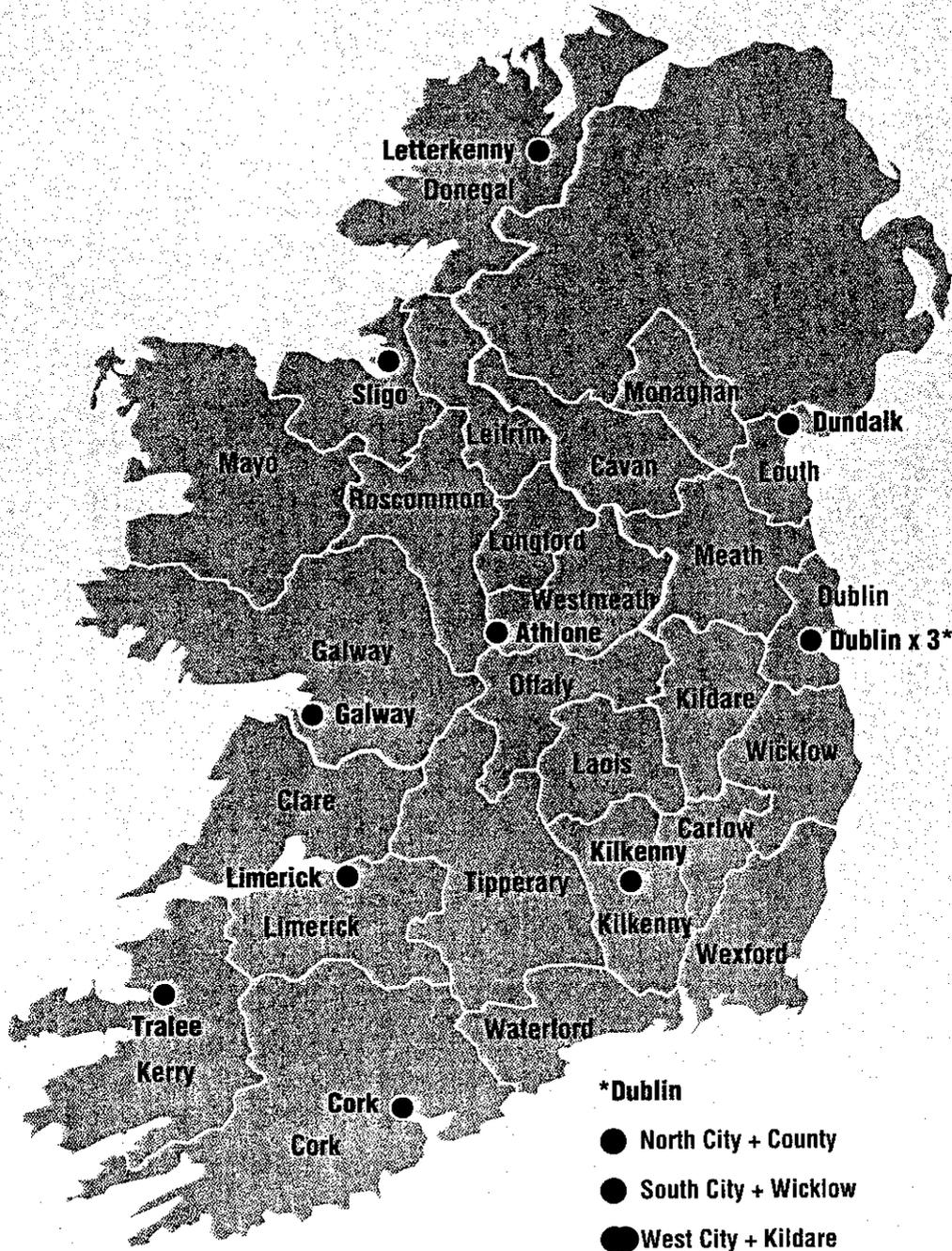


Issues arising from Regional Youth Health Fora

Twelve Regional Youth Health Fora were held between October 1997 and March 1998. One

was held in each health board area except in the North-Western and the Southern Health Boards where two were held in each due to their large geographical size and in Dublin where three were held in order to try to be representative of the city's population (see map for locations).

Regional Health Fora



AIMS OF THE REGIONAL HEALTH FORA

The aims of the fora were to bring together those responsible for service provision for young people at risk in order to

- increase awareness of the health needs of young people at risk
- provide an opportunity to share information, learn from each other and identify the gaps in terms of addressing the health needs of young people at risk
- identify the circumstances and structures which influence the health status of young people
- make recommendations as to how these young people's health needs could be addressed more effectively.

Target audience

Participants invited to the fora were those in the region working with young people at risk. Relevant professionals in the regions were consulted with in order to target the most appropriate participants. These included youth and community workers, staff and volunteers from youth organisations, communities and clubs, youth trainers from Youthreach centres, Early School Leaving projects and Community Training Workshops, health board personnel including social workers, childcare workers, residential care workers, drugs/AIDS education workers, outreach workers, psychologists, addiction counsellors, health promotion officers and their team members, drugs co-ordinators and project workers, public health nurses, public health specialists, Garda Juvenile Liaison Officers (JLOs), probation officers, school staff including teachers, guidance counsellors, school nurses and home-school liaison officers, voluntary organisations, Partnerships and Local Area Task Force representatives, Prison and Special Schools staff, representation from Government

Departments, religious and academics. For a breakdown of representation see Appendix A.

Numbers attending

Between 30 and 80 were invited to each fora depending on the area and attendance varied between 18 and 55. A total of 262 people attended the fora around the country. On average there were 22 at each.

Agenda

Participants were brought together for a day and full day participation was requested in order to gain maximum benefit from the process. The days were facilitated by Sara Burke, Youth Health Promotion Project Officer and Siobhan McGrory of the National Youth Health Programme (NYHP).

Each day began with a concerns and expectations exercise. In this session, in each of the fora, there were many concerns stated in relation to circumstances not changing for children at risk and cynicism as to whether anything could change as a result of this consultation. There was however also some optimism that those working on the ground were being consulted with by the Department of Health and Children and hopes expressed that change would occur as a result of this process.

Participants then focused on the work they are currently involved in that addresses the health needs of young people. This part of the fora was welcomed as it gave participants time to reflect on the work that they do, to look at 'health' in it's broadest sense and to share their work practices and experiences with others present. It is not possible in this report to document all the work of those who participated in the fora. The fora clearly

demonstrated that the extent of work going on locally and regionally cannot be understated, even though much of this work relates to health and health status, it is not being carried out under the name of 'health education' or 'health promotion'.

They also demonstrated that while there are many in the health board regions working with this target audience, they are not always working in a cohesive and co-operative way. The next part of the day was a presentation on the outcomes of the focus groups as outlined in chapter 2.

The majority of the day was spent identifying the circumstances and structures influencing the health status of young people at risk and producing recommendations as to how these issues could be addressed more effectively in the future at local, regional and national levels. These findings were then presented to a gathering of regional and national policy makers from relevant sectors who were brought through a similar process in April 1998.

Identification of the circumstances and structures influencing the health status of young people at risk

Each fora named many issues that influence the health status of young people and then prioritised them. The issues of:

- a. education ;
- b. access to and availability of services and facilities ;
- c. socio-economic policies ;
- d. parenting and family support ;
- e. integration of services ;

were identified by the regional fora as the most important factors that influence their health status and behaviour. Each issue will

be discussed in turn, however no one issue should be considered in isolation of the others outlined. The discussion of each issue is a reflection of the views of those who participated in the fora.

A. Education

Young people's participation in and experience of education can play a critical role in positively influencing their health behaviour. The term education is used in this report to encompass pre-school programmes, primary school and second level school, youth training and the non-formal education system e.g. youth organisations and clubs. Education was identified by all of the twelve regional fora as a key factor influencing the health behaviour and status of young people.

PRE-SCHOOL PROGRAMMES

Children's participation in education can begin at the toddler stage with involvement in pre-school programmes. For most children and families, but particularly those more at risk, this early involvement was named as playing a key role in both the child's development and support for the family. It also allows for a smoother entry in to the formal education sector and establishes at an early stage positive relationships between the family and those working with their children. An example of such an initiative that was cited by the fora as *doing good work in this area* is the 'Early Start' Pre-School Project. (See chapter 4 for details).

PRIMARY SCHOOL

The progression of young people through primary and in to post-primary school is essential to their positive experience of education which in turn impacts upon their health behaviour. Primary school teachers maintain that the pupils who are in need of

additional social, emotional and educational support can be identified at a very early stage. If these needs can be met at this early stage, appropriate interventions can be very effective. In order for such interventions to take place, some of the additional supports named as necessary were special needs teachers, smaller class sizes, a focus on literacy and access to psychological and therapeutic services.

TRANSITION TIMES

The transfer of children from primary to post-primary was identified by the fora as a crucial stage in a young person's educational career. In some areas of the country, additional support has been provided. Mentoring programmes, for young people considered at risk of early school leaving, which have contributed to the successful transfer of some of these young people to post-primary school, was given as an example of supporting young people during this difficult transition time.

EXPERIENCE OF SCHOOL AND EARLY SCHOOL LEAVING

A direct link was identified at the fora between a young person's length of time and experience of school and his/her health behaviour. Young people who leave the school before the official school leaving age of 15 were believed to be more at risk in terms of their health behaviour. Thus throughout the country participants felt there should be a huge emphasis on preventing early school leaving and targeting pupils from disadvantaged areas who are at risk of not achieving their potential in the education system.

Some young people remain in school physically but it has such negative impacts upon them that they are also at high risk of leaving early and being educationally disadvantaged. There was repeated praise of

the benefits of programmes such as the home-school-community liaison scheme and other initiatives targeting disadvantage. The new pilot project 'the 8 to 15 year olds project' established by the Department of Education and Science to address early school leaving was seen as a welcome development. The detection and follow up of persistent non-attenders and early school leavers and their reintegration back in to the school system was identified as crucial.

Some of the young people most at risk who are irregular school goers or early school leavers are in contact with youth and community groups. Often these can be the only place of contact where these young people have a positive relationship with an adult and are provided with alternative supports and education e.g. Coxes Demesne Second Chance Project and Neighbourhood Youth Projects in Dublin, Galway and Cork which provide a community based alternative to school for young people at risk of early school leaving or for those who have left already. (See chapter 4: Examples of good practice).

HOLISTIC EDUCATION

There are also many young people who stay within the school system who are very much at risk as well. These young people need additional supports to maintain them within the school system similar to those identified above as needed for primary schools. From both the young people and the fora, an emphasis was placed on holistic education. A more holistic education was advocated for, where young people's emotional, spiritual, physical, vocational and environmental needs are given equal emphasis to their academic needs.

In areas where whole school policies on health education and health promoting

schools were in place, these are very welcome developments e.g. NWHB Lifeskills schools programme, Health Promoting Schools Network (HPSN). (See chapter 4). The implementation of Relationships and Sexuality Education (RSE) was also welcomed and there were unanimous calls from the fora for Social Personal and Health Education (SPHE) to be in place and supported in all schools.

YOUTH TRAINING

There was an acknowledgement that there will always be young people who leave the formal education sector before or soon after the official school leaving age of 15. For these young people alternative, skills based, holistic training is required e.g. Neighbourhood Youth Projects (N.Y.P.s), Youthreach and Community Training Workshops (C.T.W.s). Improved relationships between schools and youth training programmes could ensure a smoother transfer of young people from the schools setting to training programmes and ensure that young people are not lost between them. Youth New Ross (YNR) is an example of this type of programme. (See chapter 4).

WORKING WITH ALL YOUNG PEOPLE EQUALLY

The exclusion of 'difficult' young people from schools, youth training and other youth programmes further alienates them from their community and tends to lead to more deviant behaviour and greater exclusion.

A commitment to the development of policies and procedures for dealing with the difficult behaviour of young people by all those working with them, could enable these young people to be worked with, within services rather than being excluded from them. Young people who are experiencing multiple disadvantage, e.g. economic, social and

geographical, have a very different experience of school to their 'advantaged' counterparts and need to be positively discriminated towards to ensure that they have equal opportunities of educational experience e.g. Dept. of Education and Science programmes targeting disadvantage. (See chapter 4 for more detail).

A CO-ORDINATED APPROACH

Many different professionals e.g. teachers, youth workers, social workers are working with the same young people but are not necessarily in contact with each other. A more effective intervention was called for throughout the fora by participants who believed that this could be brought about through greater co-operation and co-ordination between professionals at local, regional and national levels. (See integrated services section, p.38).

PARENTAL INVOLVEMENT

The involvement of parents in their child's education was identified as essential in positively influencing children's experience of school. (See parental and family support section p.37).

B. Access to and availability of services and facilities

The use of the term services in this report refers to health, educational, youth and social services. The use of the term facilities means recreational, sports and leisure facilities. Services and facilities will be dealt with separately. These issues arose in some way at all of the Health Fora and in the focus groups and were identified as a key influence on the health behaviour and status of young people at risk. Access to services can be denied due to financial constraints, geography/ location, lack of information on

the availability and the purpose of services and exclusion from them. The availability of services can be denied due to the lack of the service itself or the existence of long or closed waiting lists for a particular service.

INFORMATION ON SERVICES

From the fora, it was apparent that many young people and adults are not aware of the services that do exist for young people. Even professionals working in the childcare/youth work area were not always aware of the existence of others working in the area with the same target audience. Information on services that are available should be youth friendly, inviting and up-to-date. Directories and maps which have been developed in some areas to address this issue are considered very useful tools.

ACCESSIBILITY OF SERVICES

It was reported at the fora that services do exist but are often irregular in their provision and those that are there are not always utilised by young people or their intended target audience. A need was identified for the development of services which are more youth friendly and within a commutable distance from the young person. The issue of availability and accessibility of services was particularly emphasised in relation to health services. In rural areas this issue is exacerbated due to the unavailability of transport and the geographical distance to the service where it does exist.

NEEDS BASED AND EVALUATED

It is perceived that service providers do not always consult with the people they are providing the services for, particularly young people. Both the regional and national fora advocated services to be established on a needs basis, not a funding led basis, and stressed that they should be constantly

evaluated and monitored so that they change to meet current needs and trends.

HEALTH AND SOCIAL SERVICES

The issue of access to and availability of health and social services came up repeatedly with particular reference to childcare provision. The specific issues varied from area to area according to the different degrees of service provision within each health board area. The predominant one was the lack of early intervention services and the fact that young people were only being worked with when they reached crisis point. In some places it was felt that young people were only being worked with once they had been criminalised. On many occasions during the fora it was expressed that resources were lacking within statutory agencies to cope with staff's caseloads. As a result of this young people were not being adequately dealt with, referred on and/or placed appropriately.

Specific reference was made to the provision of appropriate foster, residential and supportive accommodation placements, drug treatment for young people (community based in-patient and out-patient services), locally based counselling, family support services, one stop shops, mobile units, outreach and out of hours services. In some areas there was a lot of anger and frustration on this particular issue and the only solution being advocated was to increase the amount of resources being made available so that these services could be provided.

FAMILY PLANNING SERVICES

There was a unanimous call for the provision of family planning and for sexual health services to be set up regionally and nationally that are free, anonymous, accessible, non-judgemental, and youth friendly. This was said with particular emphasis on providing

more accessible and affordable contraception and Sexually Transmitted Infections (STIs) prevention.

FACILITIES

There were many criticisms regarding the lack of recreational, leisure and sports facilities nationally. Those that do exist are often inadequate and of extremely poor standards. In areas where resources were available and energy has been put in to developing these, it has been very beneficial to the young people and their community. The Nucleus in Derry, which is a cafe that provides youth services, information, a training centre and recreational facilities, was cited as such an example. Buildings and facilities which are there, were reported as not always being made available to young people or those organising events for them.

At the moment the most disadvantaged young people tend to live in areas with the poorest quality facilities for youth development. If better sporting and leisure facilities were developed, with local people trained to run them and work with young people at risk, many of these young people could be motivated to participate in such activities as sport, music and drama that could enable them to have positive experiences, develop their self-esteem and adopt healthier lifestyles.

A greater emphasis on community development focused on young people and their families and a greater sharing of resources within communities and areas would be a positive step towards addressing this issue. Participants felt that currently many young people are excluded from involvement in such groups due to being labelled difficult and/or the cost of participation in them e.g. membership fees and equipment costs. It

was felt that the criteria for grants for local sport and community groups should be based on them having a proviso of equal access for all and an outreach element directed towards young people at risk.

C. Social and Economic Policy

Current social and economic policies were named in ten of the twelve fora as one of the prioritised circumstances influencing the health status of young people. Two main issues emerged. Firstly the perceived inequity of social and economic policies, particularly in relation to poverty, housing, educational and employment issues. Secondly, the call for a National Childcare Strategy and a National Youth Policy.

INEQUITY OF SOCIAL AND ECONOMIC POLICIES

Participants in the fora perceived that for many of the young people with whom they worked, poverty, marginalisation and social exclusion have become institutionalised and inter-generational. The social policies that have been developed in relation to economic development, education, employment and housing were named as directly influencing people's health behaviour and status.

The following were given as examples of the recurring inequalities cited around the country. In relation to education policies, the inequalities are highlighted by what is perceived as an uneven allocation of resources e.g. the abolition of free fees to third level colleges while some primary schools still remain without adequate sanitation.

In economic policies, the contrast between those who are benefiting from the strong economy and those who remain below the

poverty line. Tax reductions for the medium to well off are not seen to directly impact upon those living in poverty. Combat Poverty estimates that over a third of the population are still living below the poverty line.

In housing policies, the increasing numbers of homeless families, young people and single people who remain without any form of permanent accommodation, and in some circumstances without any accommodation at all, is a cause for great concern.

It was generally acknowledged that in the recent past there had been a shift in emphasis towards more equal distribution of wealth particularly in such policies as the improvement in job creation and the National Anti-Poverty Strategy. One consistent recommendation was for the full implementation of the National Anti Poverty Strategy.

Secondly, in relation to youth and childcare policies there were repeated calls for a National Childcare Strategy and a National Youth Policy.

A NATIONAL CHILD CARE STRATEGY

The experience of practitioners on the ground reflected in the fora was that despite the large increase in resources and staffing there are still not enough resources to meet the needs of young people and families at risk. The development and implementation of a National Child Care Strategy that would plan in a strategic way and ensure resourcing so as to enable the full implementation of the Child Care Act was identified as a first critical step towards addressing the current crisis within childcare services.

A NATIONAL YOUTH POLICY

There were also calls for the development of a National Youth Policy that would draw

together all issues in relation to young people e.g. health issues, rights of young people, employment issues. It was suggested that such a document could focus on the benefits of young people and how they can be a positive resource to the country.

D. Parenting and family support

The issue of education and support for parents and families within communities was identified as critical to the health status and behaviour of young people. Seven of the twelve fora prioritised this issue, which emerged as a theme in each of the fora. Many young people at risk come from families where there is a cycle of poverty and in some cases other multiple risk factors such as addiction, abuse, family breakdown and crime. There is a need for early intervention, training and support particularly in the areas of parenting, developing self-esteem, confidence building and the provision of family support.

COMMUNITY BASED, PEER LED PARENTING PROGRAMMES

The establishment of parenting and family support programmes nationally in a strategic and planned way was named as a first and vital step towards involving and educating parents in many aspects of their children's lives. Incentives may be needed to get the parents most at risk involved in such interventions.

There was an emphasis on such programmes being backed up with support and interventions taking place at a local level. This would enable people to utilise their own and existing resources as part of a community development approach which enables communities to identify their local needs and seek to address them.

The involvement, leadership and participation of parents and communities is paramount to the success of these programmes. Examples of such programmes taking place that were cited were Lifestart and the Community Mothers Scheme, (which are peer led programmes run by mothers for mothers in the community and are supported by the local public health nurse), the Westside NYP in Galway, (which has developed it's work with families) and the newly developed Springboard Projects (which are pilot projects targeting families at risk, funded by the Dept. of Health and Children).

In accordance with such programmes, there needs to be a greater willingness to involve parents in the community and in their children's lives, i.e. in schools, homework clubs, parent and toddler groups, local health, youth and social services. (A detailed, up to date description and analysis of parenting programmes is available in 'Enhancing the Future', Barnardos, 1998).

EDUCATION AND CHILDCARE FACILITIES FOR PARENTS

Parents need to be educated as well as their children. Health education for parents must be an essential part of these programmes and a concurrent part of their children's education. It was felt that there is a need for accessible, affordable childcare facilities within communities so that parents have an option to work outside the home, re-enter the education system and have access to additional support.

E. Integration of services

The issue of co-operation and integration of service provision was another consistent issue arising in the fora. Many of those who attended the fora were working with the

same young people in the same area and yet had not been in the same room before. In some areas through partnerships, task forces or local initiatives people have begun to work together but there seemed to be little consistency as to how or where this happened and who was involved.

THE DEVELOPMENT OF LOCAL NETWORKS

In the areas where this issue was prioritised as a circumstance or structure influencing the health status of young people at risk, there was unanimous agreement that all those working with young people at a local level need to work closer together. This, be it networking, co-operation, collaboration or integration, would ensure a more effective provision of services and use of resources for all young people, but particularly for young people at risk. It would also be a mechanism to support those working in the community who often feel very isolated i.e. health, youth and social workers, teachers and gardai. Examples of such programmes are: Tralee Education Network (TEN); Rialto Children and Young People's forum (see chapter 4); and the recently formed committees in the 14 areas participating in the Department of Education and Science 8 to 15 scheme.

Such networks could identify their local needs and look at ways to achieve further collaboration. This would involve significant changes in current practice and would need very clear guidelines and support to guarantee effectiveness. Problem areas could emerge with regard to such issues as confidentiality.

In areas where similar networks or partnerships exist, the issue of young people at risk should be prioritised. It was felt that there is no need for duplication of such initiatives by the setting up of new ones if

existing structures can be used. The current research by the Children's Centre in Trinity College Dublin on *Integrated Services for young people at risk* should inform such practices in the future.

LINKING LOCAL NETWORKS AT REGIONAL, NATIONAL AND POSSIBLY EUROPEAN LEVELS

These networks should be supported locally, regionally and nationally and be connected to each other in order to form and link regional, national and European networks. This was said particularly in relation to funding as it was felt on the ground that many of the *organisations working with the same young people* were competing for funding locally, regionally and nationally and that much of this funding came from Europe.

INTEGRATION TO BE A CRITERIA FOR FUNDING

One way of addressing this would be to make co-operation, co-ordination and integration between organisations and services in the same area a criteria for funding.

NATIONAL CO-ORDINATION AT DEPARTMENTAL LEVEL

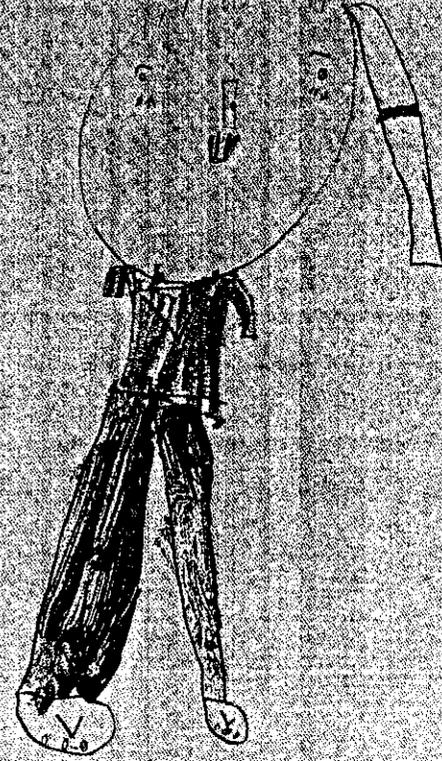
Even if local and regional networks are working well, it was felt that no real long term development or progress will take place unless this co-operation, co-ordination and

integration is reflected nationally. Co-operation between the various different government departments (e.g. Departments of Health and Children, Education and Science, Family, Community and Social Affairs, Justice, Equality and Law Reform, Environment, Tourism, Sport and Recreation, Employment and Enterprise) with responsibilities for young people is critical to the development of consistent policies and the development of a more co-ordinated approach.

Recent initiatives such as the appointment of a Minister of State with responsibility for children and the pilot scheme 'Integrated Services Process' (the aim of this process is to develop new procedures to ensure a more focused and better co-ordinated response by the statutory authorities to the needs of communities with the greatest levels of disadvantage, as a basis for a model of best practice) established by the Department of Social, Community and Family Affairs are welcome developments and point the way towards providing a more effective response in dealing with the problems encountered by young people at risk. Many of the fora which identified this issue as pertinent called for a specific Department of Children and Young People to co-ordinate and lead many of the above recommendations.

CHAPTER FOUR

Examples of good practice



Examples of good practice

This chapter has been included in this report for two reasons. Firstly, to show tangible examples of innovative, targeted and effective policies and practices that are currently carried out in Ireland today. And, secondly to give a sample of the huge number of projects, services and practices that were encountered during this consultative process.

The examples of good practice that are detailed below are not necessarily better than any of the other projects and services that took part in the consultation, but are examples that relate to the recommendations being made at local, regional and national levels. Most of those that are included have been evaluated. Further information and evaluations are available from the contact persons as listed below.

Copping On: National Youthreach Crime Awareness Initiative

The Copping On programme is a joint initiative between the Department of Education and Science, and the Department of Justice, Equality and Law Reform. Its focus is the implementation of a national crime awareness programme with early school leavers and young people at risk, and the development and support of local multi-agency responses to the issue of youth offending.

In its implementation with young people, the programme focuses on enabling young people to identify where they can make change, and supporting them in doing so. A comprehensive resource pack provides both information, and activities which are designed

to stimulate discussion as well as challenging the young people.

Residential training for local consortia is a fundamental aspect of the programme.

Support is provided prior to the training, aimed at ensuring representation from all key agencies, whilst on-going support is offered in order to maintain supports and develop linkages.

The first year of the Copping On programme has been evaluated by the Children's Centre, Trinity College. This report will be published in 1999. Whilst the evaluation is positive about the programme, and the opportunity it offers for engaging young people, it also identifies some key issues, particularly with regard to the training of those working with young people, and issues regarding openness to developing co-operative ways of working.

For further information about Copping On, please contact:

**Marion Quinn, Co-ordinator,
Copping On,**

**Centre for Adult and Community Education,
NUI Maynooth, Co. Kildare.**

Tel: 01 708 3468 Fax: 01 628 9370

Email: ae94901333@may.ie

Westside Neighbourhood Youth Project

The Neighbourhood Youth Project was established in the Westside of Galway City. This family support service provides individual and groupwork to children (9 to 16 years approx.) and their families. The NYP is staffed by a Project Leader, 3 Project Workers and a part-time Community Artist, all of whom are professionally trained. The NYP provides a range of self-esteem enhancing experiences including swimming, hillwalking, arts and craft, indoor soccer and discussion groups. In addition, the staff on the project provide ongoing individual work for some of

the children who need special support, for a variety of reasons. The NYP is very much *child-centred in its approach and the Project staff work only with small groups*. The Project now provides support to parents of adolescents through individual home visits and parent education training groups. Individual group programmes are run in local primary and secondary schools. Most of the groups run in the afternoons and early evenings throughout the year. Residential weekends for groups and summer projects are also provided. Access to the Project is made as simple as possible, referrals can be made through the schools and all main Health Board services, or enquiries can be made directly to Project staff who work closely with local community groups. The NYP is based on Seamus Quirke Road, Newcastle, Galway. The basic philosophy of the Project is to work person to person with specific children and teenagers in their own community in a non-threatening way which is enjoyable and which goes some way towards meeting their needs. Essentially the NYP is in existence to support the Westside community in any way it can.

For further details about the Neighbourhood Youth Project please feel free to contact: the staff at Seamus Quirke Road, Newcastle, Galway. Tel: 091 527568

Cox's Demesne Youth and Community 'Second Chance' Project

The Second Chance Project is based in Cox's Demesne Youth and Community Project, Dundalk. The project is funded under the Youthstart 1998-1999 programme and builds on the work of the LEBO project by addressing the gaps in the mainstream education provision and by creating links between a local community based project and the formal school

context. The project works with early school leavers and potential early school leavers, aged 12 to 15 years. The key aspects of the Second Chance project are counselling and therapy, alternative activities to solvent abuse, alcohol abuse, crime and prostitution and an integration of the non-formal youth work model of education and training with the mainstream formal system. In addition, the project focuses on personal and social development, literacy and numeracy training, skills sampling etc. The key elements of the practice include community based approach, small groups, sense of ownership, positive relationships, personal development, flexible, holistic and needs based programmes and support.

The relationships with school, parents and other agencies is also crucial to the success of the project.

It is anticipated that young people will benefit from the project by remaining in education; progressing to further education/training; availing of the counselling service; having access to alternative recreational activities; experiencing increased self confidence and self esteem.

The main challenges and issues which arise for the Second Chance project are :

the integration of a community based informal model of education with the mainstream education system; perception of the programme by the local community; alcohol, drugs, solvents and crime; interagency work; accessing core funding. In conclusion, the Second Chance project represents an exciting and innovative model to tackle the issue of early school leaving by working in partnership with young people, parents, the school and other agencies.

For further information, contact: Brian Doyle at Cox's Demesne Youth and Community Project Ltd, The House, 15 - 16 Oakland Park, Dundalk, Co. Louth. Tel: 042-9330432 Email: coxscycp@aonad.iol.ie

The Alliance Centre For AIDS & Sexual Health Peer Educational Project

The overall aim of this project is to involve young people in the implementation and development of the Alliance's education programme. The specific aims of it are

- to organise, develop and participate in a Helpline on sex and drugs issues for young people
- with Alliance staff, to set targets for peer-led prevention programmes, policy developments and resource allocations so that these programmes may be effective
- to participate in education programmes, with other Alliance staff and volunteers.

The Alliance is involved in schools, youth organisations, prisons and community organisations using participatory methods of education on AIDS and sexual health. In 1997 the Alliance undertook research into the attitudes and behaviour of over 800 young people in Cork in relation to sex, AIDS and drugs. ("What On Earth Are They Doing," is available from the Alliance office). This research has shaped the Alliance's education programmes to the stated needs of young people for clear and honest information. The Alliance has since adapted a sexual health promotion rather than a disease prevention perspective. The research also illustrated that young people themselves have a great interest in and concern about the subjects of sex and drugs, and it was felt that peer-led programmes should be prioritised by the Alliance.

After an initial pilot training programme with a group of young people, it was decided that recruitment of peer educators would be city-wide, drawing on a broad range of young people from diverse backgrounds, ages and lifestyles. The targeted age group for educators is 16-21. Some young people who are under 16 and over 21 may also be included, if they meet the recruitment criteria

(i.e. the diversity criteria outlined above, be able to impart information clearly, be able to empathise with the target groups, be able, after training, to discuss matters of an intimate nature in a clear and non-judgemental manner, be willing to make a commitment of a minimum of one year). Participants were recruited by placing posters in schools and youth clubs and by making direct approaches to young people who Alliance education staff met in the course of their work who they felt met the criteria. All potential participants were interviewed before selection.

Training, Support and Supervision is provided by Alliance staff and outside trainers and support is accessed where required. It is envisaged that there may be a necessity to provide support from counsellors outside of the organisation at some stage in the future, finances permitting. All Alliance staff who have contact with the public, through education work, counselling or telephone helplines participate in supervision sessions with their managers.

As this particular programme is relatively new, programme and process evaluation results are not yet available.

For further information, please contact:

Teresa Mc Elhinney, Education Officer,
Beverly Mc Carthy, Peer-education
Co-ordinator, Deirdre Seery, Director
Alliance Centre for AIDS & Sexual Health,
16 Peters Street, Cork
Tel: 021 275837 Fax: 021 274370
Email: alliance@tinet.ie

The Health Promoting Schools Network (HPSN)

Ireland has been a member of the European Network of Health Promoting Schools since Autumn 1992. Health promotion in the school setting is a combination of health education

and all other actions that a school takes to protect and improve the health of those within its community. In essence the HPS is one which balances the effort and attention given to curriculum development and classroom teaching with action directed towards improving the environment of the school and links with the family and wider community. Thus the four main elements of a HPS are:

- the Social and Personal Health Education (SPHE) curriculum
- the schools social and physical environment
- links with home and community
- policies which support the first three elements.

Ten schools (5 primary and 5 post-primary) were designated as member schools in 1993. In 1996, 30 additional schools (15 primary and 15 post-primary) joined the INHPS. Each of the phases was seen as having a 3 year time frame. On joining the network, schools are issued with a School Planner and asked to engage in a process of whole-school planning to prioritise objectives within the four main elements. In planning and working towards objectives schools are assisted by the National Co-ordination Centre through:

- in-service meetings for parents, principals and co-ordinators
- summer school for teachers
- parent training
- schools visits
- school-based in-service (whole school and classroom management/ participative skills training)
- programme planning and resource development
- newsletter

As a model for developing school plans, for the provision of SPHE, and for in-service teacher training, the INHPS matches the aspirations of the White Paper "Charting our Future in Education" (Department of

Education and Science, 1995) and "A Health Promoting Strategy" (Department of Health, 1995). By engaging in the evaluation of where the school is now, and the process of prioritising goals for future development the school community is empowered to take charge of its own development at local level within an agreed framework.

For further information contact:

**Mr John Lahiff, National Co-ordinator, INHPS,
Marino Institute of Education, Griffith
Avenue, Dublin 9.
Tel: 01 8330101**

Youth New Ross

"Youth New Ross (YNR) is a local organisation set up in the early 1990s with the objective of providing social, recreational and education services to disadvantaged young people in New Ross. The organisation consists of persons who are involved in local, public and social service - nursing, social work, teaching, religious and police. Despite many attempts to attract public funding for its work, YNR survived on a shoestring for its first years and achieved very little progress. However, with the formation of the Wexford County Partnership under the Local Development Programme, YNR received financial support over a period of two years to recruit staff and to operate a programme of social and educational supports to those who were experiencing particular difficulties with the educational, social service and legal systems. The project was perceived to be successful in targeting and engaging young people at greatest risk and arising from this the programme attracted significant mainstream funding. The project now has two workers, it no longer relies on partnership company funding and it is able to plan a more comprehensive and long term programme. The County Partnership company is now

using a similar approach to develop and initiate services for young people at risk in two other main towns in its county area" (Cullen, B. 1998).

For further information, contact:

**Julie Somers or Conor Dervan,
Youth New Ross, The Monastery,
Mount St. Joseph, New Ross, Co. Wexford.
Tel: 051 425415**

Rialto Children and Young Person's Forum

"In 1993 the only substantial community resource in the Rialto area was a funded youth project which employed two full-time workers in two small offices in a community building in which facilities for an area-designated health board addiction counsellor were also provided. Although the project was highly regarded, particularly in its use of art and drama for developing meaningful relationships with young people, many of whom seemed otherwise destined for an involvement in drugs and crime, it nonetheless experienced great difficulties in drawing the state agencies' attentions to the area's needs. Four years after the partnership process commenced this youth project now has four full-time workers and is more visible in providing direct services in the two flat complexes. It also has been given a substantial grant to refurbish a designated community premises. Furthermore, the project has formed links with an adjacent youth project in its partnership area and together with other groups and organisations involved with children and young people, these have formed a Children and Young Person's Forum, as the first stage in bringing about a regional youth service for the partnership area, which, if successful, would be the first such, bottom-up, regional youth service within the Dublin catchment area" (Cullen, B. 1998)

For further information contact:
**John Bisset, Rialto Youth Project,
St Andrews Resource Centre,
South Circular Road, Dublin 8.
Tel: 01 4531638**

The Home School Community Liaison Scheme

This scheme, which commenced in 1990, is targeted at pupils from disadvantaged areas who are at risk of not reaching their potential in the education system. It aims to establish partnership between parents and teachers and communities in the interests of children's learning. It currently operates in 176 primary schools and 84 second level schools. Some features include:

- preventative rather than curative approaches
- a focus on parents and teachers
- the development of a whole school approach
- developing relationships between schools and families
- networking with other statutory and voluntary agencies
- community ownership.

For further information, contact:

**Concepta Conaty, Home, School, Community Liaison Scheme, Department of Education and Science, Marlboro Street, Dublin 1.
Tel: 01 8734700**

Breaking the Cycle

In 1995 the Combat Poverty Agency and the Educational Research Centre (ERC) were requested to conduct research into the Department of Education and Science initiatives in schools in areas of disadvantage. In May 1996, the Minister for Education announced "Breaking the Cycle", an initiative which targets resources at those pupils in the

most disadvantaged urban schools and in small rural schools who are at risk of not reaching their potential in the education system.

The ERC was contracted to invite applications from the targeted schools - designated schools in Dublin, Cork, Limerick, Waterford and Galway, and small rural schools with fewer than 5 teachers and 127 pupils.

A co-ordinator in each of 25 clusters of rural schools is supported by the Department's National Co-ordinator.

For further information, contact:

**Maura Grant, Breaking the Cycle,
Department of Education and Science,
Marlboro Street, Dublin 1.
Tel: 01 873 4700**

"Early Start" Pre-School Project

The Early Start Pre-School Intervention Project, which commenced in 1994, has places for 1,665 three year olds in forty schools in designated areas of disadvantage in Dublin, Cork, Limerick, Galway, Waterford, Dundalk and Drogheda.

There are 55 teachers and 55 childcare workers in 15 full centres and 25 half centres. In-career development of teachers and childcare workers has highlighted the issues of curriculum and behavioural objectives, and the quality of adult/child interaction.

For further information, contact:

**Toni Dalton, Early Start Pre-school Project,
Special Education 2,
Department of Education and Science,
Athlone.
Tel: 0902 74621**

The 8 to 15 Year Old Early School Leavers Initiative.

In Spring 1998, £2.96m was allocated towards the formulation of preventive and interventive

measures to combat early school leaving. In essence, a series of structured pilot projects in urban and rural areas of disadvantage are to be piloted over the next two years which will examine models for the development and implementation of an intergrated area based co-ordination of services for young people at risk of early school leaving. The primary objective of the projects is to develop models of good practice with a view to their integration, following structured evaluation, into mainstream policy and practice.

In May 1998, consortia of primary and post-primary schools in collaboration with youth groups, area based partnerships and statutory and voluntary agencies submitted detailed proposal which included in-school and out-of-school actions, designed to combat educational failure, underachievement and drop out. Fourteen project areas were selected to pilot the initiative and were informed in August 1998.

Each project has developed a variety of programmes focused on a target cohort of young people who have been identified as potential early school leavers, and equally on pupils within this age range who may have already left mainstream provision. For these pupils, specific actions have been developed to facilitate their gradual return to education together with a range of supports to enhance the likelihood of their retention and success within the formal system. In addition, projects clearly demonstrate a commitment to develop programmes which promote parental and family involvement, stimulate the interest and participation of the target group, encourage the genuine and continued integration of services, improve school attendance, behaviour and attainment, support staff and provide a series of supportive measures which will maximise participation in the education system. Each project is directed and managed by a steering committee representing all relevant interests in the community.

In addition to the Projects' strand of the initiative, there are research and support strands. The latter includes formal evaluation of the programme, local and national training for the key stakeholders and the provision of a co-ordinator at national level. The formal evaluation of the programme, will set the initiatives in the context of early school leaving nationally and relate it to other initiatives promoting integrated responses to educational disadvantage. Equally, it will document and analyse the experiences of the range of stakeholders, document models of good practice and draw out conclusions and recommendations for influencing future policy and practice. The formal research will be conducted by the ERC in Drumcondra and will commence in due course.

For further information, contact:
Clare Ryan, ESLs Projects' Co-ordinator,
The Curriculum Development Unit,
Sundrive Road,
Dublin 12.

Ph: (01) 453 5487 Fax: (01) 453 7659
E-mail: clare.ryan@cdu.cdvec.ie

or

Catriona O'Brien
Higher Education Officer at Special Education
Section II,
The Department of Education and Science,
Cornmaddy,
Athlone,
Co Westmeath.
Ph: (0902) 74621 Ext: 5215 Fax: (0902) 76939
E-mail: obrienc@educ.irlgov.ie

Southhill Outreach Programme, Limerick

Outreach is a community based youth project funded by the Department of Justice, Equality and Law Reform and managed by a voluntary management committee made up of people

who live and work in the Southhill area of Limerick, working with 14-18 year olds who are early school leavers or who may be at risk of leaving school early, or becoming involved in criminal activity. Outreach meets and advocates for young people on many issues. Initial contact is made on the streets of Southhill where relationships are first built and a programme of daytime activities is offered, both educational and recreational. These activities range from horse riding and boating to snooker and simply meeting for tea and biscuits. The project also participates in European exchanges to Italy, Germany and England thus providing travel opportunity which the young people would be unlikely to experience otherwise.

Outreach has strong links with the training schemes and workshops in the area and assists young people in taking up places and supports them in continuing their training. Outreach is also active in campaigning for appropriate facilities for young people such as alternatives in education for early school leavers, and hostel places for young people "out of the house". The project endeavours to maintain contact with young people who are in detention in order to assist them on their release with the many problems which face them in returning to their community. Outreach also works to support the families of young people with whom we work.

For further information contact:
Larry de Clair, Southhill Outreach, 7A Parnell
Mall, Parnell Street, Limerick
Tel: 061 410900

Denny Street Youth Cafe, Tralee, Co Kerry

Denny Street Youth Cafe is a Partnership Project between the Kerry Diocesan Youth Service (KDYS) and FAS. It is being used as a progression route primarily for young people

who have previously been involved in projects within the KDYS such as Transform Alley and who are interested in pursuing a career within the Catering or Service Industry.

The target group for use of the cafe was initially young people but this was not a complete success so it was decided that the cafe would be marketed towards business people who would be willing to pay a little extra for a meal.

Tralee is a very busy town welcoming over half a million tourists each year. This is an increase of over 300% since 1992 and is expected to rise. Although not in the centre of town the location of the cafe is ideal for attracting tourists. Also it is situated on the business street in town. It is centrally located in terms of schools.

Each trainee spends six months within the kitchen and six months on food and beverage services. They also get the opportunity of receiving a period of one weeks work *experience outside of the cafe.*

Certification of the project is essential for the trainees to progress into employment.

Trainees are supervised on a monthly basis using a trainee profile form. Five skills categories are referred to. These are communication skills, decision making skills, personal skills, social skills, practical skills. It is realised that funding will play a major role in deciding the future of the project and any changes that have to be made.

For further information, please contact:
Mary McElligott, KDYS, Denny Street, Tralee, Co Kerry.
Tel: 068 21544

The Youth Education & Training Mentor Programme,
 Tralee, Co. Kerry

The Mentor programme is an employment youthstart project promoted by FAS and the

National Youth Federation. It is a response to the problem of Early School Leaving and the pilot project began in Tralee in 1996 where it is jointly managed by FAS and the KDYS. The target group is 15 to 20 year old Early School Leavers (ESLs).

Two Mentors are currently in place in Tralee and another one has recently been appointed to the Listowel area. The role of the Mentors is to *identify and make contact with ESLs in the area.* The Mentors liaise regularly with the various service providers, social services, probation services, community workers and other young people in the community to identify young people at risk.

The names of the ESLs are added to a database which is updated on a regular basis. Once contact is made with the young person the Mentor then provides a system of informal guidance and counselling, over a period of time, to enable the young person to identify and access suitable support which will enable them to develop a variety of skills and competencies e.g. return to education, training or employment.

The Mentors in their involvement in the Tralee Education Network (TEN) - (formerly the Tralee Early School Leavers Committee) and the Literacy Network, have been active in highlighting needs and gaps in provision for ESLs.

Finally the Mentor programme has evolved considerably since its introduction and this has been mainly due to the high level of commitment from the many service providers to strive towards providing a more integrated response to the needs of Early School Leavers.

For further information, please contact:
Mary McElligott, KDYS, Denny Street, Tralee, Co Kerry.
Tel: 068 21544

The Integrated Services Initiative

The Integrated Services Initiative (ISI) is a joint community-statutory project which was established to develop new models of social service provision in Dublin North East Inner City. It was established in 1995 as the result of a proposal by the Inner City Organisations Network (ICON). Underlying the work of ISI is the belief that economic policies to generate local employment must be supplemented by concerted action to improve educational and social support measures for families and children.

ISI's work to date has included

- the performance of research on a wide range of local services
- extensive local consultation
- the preparation and publication of the report "Common Goals, Unmet Needs" which made recommendations to improve the effectiveness of services for children and families, and which concentrated particularly on ways of bringing about closer collaboration between statutory organisations
- planning the establishment of a local pilot project for young parents and their children which aims to ease access to existing services and to provide some new and necessary services. Premises are now being sought for this project, for which part-funding has been approved by the Department of Social, Community and Family Affairs
- participation in the "Integrated Services Process" in 1998-99. This is an initiative of the Cabinet Committee on Social Inclusion. It aims to improve the co-ordination of all State-funded services in areas of disadvantage.

Initially funded wholly by the Department of Social, Community and Family Affairs, funding for ISI in 1997-98 was secured from all of the major State bodies relevant to its work: (Department of Education and Science, Department of Justice, Equality and Law Reform, Department of Social, Community and Family Affairs, National Lottery, Dublin Corporation, Dublin Inner City Partnership, Eastern Health Board). For 1998-99, ISI is funded wholly by ADM (Area Development Management) under the auspices of the "Integrated Services Process".

For further information, please contact:

Ger Doherty, ISI.

Tel: 01 8780553

Research in to the health needs of young people at risk by the Midland Health Board

This Research Project was proposed as a result of a request from MHB staff, who from their own experience and links with other agencies have become concerned about a group of young people who have no formal links with groups (Schools, Training Centres, Youth Centres) within their own communities. This group for many reasons have not been able to cope with the structures which would have allowed them to continue in the main stream system. Therefore, concerns have arisen as to whether their health/lifestyle needs are being met.

The research is carried out to gain a better and more accurate understanding of the target audiences expectations but also to harness their ideas and opinions to shape the service of the future.

This research is being conducted to:

- Provide detailed and accurate information

as to why some young people fall through the system

- Identify influences on the young person from primary and secondary socialisation and what self perception does this generate for the young person
- Examine social influences - drink, drugs, smoking, sexuality, relationships, contraception, who is most likely to get involved in underage drinking, drug-taking, criminal activities and how is this perceived by those in this age group etc
- Examine systems influences - education (all levels), welfare, legal, health and youth, on the young person's life.
- Explore the culture of the marginalised young person, what are the needs of the young person and how can these needs be catered for.

Focus groups and semi-structured interviews are used.

Young people will be accessed through youth, training and community organisations in the region. Snowball sampling method will be used to access young people who are not in contact with any form of services. A sub-sampling of parents will also take place on a smaller scale, providing an overview of the young person's situation, how the behaviour of the young person is perceived and acted upon within the home environment. This will help to substantiate some of the issues discussed by the young people, thereby adding credibility to the overall findings. The research is funded by the Midland Health Board through funding made available from the Department of Health and Children for measures to reduce the demand for drugs. The research will be carried out by the Midland Youth Council in partnership with Training Centres, Gardai, Probation and Welfare Service, Midland Health Board, other Voluntary and Community Bodies, Parents and Young People.

For further information contact:

Ashling Duggan, Research, Department of Public Health Medicine, Midland Health Board; Emer Sheerin, Researcher, Midland Regional Youth Council; Dr Colette Bonner, Registrar in Public Health Medicine, Midland Health Board.

The Athlone Youth Drama Initiative

The Project was developed from recognising that increasing numbers of young people (13-18 years) were dropping out of school and therefore not availing of Life Skills Programmes. The aim of the Project is to provide a range of activities through the medium of drama that will help this group to develop communication and social skills, hence empowering the young people to play a more positive role in their community. There are many groups working with youth in the community. This project enhances existing work focusing on inter-agencies co-operation in order to maximise the benefit to young people. It involves liaison between both the voluntary and statutory sectors in identifying young people at risk and developing an appropriate programme relating to their needs.

The main aims of the Project are:

- To develop personal skills with disadvantaged youth through involvement in drama
- To provide a participatory educational input around drugs and lifeskill issues through group work
- To provide an educational input to the local community through the medium of drama to the community

When all the various aspects of the project are drawn together, it is envisaged that a play will be performed in the community. For

those involved this will be an example of team-work in action.

As many of these young people have limited educational qualifications it is proposed that their participation and work would be assessed on a module basis and a FAS or NCEA certificate be presented to the young people at the end of the project. The Project was devised by the Midland Health Board, The Athlone Youth Project, the Gardai; Athlone Community Training Workshop, and TONNTA, a community drama group. The Project is funded by the Midland Health Board through funding made available under the Measures to Reduce the Demand for Drugs and the Health Promotion Unit, Department of Health and Children.

Further information contact:

Health Promotion Officer,

Midland Health Board

Tel: 0506 46740

The National Youth Health Programme (NYHP)

The NYHP is a partnership between the National Youth Council of Ireland, the Health Promotion Unit of the Department of Health and Children and the Youth Affairs Section of the Department of Education and Science. The aim of the NYHP is to provide a broad-based flexible youth health education programme within the non-formal education sector, incorporating information, training and programme development components. It provides resources, support and training to youth workers, leaders and volunteers working within the Youth Service, as well as all other community groups addressing health issues within the non-formal education sector. The NYHP is currently developing the Health Promoting Youth Service Initiative. This is a national initiative, developed to encourage

and support youth organisations and to plan, implement and evaluate a holistic approach to promoting health with young people, staff, volunteers and within organisations in general.

It aims to benefit organisations

- through the implementation of a comprehensive Health Promotion Strategy specifically developed and produced to assist youth organisations in becoming health promoting organisations
- through the provision of high quality training at national, regional and organisational level which will equip staff and volunteers with the skills, knowledge and expertise to promote health and to influence change within youth organisations
- through the recognition of this training with appropriate accreditation to Diploma level for National Co-ordinators and to Certificate level for all other staff and volunteers who participate in training within organisations
- through a programme of ongoing support and training for each organisation involved
- through the development of a national network of Health Promoting Youth Organisations providing access to a wide range of materials, resources, training and expertise for all those involved in the initiative
- through the provision of a Q-Mark for all youth organisations who have actively participated in the initiative over a two year period.

For further information contact:

**Siobhan McGrory, Health Promotion
Co-ordinator, National Youth Council of
Ireland, 3 Montague Street, Dublin 2.**

Tel: 01 4784122

Recommendations



Recommendations

These are the recommendations of the National Consultative Committee on Health Promotion (NCCHP). They arise from the consultative process with young people at risk themselves and professionals and policy makers at regional and national levels from the relevant sectors who work with this target audience. These recommendations are made giving due regard to relevant national policies and international trends. They are detailed under a number of separate categories and resourcing issues are not detailed. What is intended is that appropriate agencies would have regard to the issues contained within these recommendations when formulating and prioritising the most appropriate response from their own particular perspective. As the building of healthy public policy and multi-sectoral activity are two of the cornerstones of health promotion, the challenge for health promotion is to pursue the development of these policies with the relevant sectors (WHO, 1995).

Youth participation and access

AIM

To ensure that young people and specifically young people at risk have equal access, and opportunity to participate meaningfully in, education, health and social services, sports and recreational activities.

RECOMMENDATIONS

- Young people at risk be specifically targeted by sports, arts and community groups to facilitate their participation in such activities. This may need to take the form of positive discrimination in favour of young people at risk to redress the current inequitable situation.
- That direct consultation with and

participation of the target audience becomes a criterion for funding so as to ensure that services being provided for young people adequately meet their needs and that they have the opportunity of meaningful participation in such services or facilities.

- That these services and facilities provided for young people are appropriate, accessible, flexible and engaging of their target audience.
- To make more widespread the use of peer education in education strategies so that young people are empowered to educate each other.
- That young people have access to comprehensive, anonymous and accessible sexual health services.

Integration of services

AIM

That services working with young people, particularly those at risk co-operate, co-ordinate and, if appropriate, integrate at local, regional and national levels in order to provide a more effective service.

RECOMMENDATIONS

- The health boards, education and justice sectors, youth and community organisations, training programmes, local authorities, partnerships and NGOs work together and that leadership of the co-ordination of services for young people at risk be undertaken by the above sectors within specific regions.
- That funding agencies for services working with children and families at risk consider the levels of co-ordination and co-operation among existing services as a key criteria for funding.
- That co-ordination of services for children and families at risk be led at a government department level.

Parenting and family support

AIM

That community based prevention and support services be developed nationally for parents and families and that they be specifically targeted towards families at risk.

RECOMMENDATIONS

- That the recommendations contained within 'Strengthening Families for Life', the Final Report of the Commission on The Family be implemented.
- That a National Child Care Strategy is developed so as to ensure resourcing to enable the full implementation of the Child Care Act 1991 in order to guarantee the protection of children and young people at risk.
- To promote the importance of the role of men in the development of healthier families and communities.

Education

AIM

To place a greater emphasis on retaining young people at risk within the mainstream education system when at all possible, as a young person's experience of school and length of stay is known to be a protective factor which enhances their future health and social well being.

RECOMMENDATIONS

- To continue and expand programmes currently targeting disadvantage e.g. Breaking the Cycle, 8 to 15 pilot projects, the home-school-community liaison scheme.
- To develop a long term strategic response to early school leaving.
- To continue the development of a broad based holistic curriculum e.g. the

introduction of Leaving Certificate Applied (LCAP) and Leaving Certificate Vocational Programme (LCVP) and to introduce and support Social Personal and Health Education (SPHE) in all schools.

- To continue to support and fund those currently providing services for young people most at risk, within and outside of the formal education setting, in training, treatment, day and support services so that more comprehensive services, training and support can be provided.
- To support co-operation between schools, training programmes and youth organisations within the education sector.

Good practice and funding

RECOMMENDATIONS

- To evaluate all services and facilities for young people at risk and to use these evaluations in establishing good practice.
- That initiatives, projects and services that have been positively evaluated are sustained and if appropriate mainstreamed.

Health Promotion

AIM

To place a greater priority on addressing the issue of poverty within health promotion work with a particular focus on young people at risk. This implies a definite commitment to reducing inequities in health which will lead to improved health status.

RECOMMENDATIONS

- To support and facilitate the relevant partners so as to ensure that the health needs of young people at risk are addressed in the overall context of social and public policy.
- To assist in a process of identifying a

leadership role for the relevant agencies in co-ordinating actions and activities of relevant government departments, health boards, local authorities and NGOs which work with young people at risk.

- To explore the role of the media in relation to the extent of its influence and responsibilities with regard to young people's health.

GLOSSARY, APPENDICES, BIBLIOGRAPHY

Glossary of terms abbreviated in report :

AIDS	Acquired Immunodeficiency Syndrome	NYCI	National Youth Council of Ireland
ADM	Area Development Management	NYF	National Youth Federation
CDYS	City of Dublin Youth Service	NYHP	National Youth Health Programme
CYC	Catholic Youth Council	NYP	Neighbourhood Youth Project
CTW	Community Training Workshop	OECD	Organisation for Economic Co-operation and Development
ERC	Educational Research Centre	RSE	Relationships and Sexuality Education
ESL	Early School Leaving	SPHE	Social and Personal Health Education
ESPAD	European School Survey Project on Alcohol and Other Drugs	STI	Sexually Transmitted Infection
ESRI	Economic and Social Research Institute	TEN	Tralee Education Network
HIV	Human Immunodeficiency Virus	VTOS	Vocational Training and Opportunities Scheme
HPS	Health Promotion Strategy	WHO	World Health Organisation
HPYS	Health Promoting Youth Service	YNR	Youth New Ross
HPSN	Health Promoting Schools Network		
HPU	Health Promotion Unit		
INHPS	International Network of Health Promoting Schools		
JLO	Juvenile Liaison Officer		
NAPS	National Anti - Poverty Strategy		
NCCHP	National Consultative Committee on Health Promotion		
NESF	National Economic and Social Forum		
NGO	Non - Governmental Organisation		
NWHB	North - Western Health Board		

Appendix A

NUMBERS ATTENDING FORA NATIONALLY BROKEN DOWN INTO OCCUPATIONS

Total attending 12 fora	264
Average	22

% BREAKDOWN

Youth / Community / Volunteer Workers	27%
Health Board Total	26%
Community Care	35%
Drugs / AIDS / Addiction Services	29%
Health Promotion/Education	22%
Others	14%
Schools	11%
Youthreach / CTW / ESL	10%
Gardai / JLO	7%
Voluntary Organisations	6%
Partnerships	3%
Residential Care	2.5%
Academic	2.5%
Probation	2%
Prison / Special Schools	1%
Government Departments	1%
Religious	0.5%

Appendix B

YOUNG PEOPLE'S SUB-COMMITTEE OF THE NATIONAL CONSULTATIVE COMMITTEE ON HEALTH PROMOTION

Mr Owen Metcalfe

Chief Health Promotion Advisor
Department of Health and Children
Chairperson

Ms Sara Burke

Youth Health Promotion Project Officer
Department of Health and Children

Ms Paula Monks

Executive Officer
Department of Health and Children

Ms Maura McNally

Health Promotion Officer
North Western Health Board

Professor Cecily Kellegher

Chair of Health Promotion
National University of Ireland, Galway
alternate

Ms Saoirse Nic Gabhainn

Assistant Academic Director
National University of Ireland, Galway

Mr Barry Dempsey

Chief Executive
Irish Cancer Society

Dr Enda Dooley

Medical Director
Department of Justice, Equality and
Law Reform

Mr John Weafer

Principal Officer
Department of the Environment
alternate

Ms Riona Ni Fhlanghaile

Principal Officer
Department of the Environment

Mr. Prionsias O'Dughaill

Divisional Inspector
Department of Education and Science

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