QUEEN ELIZABETH THE QUEEN MOTHER FELLOWSHIP LECTURE

REFLECTIONS ON CHILDREN, CHILD HEALTH AND SOCIETY

Professor Sir Albert Aynsley-Green

The Nuffield Trust
FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES

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Telephone: 020 7631 8450
Facsimile: 020 7631 8451

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Author's note

This monograph is dedicated to all children and young people in England, but especially to those who suffer illness, disability and disadvantage though no fault of their own.

I also give it in gratitude to my family – my wife Rosemary, my daughters Sarah and Victoria and my delightful and precious grandchildren Imogen, Tristan, Joshua, Amelia, Lily and Sebastian.

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Preface

It is a privilege as well as a genuine delight to hold the prestigious Queen Elizabeth the Queen Mother Fellowship of the Nuffield Trust. The Fellowship gives me the opportunity to present a public lecture on a subject of my choice in the presence of Her Royal Highness the Princess Royal, as well as the stimulus to produce a monograph in which I can offer personal views on the subject of the Fellowship.

I chose the title 'Children, Child Health and Society' for my Fellowship because of the extraordinary constellation of experiences in my professional life as a children's physician over the last 30 years or more. I began my training in paediatric medicine in Oxford in 1973, subsequently developing my subspecialty knowledge in the field of paediatric endocrinology through training in the University Children's Hospital in Zurich, Switzerland. I then applied this through leading research groups studying the importance of hormones in early life. In 1984 I was appointed James Spence Professor of Child Health at the University of Newcastle upon Tyne, this immediately widening my horizon and my understanding of the diseases of children. I inherited there the mantle of Sir James Spence. Arguably the most important and influential paediatrician the UK has ever produced, Spence was the first to show scientifically the impact of social circumstance on the health of children through his famous and seminal 1000 Family Study.[1] The Headship of his department, the first in child health in England, gave me the chance to understand in depth the relevance and importance of social paediatrics and triggered my interest in the circumstances of children in society, particularly the adverse influences of poverty and deprivation.

In 1993 I was appointed the Nuffield Professor of Child Health and Executive Director of Clinical Research and Development at Great Ormond Street Hospital for Children and the Institute of Child Health in London. There I learned of the origins of the hospital that were driven by the tenacity and vision of Charles West and Charles Dickens, men outraged over the plight of the sick children of the poor in mid-Victorian London. This exposed my thinking to the history of childhood, realising to

my shame that despite working with children for 30 years I had never been interested in the nature and the changing status of childhood.

My involvement in the political arena of the National Health Service began by my appointment in 2000 as Chair of the first National Children's Taskforce in the Department of Health, being followed in 2001 by my appointment as the first National Clinical Director for Children, to be responsible for leading the development of government policy for children's health. This experience gave me insights into the working of government departments of state, and the process of formulating national policy. Of greater importance, through a series of over 400 meetings and events held across all parts of England I was able to see for myself the delivery of health services for children and young people, in settings ranging from the inner-city to the remote and rural. Finally, while holding this Fellowship from the Nuffield Trust, I was appointed in March 2005 to be the first Children's Commissioner for England, a post created by Act of Parliament to be the independent voice to speak for the views, interests and needs of the 11.8 million children and young people in England.

In January 2006 I presented my Queen Elizabeth the Queen Mother Lecture in the presence of Her Royal Highness the Princess Royal. This monograph has been developed from that lecture. The genesis of the work has taken longer than expected, not least because of the ferocious pace of change in government policy for children since January 2006. A health warning therefore! I do not set out to produce a comprehensive, up-to-date and fully referenced commentary on every aspect of that policy. Rather, I weave together some highly selected threads of science with aspects of the history of childhood relating to child health, and a perspective on the political dimensions of developing and implementing government health policy for children. I conclude with a commentary of what now needs to be done to ensure that all children and young people are supported to attain their full potential in life by the delivery of effective, evidence-based and needs-led health services.

I must emphasise that the views and opinions in this publication are personal, are designed to be provocative, and should not be taken to reflect any statement of policy or philosophy from the Nuffield Trust, the Department of Health, the Department for Education and Skills (now the Department for Children, Schools and Families) or from 11MILLION, the Office of the Children's Commissioner.

Sir Albert Aynsley-Green
October 2007

Your children are not your children
They are the sons and daughters of Life's
longing for itself.
They came through you but not from you,
And through you they are with you yet they
belong not to you.

You may give them your love but not your thoughts,
For they have their own thoughts.
You may house their bodies but not their souls,
for their souls dwell in the house of tomorrow,
Which you cannot visit, not even in your dreams.
You may strive to be like them, but seek not to
make them like you.
For life goes not backward nor tarries with yesterday.
You are the bows from which your children as
living arrows are sent forth.

The Prophet (1923)
Kahil Gibran (1883–1931)
Lebanese poet, mystic and painter

1. SETTING THE SCENE

Children are the living message we send to a time we will not see.
Neil Postman, *The Disappearance of Childhood*

Everyone under 18 years of age has all the rights in this convention.
United Nations Convention on the Rights of the Child (UNCRC): Article 1

We are living in an era of unprecedented political and public focus on the needs of children and young people in England. More has been done in the last ten years to improve the lives and health of our young citizens through government policy than in the previous 30 years. Indeed, I argue that perhaps not since the Victorian times has there been so much scrutiny on the lives and health of children and young people, and their role in society. This monograph offers a personal series of highly selected reflections on why this has happened, what is being done and what still needs to be done to ensure that every one of the 11.8 million children and young people in England is supported to ensure that she or he achieves the best outcomes for health and the attainment of full potential in life.

Nothing matters more to the majority of parents than the health and well-being of their children.* As my wife and I know from our own two daughters and six grandchildren, no pleasure or reward is greater than seeing a son or daughter grow through childhood and adolescence into a confident, successful, healthy and secure adult. This pleasure is further reinforced by the delight of seeing the birth of the next generation of grandchildren. There is, therefore, an irrefutable fact, namely, that children matter

* The terms child and children are frequently used throughout this commentary as shorthand to cover all children and young people below 18 years of age. The phrase 'young people' is used where relevant to refer to adolescents, who dislike being called children.

greatly to families, whatever the construction of that family. With respect to our nation, children and young people are of vital importance. First and foremost, they are citizens of today, but our future success and survival in an intensely competitive international community of nations also depends on them. We need children to become the successful and productive adults of tomorrow, yet many of the obstacles to achieve this have their roots in childhood. Thus, for example, much adult physical and emotional ill-health has its antecedents in early life, and there is increasing evidence that adverse outcomes in adulthood can be prevented by interventions during childhood. Against these considerations on the importance of children, a man from Mars visiting our planet would surely say "O Earthlings, why are you not spending every penny you can possibly afford on the nurture of your most precious resource?"

It is certainly true that in the last 150 years there has been a massive improvement in the health and survival of children. Parents now expect their children to survive; they do not expect them to suffer a disability or to die. Health, nutrition and material benefit have improved beyond recognition or expectation. Children are better educated than ever before, diseases previously the scourge of childhood have been all but eliminated through effective immunisation and public health interventions and opportunities for education, travel and access to information have all contributed to the benefit of children in an affluent society.

Figure 1. A newborn human citizen showing her rapturous gaze at the face of an adult – a fundamental trigger for 'attachment'.
Photograph © the author

However, the human newborn infant (see Figure 1) is born totally defenceless, helpless and vulnerable, and depends for its survival and future well-being on the quality of nurture provided by its carers, particularly its mother. There is increasing evidence on the crucial importance of 'attachment' to the infant's carers in the first few months after birth for the basis for adult emotional competence. The baby's chances for survival and quality of life are further influenced by its wider family environment and by the community in which it lives. Government, national and local, provides the policies and resources for the delivery of services to address their changing needs during childhood. It can truly be said, therefore, that the effective nurture of children should be everybody's business!

It is important to remember that when considering the needs of children it is not a case of 'one size fits all'! There are seven 'ages' of childhood:

- newborn baby
- infant
- toddler
- pre-school child
- school-age child
- adolescent
- those making the transition to adulthood.

Each 'age' has specific competencies and needs which must be addressed in the development of policies and services and the support from communities.

If we acknowledge that children are the lifeblood of the nation and are vital for personal and national survival, we must also accept that as a society we are facing a real problem. We are faced with the consequences of a significant fall in the birth rate: children and young people now only make up about 20% of our population, compared to over 40% 150 years ago. The birth rate has been falling, and although it may now be showing signs of stabilising in England, this will have a massive impact on both the demography and vitality of our nation. For the first time in many developed countries, particularly in Europe, fewer children per couple are being born than the numbers required for population stability. This situation is even more serious in other countries: in Japan for example, where there are more people over the age of 70 than there are children under the age of ten. What are the factors behind this falling birth rate? Are we becoming too selfish and greedy as a society? Do we rank individual wealth and career success before the desire to nurture a family? How do the changing roles of women and men influence the decisions to produce children? Do working conditions discourage employees from having children? Do government policies actively encourage parents to have children and nurture and support the family? In their thought-provoking book *What are Children For?*[2]

Laurie and Matthew Taylor discuss some of these issues and expose the existence of 'TINKERS' – 'Two Incomes, No Kids and Early Retirement'! These are people, often in positions of considerable authority who determine policies, budgets and practice, who have chosen not to have children, and see no reason why they should be important. We have to persuade them to the contrary view!

I argue that we really must consider children and young people in our society as our most precious and valuable asset. They will be the adults of tomorrow, the teachers, the carers, the parents, the policy-makers. They will have a major impact on how we will live in years to come. But now in so many ways we continue to let our children down as citizens of today. That all is not well with the overall circumstance of children and young people today is exposed in the recent research report from UNICEF[3] on the well-being of children and young people in the 21 richest nations of the world. Although there may well be legitimate challenges to the methodology and currency of the data, the shocking conclusion is that the UK ranks at the bottom of the league table, having within our country substantial numbers of children and young people that are unhappy, unhealthy, have poor relationships with their peers and parents, have low aspirations, expose themselves to risky behaviour and feel unsafe and insecure. This is a reflection that, for far too long, they have been all but invisible to those who make public policy, and this report should be a wake-up call to society to get to grips with the enormity of the malaise at its heart.

While the majority of children are undoubtedly loved by their families, are working hard to obtain qualifications and contribute to communities, nonetheless, large numbers of children are struggling in today's turbulent society. They are not receiving the love, care and support that they require to develop and grow into the adults of tomorrow. They are let down by parents, by local communities and by the very services that should be in place to support them. We need to understand that these children are not just someone else's children and someone else's problem. For, if we do not find it within ourselves to pay attention to them as young children today, they may force us to pay attention to them as troubled adults tomorrow.

"Large numbers of children are struggling in today's turbulent society."

The changes in the way we live in the 21st century have resulted in an increasing feeling of isolation for both adults and children and the perception that we live in a dangerous environment for children. It is not politically incorrect to highlight the fact that the erosion of the traditional family through the breakdown of marriage, increasing number

of single parent families, the loss of 'jobs for life' and less time spent enjoying and nurturing our children have important consequences for the whole of society. Some hard facts need to be considered regarding modern family life (see Box 1). What is the impact of these changes on the health and well-being of children, and where is the debate?

Box 1: The breakdown of 'traditional' family life in England and Wales in the 21st century

- In 2005 there were 244,710 marriages, the lowest figure since records began in 1896.
- In 2003, 41% of births were outside marriage; in 1980 the figure was 12%.
- 167,000 divorces took place in 2003, the third successive annual rise; one in four affected children is aged less than five; seven in ten less than ten years old.
- Only one in 20 children in divorce cases believe that their parents' separation was properly explained to them.
- In 2004, 24% (3.9 million) children lived in lone-parent households; in 1972 the figure was 8%.
- About 750,000 children witness domestic violence each year.
  Source: Department of Health (2005) *Responding to Domestic Abuse: A Handbook for Health Professionals*
- Children living without their biological fathers:
  - are more likely to live in poverty and deprivation
  - have more trouble in school
  - have higher risk of health problems
  - are at greater risk of suffering physical, emotional or sexual abuse
  - are more likely to run away from home.

  Source: O'Neill R (2002) *Experiments in Living: the Fatherless Family*. Civitas
- 200–300,000 children live with relatives other than parents.
- Approximately 20,000 children and young people are bereaved of a parent every year – around 53 per day.

Source: Office of National Statistics (except where stated)

The components of nurture that children need to become confident adults include love and care, physical contact, comfort, nutrition, warmth and protection from harm coupled with, above all, security and stability. They need places to play, spaces to explore, room to grow and gain confidence through exposure to managed risk. They need friendships and respect and a moral compass of values, boundaries, expectation and purpose in life. Yet in so many ways, life in modern England fails to nurture them and curtails these freedoms; it restricts the child's right to roam, to explore and take risks. At its worst, it robs them of their childhood. Increasing commercial pressures are also leading to the disappearance of the type of childhood that has been experienced by many adults. All forms of media bombard children and young people with messages to look a certain way, to eat certain foods, to behave in certain ways, including engaging in early sexual experiences. Today's role models are instant celebrities such as reality-show contestants and WAGS (wives and girlfriends of soccer stars). Children and young people are exposed to unprecedented pressures to conform and I argue that these pressures are taking their toll in terms of physical and emotional well-being and health. The gap between the very rich and the very poor in England remains a huge political challenge. This is leading to increasing needs in terms of social support, health services and education. Are current services rising to the challenge, and are they meeting the needs of the most vulnerable children and young people and their families?

Deep down, we know that healthy mothers produce healthy children, who become healthy adults. As John Bowlby pointed out years ago, the attachment of the infant to its mother is the foundation upon which its whole life will be built. And yet even this simple truth is often ignored as we are caught up in the rush of everyday life. If we were to pause long enough, however, we would realise the folly of ignoring the health and emotional problems that start early in life. We know that many of the afflictions of adult life – and early adult death – have their roots in childhood. Health economists are predicting that health services will soon be groaning under the impact of health problems caused by obesity in adults who have been obese since childhood. Prevention of adult mortality and morbidity through a focus on ensuring optimal health, particularly cardiovascular and metabolic health in childhood, would seem intuitively to be important. The economic cost of the current success of using statins in ameliorating heart disease in the elderly is massive, yet where is there an equivalent focus on preventing such disease in the first place – in early life? Where is the debate on this issue and who in society cares?

Being seriously provocative, I argue that the current difficulties confronting children and children's services reflect the low standing and value of children, young people and

parenting in contemporary society. Why is English society ambivalent in its approach to children and young people? On one hand there is the desire to love and nurture our own children, but what about other peoples' children? Why as a society do we not cry out for those who are the most vulnerable? Central to this, I believe, is the failure of our nation to recognise that children have human rights. In my view the most important recent milestone in the history of childhood is the creation of the United Nations Convention on the Rights of the Child (UNCRC). Although children represent our hopes for the future it is important to remember that children are not just the future. They are the present. While they are not yet adults they are citizens now, with rights, hopes and aspirations. Why are the rights of children, especially the disadvantaged, so hard to enforce? And why is their voice so rarely heard? As said above, while all of us care passionately about the fate of our own children, all too many of us seem blind to the fortunes – and misfortunes – of others.

The present government, through its Every Child Matters[4] policy programme, has made a clear and unprecedented commitment to improving the lives of children and young people, particularly those who are most vulnerable. But inevitably there are pressures and tensions in the development, delivery and cohesion of these policies. The practical challenge we now face, and it is an immense challenge, is how to translate the numerous recent public policy proposals into robust and durable measures that benefit and protect children, not just in the short term, but for the long term. It would be wrong though, to suppose that the burden of blame or responsibility lies entirely with any government. As Hillary Rodham Clinton highlights in her book *It Takes a Village*,[5] the nurture of children should be everybody's business: parents, families, schools, faiths and local communities as well as government. Parents and families have a central responsibility to nurture and instruct their children, but society as a whole has a responsibility to provide for and support its children.

Writing this commentary has given me the opportunity to examine the experiences of children and young people in England and to consider the impact of policy initiatives on their lives and health. In my opinion there are emotional, demographic, economic and health service reasons why children and childhood should be a focus for government action, giving them appropriate priority and resources. However, as I tour the country I am always very surprised to find what little understanding there is about the issues of children and childhood in the minds of many adults, especially those with responsibility for their services. How can we improve the understanding of children and childhood in the minds of people who make things happen?

This book asks many questions, and it may not provide all the answers, but it is a genuine attempt to reflect on the opportunities available for our children and young people now in making the voiceless heard and the invisible seen. I set out deliberately to provoke because my recent experiences have generated three emotions in me. I have exhilaration at meeting so many outstanding children and young people, many of whom face intolerable difficulties in their lives with astonishing courage and hope. I then have, second, despair at seeing the sheer awfulness of so many children and young people's lives – children with disability, children sleeping under the railway arches, children in prison or facing deportation, living in blighted inner-city estates or in rural isolation. Finally, I have deep anger at the injustices I see repeatedly and in the way in which adult society is oblivious to the needs of so many children. I hope what I say will generate discussion and debate. You may not like what I write; but at least take the time to consider whether there may be some truth in it.

2. LEARNING FROM THE PAST?

When we sob aloud, the human creatures near us pass by, hearing not, or answer not a word.
Elizabeth Barrett Browning, *The Cry of the Children* (1843)

All children have the right to life. Governments should ensure that children survive and develop healthily.

UNCRC: Article 6

Unless we understand how our attitudes to children and childhood have evolved from the past, we will never be able to improve the lives of our children in the years to come. However, reviewing how we have treated our children through the centuries is an uncomfortable process. The historian Lloyd de Mause wrote that: "The history of childhood is a nightmare from which we have only recently begun to awake. The further back in history one goes the lower the level of childcare and the more likely children are to be killed, abandoned, beaten, terrorised and sexually abused."[6]

From the first expressions of the history of what we now call Western civilisation, children have been noticeable chiefly by their absence. It was not until very recently – as late as the 1970s in fact – that historians even bothered to record and study children as people in their own right, or to examine childhood as a specific entity. Although children and childhood may have been used as illustrations of bigger or broader pictures, children have never been in a position either to write their own histories, or to ask awkward questions of those who hold power over them. This, in large part, explains why children have been seen but not heard in the annals of history. One modern historian who has tried to bring the lives of children in the past into sharp focus is Nicholas Orme. In his remarkable book on medieval children[7] he shows that during the Middle Ages there was a significant shift in attitudes to children. It was during this period that, for the first time perhaps, a

concern for the well-being of children began to manifest itself in Europe. Children, as he argues, were recognised to be different to adults, and had their own culture.

It was also during this period that children became much more visible in the public sphere, as Breughel's painting *Children's Games* (1559) illustrates (see Figure 2). In this painting children were portrayed as individuals, absorbed in playing more than 80 different games and activities – many of which survive in playgrounds to this day.

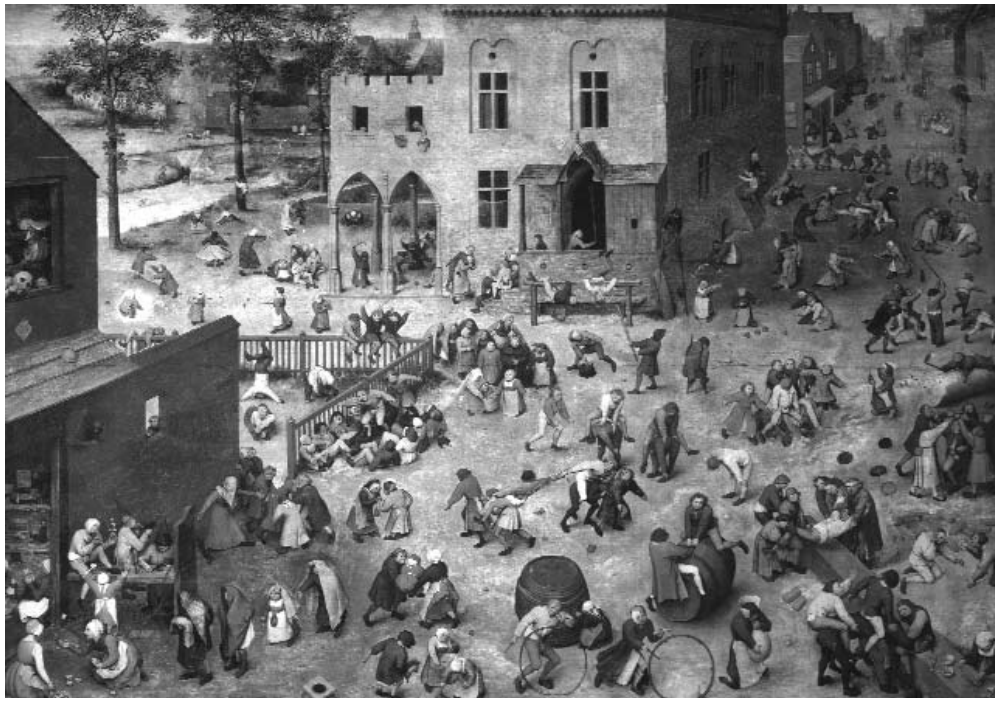

Figure 2. Pieter Breughel the Elder: *Children's Games*, 1559
Kunsthistorisches Museum, Vienna

But it was the advent of the printing press in the 15th century that had perhaps the biggest impact on modern Western culture and the representation of children in particular. The word 'childhood' now emerged and was used to describe a stage in life when one has to learn to read and write in order to become a good, God-fearing adult. The expansion and availability of the printed word brought about the spread in schooling and education. Indeed, by the Middle Ages, England was thought to be the most educated country in Europe. As Shakespeare wrote: "the whining schoolboy, with his satchel and shining morning face, creeping like a snail, unwillingly to school".[8]

With the emergence of childhood as a distinct phenomenon, it was inevitable that philosophers in this intellectually fertile period would turn their minds to explore its deeper meaning. Two men stand out as the principal cartographers of childhood at this time: John Locke,[9] and Jean Jacques Rousseau.[10] Locke, a qualified medical doctor and Oxford don, articulated the idea that a child's mind, far from being a source of evil – as in some aspects of the Christian tradition – was a tabula rasa or blank slate onto which it was the responsibility of adults to write.[11] Rousseau's view of the child was different. He identified three key aspects of childhood. First was the notion that children have rights of their own. This idea, as we shall see, remains controversial to this day. Second, Rousseau was concerned with the essence or the spirit of childhood – its joie de vivre – which he captured by writing about the sense of wonder and awe, the vigour and the enthusiasm of childhood, a sentiment which is also evident in Breughel's painting. Third, and perhaps most important for the field of education, Rousseau also thought that children learn best through experience – a concept which has since been built on by the likes of Froebel[12] and Montessori[13] in their own distinctive approaches to teaching and education. The very different philosophies of Locke and Rousseau may have set the trajectories for the subsequent diverging approaches to children in society in the Anglo-Saxon and French worlds. Nonetheless, at the same time as Rousseau and Locke were outlining the morality and philosophy of childhood, an equally important social development could be found in the emergence of 'parenting' as a distinct phenomenon.

While these were the emerging philosophical approaches to children, the prevailing public view of childhood in 18th-century England, and especially in its capital city, London, was rather different. Instead of being their custodians, adults often regarded their children as millstones. Many were abandoned. They were, quite literally, left out to die. Although small by today's standards – a population of 600,000 souls – London was growing rapidly and with clear class distinctions. Unlike in medieval times, when rich and poor lived cheek by jowl in the capital's fetid streets, the London which emerged 50 years after the Great Fire was a very different place. The fire had swept away much of the old London, and the rich saw this as an opportunity to start anew. As the re-born metropolis emerged from the ashes of the old, the rich migrated west and the poor, who were left behind in the City, tended to migrate towards the east – a polarity that still exists in London today. The yawning gulf in incomes between rich and poor fuelled an unprecedented crime wave. Newspapers – another new phenomenon – then compounded the problem by publishing sensational stories about highwaymen and murderers, designed to terrify their readers. The reality of crime, and the exaggerated fear of crime, made London a truly frightening place to live. Does this sound familiar?

Figure 3. William Hogarth: *Gin Lane*, 1751

Bibliotheque Nationale, Paris, France / The Bridgeman Art Library.

William Hogarth, an illustrator and artist, was horrified by what he witnessed as he moved around London. Hogarth was a remarkable artist because he was one of the first to portray the reality of children living in appalling social conditions. At that time, 75% of children died before they were five years old, illegitimacy was rife, and countless numbers of children were abandoned by parents ruined by the effects of gin – shockingly portrayed by Hogarth in his picture of Gin Lane in 1751 (see Figure 3). There were no safety nets – no systems in place to support these children.

This was not the picture throughout Europe, however, where foundlings had been thought of and cared for down the centuries. Indeed, in most European countries there were foundling hospitals, England being unique in ignoring the existence of babies, literally, thrown on the dung heaps to die. In Venice, for instance, an institution for foundlings had been established as early as the 12th century – but not in England. Here there was a morbid fear that such provision would encourage promiscuity, as a contemporary quotation illustrates:

It is better for such creatures to die in a state of innocence than to grow up and imitate their mothers; for nothing better can be expected of them.[14]

So it is clear that there was already a world of difference between Europe's enlightened attitude to children and foundlings, and the deeply hostile approach evident in England. It was against this attitude that Thomas Coram found himself fighting for the cause of foundlings. A man of integrity and courage in an age of corruption and moral complacency, Coram was as outraged as Hogarth at what he saw, not least because of his experiences on the value of all human life in the colonies of North America as they struggled to exist in a hostile environment. Affected by the death of his only brother, William, as an infant, and having no children of his own, Coram could not sit idly by and let these babies die. In October 1739 he was able to write: "After seventeen years and a half's labour and fatigue I have obtained a charter for establishing a hospital for the reception, proper maintenance and employment of exposed and deserted young children."[15]

I believe that this sense of moral outrage could and should be as powerful a motivating force in 21st century England as it was for Coram three centuries earlier. But who is outraged today by the effects of poverty on the lives and outcomes of contemporary children? Coram's inspiration was to harness the interests of 16 high-born ladies, 25 dukes, 31 earls, 26 other peers and 38 knights, and to couple their support to entrepreneurial fund-raising by engaging with the world of the arts through Hogarth and Handel. This association between fund-raising and high society and the arts to support destitute, ill and disadvantaged children remains as powerful today as it was 300 years ago.

Figure 4. Sophie Anderson: *Foundling Girls at Prayer in the Chapel*, c.1877

Towards the end of the 18th century basic educational opportunities became more widely available particularly through the introduction of Sunday schools fuelled by the indignation of churchmen and the churches that were intent on saving the souls of the poor. For the middle and upper classes, the 19th century also saw a significant divide in educational opportunities for boys and girls, with the creation of famous 'public' schools for boys whose main function was to provide the servants of the emerging British Empire.

In the 19th century England underwent perhaps the most turbulent period in its social history. The origins of this turbulence have been well described by Walvin[16] in his outstanding book on the world of the Victorian child. The population of England and Wales mushroomed from 10 million in 1800 to more than three times that figure at the start of the next century. The population of London exploded from 600,000 to 3 million in the space of a few decades. Industrialisation, urbanisation and the migration of countless thousands of people to the expanding cities created huge social changes, with a vast and widening gulf between rich and poor. During this century the world of the child was one of dramatic change.[17] The ambivalence in our thinking about children was again apparent. During this period the middle and upper classes held a strong belief in the role of families and especially the importance of mothers, exemplified by the relationship between Queen Victoria and Prince Albert and the real importance of children in their family. And yet, when the Poor Law was introduced in 1834 to provide relief for the most vulnerable, a condition of entering the workhouse was that family units were split up.

By the middle of the Victorian era, the proportion of children under the age of 14 years old had risen to more than 40% of the total population. That is twice the proportion we have today: children were everywhere! Yet, at the same time, they seemed to be utterly absent from public policy. To the Victorian political classes children were, quite literally, seen but not heard. But society could not ignore the pressure that was building up. Poverty, illness, disease and premature death lurked around every crowded street corner. In England's cities half of all infants died prematurely, the innocent victims of a lethal cocktail of dirt, neglect and ignorance coupled with poor water and impoverished diet. Diseases long since almost eradicated such as diarrhoea, measles, whooping cough, diphtheria, smallpox and tuberculosis stalked the land and claimed countless victims. In older children, accidents were (as they are to this day) one of the most important causes of death and handicap. Children were forced to work in intolerable conditions in the factories and mines, and many of them – unprotected by any law – were fatally injured or suffered permanent disability as a consequence of these dreadful conditions. Children as young as four were employed in the mines to act as 'trappers' to open and close trap doors to secure the air flow in the shafts as the coal wagons passed by. Working in

darkness for up to 18 hours each day, it is not surprising that many became lost in the labyrinths. Others worked as 'scavengers' in the mills, crawling beneath the whirling machinery to rescue lint and pieces of cloth.

In 1838 a mine disaster occurred at the Husker pit at Silkstone in Yorkshire in which 26 children were drowned in a flash flood during a thunderstorm. Alan Gallop in his outstanding book *Children of the Dark*[18] gives a powerful and moving account of the event, and a description of the lives of children working in such intolerable conditions. He also documents the public outcry that followed once the newspapers of the day had exposed the shocking circumstances of children in the mines. The call to improve their lives was taken up by Lord Ashley, later the Earl of Shaftsbury, a courageous politician who against ferocious opposition from the mine owners and politicians, including the Prime Minister Robert Peel, introduced a reform bill in Parliament. In 1842 the Mines Act, a seminal political development, was eventually passed, prohibiting the working of women and children underground.

A further case involved an 11-year-old boy, George Brewster, who died from suffocation while working as a climbing boy for a chimney sweep in Cambridge. His death also became headline news. This case once again appalled the public and prompted Lord Shaftsbury to table The Climbing Boys Act in 1875 which prohibited the use of climbing boys. The plight of such children was romanticised in the novel *The Water Babies*[19] by Charles Kingsley.

If conditions at work were bad, home life was no better. The slums of our great cities were plagued by poverty and overcrowding. Child destitution was rife. Children were orphaned, deserted, neglected and left to fend for themselves. Street urchins, marauding gangs, theft, scavenging and prostitution were commonplace in poor communities.[20] In the poorest parts of the country – but in London in particular – the mortality rate for babies was 500 per 1,000 births. In other words, half of all babies died before they even reached early childhood. By comparison, the rate across England and Wales today is about five per 1,000 births.[21] Even where medicine was available to alleviate illness, it was often misused. Popular remedies such as 'Godfrey's Cordial' were stiff with opiates and were deliberately given to babies and young children to keep them quiet.[22] In Coventry, in one week alone, 12,000 doses were bought. That is the equivalent of ten gallons of opiate cordial. Why was this necessary? Was it because adults felt they needed to keep children quiet and under control in the crowded slums in which they lived? Without adequate historical records it is impossible to say what the full effect of this practice had on childhood morbidity, but it must have been profound.

It was in reaction to these circumstances that Elizabeth Barrett Browning was moved to write her poem *The Cry of the Children* in 1843.[23] Here is one of the most heartrending of the verses:

Now tell the poor young children, O my Brothers
Look up to Him and pray;
So the blessed One who blesseth all the others,
Will bless them another day.
They answer, 'Who is God that He should hear us
While the rushing of iron wheels is stirred?
When we sob aloud, the human creatures near us
Pass by, hearing not, or answer not a word.
And we hear not (for the wheels in their resounding)
Strangers speaking at the door;
It is likely God, with angels singing round Him,
Hears our weeping any more?'

For many, religion and the expectation of a happy afterlife was a source of great consolation and comfort. But for a few stubborn social reformers, such palliatives were woefully inadequate. What mattered to them was not the afterlife but this life, and how to make it better. We can learn much from their example. In art and literature, on the stage and on the floor of the House of Commons, a sense of outrage at was happening to those trapped at the bottom of the social heap began to trouble the nation's conscience. And, in that process, the voice for children, often among the most vulnerable and oppressed, was finally beginning to emerge. During this time there was growing concern about the very poorest children – those who worked on the streets and who were not protected by the rafts of emerging legislation on child employment and education. The debate was growing – should society try to help them or try to control them? This debate continues to this day: consider our current pre-occupation with anti-social behaviour and our reactions to young offenders.

More perhaps than any other writer of his time, Charles Dickens held a literary mirror up to the underbelly of Victorian England and what he revealed caused revulsion and outrage in equal measure.[24] Dickens knew poverty at first hand. His father had been imprisoned because of bankruptcy, and the young Charles had had to work as a child labourer in a blacking factory. He was rescued when his father was released and he became perhaps the first campaigning journalist – a keen social observer who shocked respectable society by recording what he saw. Children were as visible in the books of Dickens as they were in the paintings of Breughel. From *Nicholas Nickleby*, written after

his experience of visiting schools in Yorkshire, to *Oliver Twist* and *Martin Chuzzlewit*, children are often the heroes of Dickens's morality tales. But it is an extract from *The Old Curiosity Shop* which best illustrates the power and potency of Dickens' writing. This is his account of the death of Little Nell:

She died soon after daybreak. They had read and talked to her in the earlier portion of the night, but as the hours crept on she sunk to sleep. They could tell by what she faintly uttered in her dreams that they were of her journeyings with the old man. They were of no painful scenes but of those to have helped and used her kindly for she often said 'God Bless you' with great fervour. Waking, she never wandered in her mind but once and that was of beautiful music which she said was in the air. God knows it may have been. Opening her eyes at last from a very quiet sleep, she begged that they would kiss her once again. That done she turned to the old man with a lovely smile on her face such, they said, as they had never seen and never could forget and clung with both her arms about his neck. They did not know that she was dead, at first.[25]

Here is a writer at the height of his powers, speaking out for a child without a voice. His power is a reflection of his own experience at losing unexpectedly his own beloved daughter, Dora. This particular passage had a profound impact on Victorian society. The irony is that Dickens' readers were as much outraged at the author for depicting the death of this tragic figure as they were at the social injustices and inequalities which he had so graphically described. This is instructive and relevant to today. It shows how those who dare to speak out about inequality and injustice are often scorned and reviled for the message they bring.

There is another lesson we can learn from the Victorian era. It is that social reformers with sufficient courage and determination can defeat even the most hostile of opposition. Thus, the outrage of Charles Dickens and his friend Charles West brought about a revolution in healthcare for some of the poorest children in London. It led directly to the founding of Great Ormond Street Hospital for Children in 1852 at a time when England was the last country in Europe to be without a hospital specifically designed for the needs of sick children.[26] But Dickens and West were not alone. The terrible impact of the demographic upheavals of Victorian society on the life and the health of children spurred a range of intellectuals to become social reformers who triggered what we now know as the 'age of philanthropy'. Among the most famous names of this era were Bramwell Booth, Thomas John Barnardo, the Reverend Waugh, Joseph Rowntree and Mary Carpenter. The latter was one of the first to argue that the courts should treat children as children and not as adults.

Jeanne Duckworth in her book *Fagin's Children*[27] describes the reality of child crime in Victorian England and the attitudes of the authorities to offenders. For example, she quotes the story of 13-year-old Emily Davies, who in 1875 was sentenced to 14 days in prison and four years in a reformatory for stealing a handful of apples in Ross-on-Wye. The chairman of the magistrates, in sentencing her, is reported to have said "It is not with any vindictive feeling that we are punishing you, but for the prevention of crime. Others will be deterred from offending through the dread of punishment." Again, this case was taken up by newspapers and led to a national outcry over the injustice. Another courageous politician, Thomas Blake, the MP for Leominster, forced the Home Secretary, Richard Ashton Cross, to climb down and set Emily free. Such a cascade could not have happened in the early years of the century and reflects the start of a momentum of change in the attitudes of the public and of politicians to children. Are some of the attitudes to young offenders still present today? Is the public pressure, fuelled by the media, over the problems of anti-social behaviour leading inexorably to government policy through its 'Respect' agenda[28] to be characterised by increasing punishment and control of children? Why are more children incarcerated in young offender prisons and secure establishments in England today than in any other Western country? Why do so many re-offend and are returned to prison? Why are the underlying severe learning difficulties and mental health problems that afflict so many young prisoners not being recognised and treated? Why are so many children dying from suicide or even restraint in prison in the 21st century? Where are the courageous politicians to rail against the appalling circumstances of children in conflict with the law?

A number of solutions were devised to address the problems of some of the most vulnerable children – the street children. Some were fostered, some sent to poor law institutions, some were sent abroad to Australia or Canada and some were placed in children's homes or 'barrack schools'. The thinking behind all these solutions was that the children must be separated from their families. However, despite these measures and the introduction of compulsory schooling by 1870 the problem of street children still existed. Indeed, this continued despite thousands of prosecutions for children who were not attending school. Is it not curious that we have similar pre-occupations today over truancy and the anti-social behaviour of children who are not in school?

Important institutions were founded at this time, many of which still exist, including the National Children's Homes, and the Waifs and Strays Society (now the Church of England Children's Society). It is highly relevant to note that this institution, famous for its relentless advocacy for children, has felt so moved by the plight of contemporary children that it has started an Inquiry into a Good Childhood in 21st Century England.

In 1884 the Liverpool Society for the Protection of Children was formed, and was subsequently transformed into the National Society for the Prevention of Cruelty to Children (NSPCC). It says something about our culture – and our attitude to children – that the Royal Society for the Prevention of Cruelty to Animals was founded 60 years earlier than the NSPCC! Has very much changed? Perhaps not, as witnessed by the disproportionate public and political interest over fox hunting compared to the lack of interest in the plight of so many of our own disadvantaged children today.

Unless we comprehend the past, we will find it hard to chart a proper course in the future. So have we listened and learned from our past? Are the attitudes of English society significantly different in the 21st century? It is my contention that our attitudes to children and young people are deeply ingrained in the past and that understanding the historical context of children within society is the key to opening the door of opportunity to those children and young people for the future. That is why the history of childhood matters, and for me there is an unequivocal message from understanding it. Is there not something perverse about English society and its attitudes to children? Are we not one of the most child-unfriendly countries in the developed world? Children, almost uniquely in modern Europe, are denied protection from physical punishment from their parents and are named for shaming in newspapers for their misdeeds; more children are incarcerated in prison than in any other equivalent country, some of them dying there from suicide or restraint, and there is growing intolerance for the activities of the young by the older generation who have forgotten how they behaved themselves as children. Is there not opening before our eyes a dangerous schism between the young and the old in society today?

"Is there not a dangerous schism between the young and the old in society today?"

It is relevant to note here that for over 50 years there has been no public celebration of Universal Children's Day in the UK. The UN created this day in 1954 and recommended that it should be observed by all countries to promote the welfare of the world's children. Why is it not celebrated in England? Change for children during the last 200 years or so did not happen by chance. It was triggered by intellectual outrage in the minds of well-connected social observers and commentators who were appalled by the effects of society on the lives and health of countless children. Their outrage initiated a cascade of effects, including the harnessing of the media of the day to expose to the wider public the shocking and unacceptable plight of so many children in the most powerful and rich country in the world. A handful of resolute and relentless social reformers demanded

change, and they captured the support of a small number of courageous politicians who against formidable opposition forced government to introduce legislation to improve the lot of the young.

Is this 'reform cascade' relevant to us today? I believe it is. Where is the intellectual outrage over the awfulness of the lives of so many of our own children? Who cares? How can the feeding frenzy of the demonisation of children and young people in contemporary newspapers be turned around, so that they become the champions of the most vulnerable in our society? There is undoubtedly much excellent practical work being done by the voluntary sector, and this should be celebrated, but being seriously provocative, is there not a need to see how through synergy and not competition, they can be much more effective advocates for contemporary children, particularly in local communities? Indeed, has the dependency of many organisations on government largesse for providing services that the state should deliver diluted and diminished the reforming zeal of their founders?

It is, of course, fascinating to see current political philosophy taking a much greater interest in parenting now than in recent years as, for example, in the recently published Social Exclusion Action Plan.[29] However, is the primary driver for this to address the best interests of children, or is it to prevent the social mayhem caused by inadequate parenting leading to anti-social behaviour in children and young people? There are encouraging signs, as I shall describe later, that political parties and politicians, both national and local, are waking up to the reality of the effects of our contemporary societal turmoil on the lives and health of children. This is welcome. Sadly, however, I see ongoing evidence that we still live in a country in which children and young people are not valued by adults, where their rights are not upheld, and where too many are being failed. The nurture of children really should be everybody's business – how do we make it so?

Key Learning Points

- Our ambivalence and lack of concern for children is apparent throughout history.
- Individual cases have motivated public outrage and led to political reform.
- We need to listen to and promote key social reformers – they can effect major changes in practice.
- Throughout our history the views of children have not been asked for and their voices have not been heard.

Key Action Points

- Read the history of children and childhood in order to understand where we have come from and the social construct of childhood.
- Be inspired by the social reformers of yesteryear.

3. IS CHILDHOOD DISAPPEARING?

It is the best of times, it is the worst of times. We live in an age of comfort, convenience and promise – a wonderful place for grown-up human beings to work and relax. But it's not always the best of all possible worlds for children. Deep in our hearts we all know it, but we're frightened to admit it. The world we've created is damaging our children's brains.

Sue Palmer, *Toxic Childhood* (2006)

Children have the right to meet together and to join groups and organisations, as long as this does not stop other people from enjoying their rights.

UNCRC: Article 15

Children have the right to reliable information from the mass media. Television, radio and newspapers should provide information that children understand, and should not promote materials that could harm children.

UNCRC: Article 17

All children have a right to relax and play, and join in a wide range of activities.

UNCRC: Article 31

Is the traditional experience of childhood a thing of the past? Has it been replaced by the perception of a more hostile society without individuals and systems committed to support, nurture and cherish our children and young people? In this section I want to look at how the shifting social and cultural landscape of modern Britain is affecting the lives and health of children and young people. There is an emerging, and in my opinion long overdue, public debate about the nature of childhood today. Some commentators have begun to express serious concern over contemporary childhood, arguing that it is bleak and under threat.[30] It has been suggested that childhood as we know it is rapidly

disappearing under the pressures of relentless commercialisation of children,[31] the insidious promotion of early sexuality and the loss of time for children to be children.[32]

How much does society encourage and support children? How welcome are children and young people in our streets, shops and playing fields? No dogs, no children, and no ball games – these are the prohibitions we see all too frequently. A new one for me was seeing recently in a public open space the notice "You are Being Watched". Witness, too, the current enthusiasm for deploying 'mosquito' devices. These are not designed to combat the winged insect, but emit a high-pitched pulsating and unpleasant noise audible only to the young, and are used with increasing public and media support to disperse groups of young people from shopping precincts and other public areas where they gather. I believe that the take-up of this device in localities is a powerful symptom and symbol of our fear of children and of our failure to recognise their rights and needs. How many adults who condemn children have made it their business to ask children why they gather in groups? "Nowhere to go, nothing to do, and nobody wants to work with us" are complaints I have heard repeatedly from asking such children. When do we ever see notices saying "children are welcome here"?

Pressures on time, and the loss of safe places to play, also make it all but impossible for children and youngsters to explore the world in their own way, free from adult meddling and manipulation, in preparation for becoming confident young adults. Have we become a nation increasingly intolerant to the very presence and antics of children and young people? And how many of us, now pillars of our local communities, can put our hands on our hearts and say honestly, I never did anything when I was young that I would rather my neighbours didn't know about now?

The commercialisation of childhood

The 18th and 19th century exploitation of children as cheap labour has been replaced in the 21st century by an equally relentless and ruthless exploitation of children as a multi-billion dollar market. If the benefits of living in the richest nations in the world are not being shared by all our children, the relentless commercial pressure they are living under is being *suffered* by all. There is hard evidence that nowadays children are subjected to ever more sophisticated and intensive marketing techniques, drawing them deeper and deeper into the consumer market. This is big business. Read the exposures of the practices of the multinational advertising agencies in *Consumer Kids – the Hostile Takeover of Childhood*[33] by Susan Linn; Martin Lindstrom's *Brand Child – Remarkable Insights into the Minds of Today's Global Kids and Their Relationships with Brands,*[34] and of greatest importance *Born to Buy*[35] by Juliet Schor. These books should be mandatory

reading for anyone concerned with the shaping of childhood today. It is shocking to be told of the enormity of the investment being made by the advertisers in predicting the future nature of childhood in order to be better placed to exploit the neurological and societal development of children and young people. The pre-school market alone is estimated to be worth £4.3 billion a year in the UK.[36] Capturing segments of the children's market is a cut-throat business. Advertisers will shamelessly play on the fact that children crave peer acceptance by implying: "You must have one of these to be popular with your peers." To reinforce this, the advertisers also perpetrate the 'nag factor' or 'pester power' by which children try to override the best intentions of parents in purchasing foodstuffs and other articles that they feel are not in the best interests of their children. Above all else, what the marketing men and women desire is to secure cradle-to-grave brand loyalty. The relentless bombarding of families with advertising messages now means that children as young as six months old are forming mental images of corporate logos. Studies in America have shown that a child's awareness of brands – and thus the first signs of brand loyalty – may begin as early as two. So it is hardly surprising that a recent study revealed that 31% of three-year-olds remember seeing a leading soft drink logo, 69% recall a fast food outlet's identity, and 66% the name of a confectionary manufacturer's products.[37]

"The average child sees several thousand advertisements a year."

It is estimated that the average child sees several thousand advertisements a year. In the resources war for our children's hearts and minds, the big corporations have all the money. Is it really any surprise, therefore, that our children are getting older younger and that childhood is changing rapidly? One of the world's leading authorities on the teen market described children as "the brightest star in the consumer constellation".[38] This, and attitudes like it, are deeply cynical and depressing. Children are the brightest stars in the human – not the consumer – constellation. It is not only teenagers that are being targeted. In America nine- to twelve-year-olds are known as 'tweens', or 'tween-agers' and they are a lucrative new market. *The Great Tween Buying Machine: Capturing Your Share of the Multi-billion-dollar Tween Market*[39] by Siegel, Coffey and Livingston should blow the lid off any complacency we might have over the ruthless pursuit of the spending power of ever-younger children. The market in magazines, particularly those aimed at young girls, is flourishing. These provide unprecedented opportunities to disseminate authoritive and helpful information to children and young people and also to 'listen' to their views. But is it any wonder that girls are confused and anxious when the cosmetic, fashion and film industry – on whose advertising such magazines depend – push utterly unrealistic images of modern beauty, such as achieving

a size zero figure, on younger and younger girls? What is the role of such images in initiating anorexia nervosa and other eating disorders?

The insidious promotion of early sexuality prevents young people – and girls in particular – from growing up and maturing at their own pace, and provides them with a distorted image of beauty which is often nothing more than an unrealistic fantasy. Such fantasies can only exacerbate early adolescent anxieties about self-worth. Why do we allow high street clothing outlets to produce lacy underwear for pre-pubescent girls, and with tank tops for five-year-olds with the slogan 'Too many boys – too little time?' What possible value can such articles of clothing have to promote childhood? Why are products being marketed to encourage young girls to remove their body hair? Why are parents not incandescent over the shameless exploitation of their children? Perhaps the worm is at last beginning to turn, with the emergence of public calls for parents to start boycotting retail outlets that promote inappropriate clothing.

Is it any wonder that against the relentless bombardment of children and young people of highly sexualised images there is an explosion of sexually transmitted infections, with the UK having one of the highest teenage pregnancy rates in Europe. Contrast, as Davina McCall so eloquently did in a recent Channel 4 documentary,[40] the huge differences between Holland, a country with low teenage pregnancy rates and sexually transmitted infections in the young, with England over the nature and content of sex and relationship education. As one 14-year-old girl told me "I'm learning about quantum physics in school, but sex is never mentioned and no-one tells me how to put on a condom." Why cannot sex education be taught effectively to young people as part of the study and understanding of human relations in the compulsory National Curriculum? The importance of establishing loving, caring relationships needs to be brought alongside the biology of reproduction, and, in my view, the two are not incompatible. How sad to know that the majority of teenage boys (and many girls) see the portrayal of adult sexual relationships from ubiquitous pornography. How distorted are their views and behaviours likely to be without role models and teaching of the alternatives? Yes, the primary responsibility for moral values must lie with parents, but many are perplexed by not having the toolkits to use in discussing such matters in an honest and authoritative way with their children. How can schools and others work with parents to provide the toolkits for some of the most difficult and sensitive conversations parents will ever engage in with their children? If we do not develop ways and means for children to obtain responsible, accurate and non-judgmental information on sex and relationships we will be betraying them and we will exacerbate the health implications now being exposed. Why is it that so many schools, especially those based on faiths, refuse to allow

Personal, Social and Health Education in their curricula? Why are adults so oblivious to the needs of children and young people in understanding sex and relationships? We must start listening to them over what they want and need if we are to reverse the worrying trends in the sexual ill-health of our young people. Is it not time to have serious open debate about these matters and demolish the conflicting messages around sexuality that we adults portray to children and young people?

In many ways, much greater concern needs to be expressed about the role the commercialisation of childhood plays in the explosion of childhood obesity and the epidemic of alcohol ingestion by children and young people. An estimated 643,513 boys and 613,048 girls between two and 15 years of age in England were overweight (from their Body Mass Index (BMI) status) in 2003 and a further 746,662 boys and 675,983 girls were obese. Among boys and girls of this age the proportion of children who were obese increased between 1995 and 2004 from 11% to 19% for boys and from 12% to 18% for girls.[41] Forecast projections show that the number of boys who are obese will increase to 792,321 in 2010. The greatest increase is projected to be for girls; around 910,630 are likely to be obese by 2010.[42]

Greg Critser, in his chilling book *Fat Land – How Americans Became the Fattest People in the World*[43] lays the blame fairly and squarely on the advertising and promotional activities of the fast-food industry coupled with profit-enhancing changes in the calorific density of their products. The health consequences of the world-wide challenge of obesity in children are staggering. Diabetes, heart disease, orthopaedic degeneration, loss of productivity from time off work and early death carry an immense cost to society, let alone to afflicted individuals. For the first time in living history, adults may outlive their children as a consequence of the programming to early death caused by obesity. Indeed, Alan Johnson, the current Secretary of State for Health, is reported to have said* that the pandemic of childhood obesity is of a magnitude similar to the effects of global warming. If this is the case then is it not time to remove the management of childhood obesity from political party differences of opinion and for a cross-party consensus to be established?

The numbers of children admitted to hospital with acute alcohol intoxication has increased dramatically in the last few years. The proportion of young women aged 16 to 24 who drink more than the recommended weekly limit has gone up by half in recent years[44] and young adults are now being seen with increasing frequency to be suffering from alcoholic cirrhosis of the liver – previously unheard of in this age range. In Canada

* in news bulletins on 14 October 2007.

I have seen for myself the concern expressed over the emergence of fetal alcohol spectrum disorder. There it is argued that exposure to alcohol in fetal life is not only the most important cause of poor behaviour and learning difficulties in schools but also the most important cause of violent crime in young people. This is due to irreversible damage to specific neural pathways during early development. Serious efforts are being taken to educate even very young children on the avoidance of alcohol during pregnancy, and a new academic department has been established in Calgary to focus on research into the condition. In the UK, by contrast, there is almost a state of denial over the existence let alone the importance of this condition. Why is this so? In the midst of an epidemic of binge drinking coupled with relentless promotion of alcohol to young people, is this not another example of the betrayal of our young people by society and the advertisers within it?

Against all the hard evidence on the harm caused by advertising, why is there not tighter regulation of the food and drink industry to protect the health of children from the relentless barrage of unhealthy products? The man from Mars would be incredulous to see our collective complacency. He might well cry in disbelief "Why, O Earthlings, are you allowing the shaping of childhood and the destruction of healthy longevity by the commercialisation of childhood, by faceless agencies whose only motive is profit?" Why indeed?

The recent debate in the UK over the curtailment of advertising to children on television is symptomatic of the enormity of the mountain still to climb. The commercial world argues for self-regulation, yet where is the evidence that anything other than cosmetic tinkering has produced any real change to date? Why did government fail to follow the example of courageous 19th century politicians to put the best interests of children first in banning the advertising to children below the age of 12 years, as has been done in Sweden? By condemning anti-social behaviour in youths from drunkenness and yet extending the licensing hours, and allowing alcohol to be cheaper now than at any time in recent history, we are exposing children and young people to mixed messages with respect to alcohol promotion. Why are the present laws against sale of alcohol to underage children not more rigorously enforced? It is already clear to me, and perhaps also to millions of parents and grandparents whose voices are not being heard, that the net effect of this commercial process is to rob children of the thing we should cherish the most – childhood itself. Yet where is the outrage? I argue that we must have more informed public debate about these issues, coupled with much better education for children and young people about the nature of advertising, and the toolkits for them to recognise the way they are being targeted and exploited. Above all we need serious government action and cross-political party support!

Demons and angels: fostering a climate of fear

There is something very peculiar about English society's ambivalence to children and young people. This is evident in a number of ways. For example, children are either portrayed as utterly innocent creatures who must be protected from the world at all costs, or they are feral predators who must be kept behind bars for the sake of decent society. Somewhere between these two polarities lies the truth. But we are rarely able to see that fact because the public's attention is remorselessly being directed to one extreme or the other.

In 1993 a toddler called Jamie Bulger was abducted and murdered in Merseyside. At first it was assumed by everyone that his abductors must be adults. Then the police released images from a shopping centre surveillance camera.[45] Captured on that grainy, flickering film were two shadowy figures leading a smaller figure away with them. His hand was placed trustingly in one of theirs. The abductors were not even teenagers; they were ten years old. The disturbing national outpouring (fuelled by extensive media coverage) following this murder lent credence to the view that many in our society still regard some children as being born evil. Continuing echoes from the 18th century! Within days of the release of this video footage, sales of toddler reins rose sharply indicating increasing parental anxiety regarding abduction. But again we must pause and ask ourselves, what is the reality of the risk of such crimes being committed?

Recorded killings by children in Britain can be traced as far back as 1748, and the last notorious child-killer before Robert Thompson and Jon Venables was Mary Bell. That was in 1968. And though a dozen other cases of homicide by children were recorded over the next quarter-century, the pattern had suggested that it is a crime that happens comparatively rarely and not that we have bred a new generation of child-monsters. Sadly, this view may need to be challenged in the light of recent events in which young men have been murdered by knives and guns as a result of an explosion of gang culture in our deprived inner-cities.

It is worth quoting at length here from the poet and journalist, Blake Morrison, who attended the full court hearings and who has written extensively on the Bulger case. What he says is instructive.

The Bulger case was iconic. But in hindsight, its lesson is almost the opposite of what it was taken to be at the time – not that children had grown big and dangerous, but that adult society had lost sight of their smallness and vulnerability. The 38 witnesses who claimed to see two boys kicking and beating a smaller boy but who didn't intervene; the failure of teachers and others to halt Robert Thompson's extraordinary level of truanting or notice Jon Venables' sense of neglect;

the barbarism of a legal system which demanded that 10-year-olds be tried as adults in a public courtroom: all these point to a failure to protect children, or act in their interests. Amid the hysteria in 1993, Thompson and Venables lost the right to be seen as children, or even as human. The kids who had killed the kid had to be killed, or at any rate locked up for life. The word used about them stopped all arguments. They were evil.[46]

Contrast the management in England of these two vulnerable children with how similar events were handled in Norway, where similar children were treated as vulnerable children first and foremost and were not subjected to adult-centric criminal proceedings.

It has been argued that the Bulger case was a tipping point in the media transformation of children from victims to villains.[47] Looking back at this tragic case several years later, it seems that the lessons Morrison is talking about have not yet been properly learned. Children and young people are not demons. They are not evil. They are, however, often troubled and – dare we say it – in need of a little more understanding and a lot less condemnation. The demonisation of children extends to the adolescent age group in particular. Figure 5 shows a selection of newspaper headlines.

Figure 5. Newspaper headlines from 8 April 2002

The media portrayal of adolescents seems to be almost entirely in a negative stereotype. Evidence published by Young People Now in 2004 showed that 71% of press stories are negative, but only 8% quoted young people's views. Young people were referred to as *thugs, yobs, evil, lout, monsters, brutes, scum, menace, feral, heartless, sick, menacing, inhuman*. The 'hoody' article of clothing has become a synonym for adolescent misbehaviour, reflecting an increasing intolerance by adults of the image of young people today. I argue that the demonisation of children has become a major issue for our society. It affects the public's support for the cause of adolescence and is driving political pressure and direction of policy to ever more punishment and control of children and young people. Of particular worry, it causes anger, alienation and frustration in young people themselves. What are we going to do to get mature debate and redress the balance? When will we start celebrating the contributions that children and young people make to society? It is worth remembering that ten times more young people volunteer to work in their communities than cause trouble, but when is this ever recognised, let alone celebrated?

In 2001 England was in the grip of another of its frequent anxiety attacks about the safety of children. It followed the abduction and the subsequent murder of ten-year-olds Jessica Chapman and Holly Wells from Soham, Cambridgeshire. There were many aspects of this case that made us recoil in disbelief and gave us pause for reflection. We all recognised that the girls' parents had taken every sensible precaution. They had insisted that they were to stay together; that they were not to go with strangers; that they were to carry a mobile phone; that they were to travel only a short distance; and they were given a time to be home. And yet they were still kidnapped and killed. The tabloid media responded, as it so often does, with eye-catching headlines suggesting that 'no child is safe'. And yet, as the official figures show, of the 490 abductions which occurred that year, the majority were taken by family members.[48] Strangers, in the majority of cases, are far less of a threat to children than either their parents or family and friends.*

There is also evidence of double standards when children are victims. An outpouring of national grief followed the murder of the two children in Soham. Large floral bouquets were laid in the churchyard and at the cathedral where a service was held. Yet there was no cathedral service for Victoria Climbié, a child who was murdered after dreadful

* After the Soham tragedy, the government established an inquiry under the chairmanship of Sir Michael Bichard to find out how the girls' murderer, Ian Huntley, was able to slip through the police and schools' vetting procedures, despite being involved in eight earlier sexual offence allegations.[49] Sir Michael, a former civil servant, made more than 30 recommendations, including the setting up of a national database and registration scheme.

torture at the hands of her malevolent carers? (See Chapter 4.) She was a black child from a deprived population. Does this mean our society has a double standard in how it looks after, regards and wishes to protect its children?

"Two-thirds of children have never been to a shop or a park by themselves."

There can be little doubt that the fear of child abduction is driving the curtailment of children's freedom. Rosemary Bennet[50] reminds us that in 1970 young children played within a radius of 840 metres from their homes; in 1997 it had shrunk to 280m, and in 2007 to the child's back garden only. In 1970, 80% of children walked to school; in 2007 the figure was 9%, and two-thirds of children had never been to a shop or a park by themselves.

A changing society

Even the most affluent of children in England today live in a confused and confusing society. For many adults the once-familiar aspects of our social and cultural landscape have all but disappeared in a nostalgic, rose-tinted glow. Today's Britain, by contrast, is a richly diverse, vibrant, multicultural and multiethnic country, and this is a cause for celebration. We are a more open, tolerant and mobile society than we have ever been. Class distinctions matter less and less. Women are now a central part of the workforce. While we should all celebrate this diversity and mobility, and the richness that it brings to life in modern Britain, we must not be blind to the implications it has for children and young people. Read Bernard Hare's graphic portrayal of life for children in one of Leeds' roughest estates in his book *Urban Grimshaw and the Shed Crew*[51] or see *Kidulthood*[52] a searing depiction of life for young people in a part of London that stands cheek-by-jowl to one of the capital's most excusive and expensive localities. Life for many children and young people caught between the demands of a conservative 'home' tradition, culture and faith, and the lure of the modern, secular, consumer society, can be a source of personal trauma and impossible choice. In some cities, true multiculturalism remains more of an aspiration than a harmonious reality. In place of integration and diversity, ethnic divisions in some of our cities have hardened into mutually suspicious ghettos.[53]

Mobility and the changing nature of work have also had a profound impact on the nature of family life. The conventional 'nuclear' family unit is now the exception rather than the rule as divorce, single parenthood, teenage pregnancy, and various forms of co-habitation become the norm. The pillars of the old manufacturing economy have been rocked to their very foundations. Once staple industries like coal, steel and shipbuilding have

declined dramatically while the service sector, with its clean jobs and opportunities for women, is in the ascendant. Both these trends present a fundamental challenge to the old assumptions about male breadwinners and the place of the father in family structures.[54] For many adults, the world has been turned upside down. For them the breaking of old customs and habits, the changing nature of work, and the questioning of familiar ways of thinking, is as disturbing a social turbulence as anything that has gone before.

The consequences of these pressures for our children and young people

At the start of this millennium a series of reports painted a bleak picture of life for our young people growing up in England today. They found that many of them drank too much, smoked too much, felt under massive work pressures and didn't really like each other. The World Health Organisation (WHO) survey on Health Behaviour in School-aged Children (HBSC)[55] is carried every four years and is based on interviews with 11-, 13- and 15-year-olds from the United States, Canada and nearly all the Eastern and Western European countries. It is the largest international study of adolescent attitudes and provides an intriguing and worrying snapshot into the lives of British teenagers compared with their peers across the world.

The findings were based on a study of more than 150,000 young people in 35 countries. In an unflattering comparison, it found that the physical and mental health of children in the UK was more like that of those living in poverty-stricken former communist nations rather than our more affluent Western European neighbours. Teenagers, in England in particular, but also their counterparts in Scotland and Wales, were shown to have some of the highest rates of drinking, smoking, drug use and underage sex and the lowest levels of life satisfaction, fruit consumption and feelings of physical well-being. It is now common knowledge that England is in the grip of an obesity epidemic. Nearly one in five 15-year-olds are overweight or obese. Linked to this epidemic are a range of psychological problems such as depression and anorexia, which have been shown to affect a significant number of adolescents. English 13-year-olds, for instance, were the least likely in the world to believe their peers were 'kind and helpful'. Only Russian 11-year-olds and Czech 15-year-olds held a lower opinion of their own generation than the same age groups in England. A third of English, Scottish and Welsh girls rated their health as no better than fair or poor, with only their peers in Ukraine, Lithuania and Latvia report feeling worse off. By comparison, less than one in five girls in Spain, Italy and Switzerland felt the same way.

When the children were asked about quality of life issues, England ranked at the lower end of the league table, alongside former eastern bloc countries. Dutch, Swedish and Greek young people, by comparison, topped the table and were the happiest. It is in the area of drinking and drunkenness, however, that English and Welsh youngsters top the score sheet. They got drunk more often and at a younger age than children from most other countries. While they had below average hours of homework, with only a quarter of 15-year-olds spending more than three hours a day on after-school assignments, they felt under greater stress. Six out of ten boys and seven out of ten girls aged 15 in England said they felt pressured by schoolwork, with only their Lithuanian and Welsh peers reporting greater stress.

Studies like this only go to confirm the fact that we are failing to tackle the serious and growing public health problems that are affecting our young people – a failure that can only lead to a destructive, self-perpetuating cycle of ill-health and social malaise. Indeed, we now have a situation where many young teenagers are simply replicating what they see the next age group up from them doing – getting legless, binge drinking and boozing regularly. If nothing else, this report is a salutary reminder to policy-makers that – as the WHO's regional director Marc Danzon says: "Looking after the health of young people is of vital importance." These serious conclusions have been echoed in other more recent reports, including that from UNICEF[56] on children's well-being in the 21 richest countries in the world. The report is a comprehensive assessment of the well-being of children and young people, with 40 separate indicators in six groups:

- material well-being;
- health and safety;
- education;
- peer and family relationships;
- behaviours and risks;
- subjective well-being.

This research drew on the findings from the WHO report and placed the UK at the bottom of the ratings for five out of six of these categories. Perhaps of greatest concern from this report was the comparative subjective data on well-being. UK children were more likely to feel left out, awkward and lonely than nearly all their peers in developed countries. Only 43% of children rated their peers as 'kind and helpful'. In addition, children in the UK rated badly in risk-taking behaviour, and more than a fifth rated their physical and mental health as poor.

The flurry of media coverage following the publication of the report revealed that, on balance, most commentators agreed that there was indeed a malaise at the heart of our society. It is important that this has been recognised and acknowledging this is a welcome development. But how many more reports are needed before we have the courage to stand up and say this is not good enough? Where is the outrage in society over the fact that we have been and are still failing so many of our children and young people?

There can be no escape from the unpalatable fact that childhood as we have known it is fast-changing, and that these changes are imposing serious pressures on the health and well-being of many of our young citizens. Clearly we need to strike a balance between taking appropriate measures to prevent children being exposed to unnecessary risk and the creation of a bureaucratic, regulatory framework which locks us into a mental prison policed by anxiety and fear. What do we need to do as a society to get that balance right? The stakes are high – if we don't get it right, the toll on the health and well-being of our children and young people will be increasingly high.

Key Learning Points

- Childhood as we have known it is fast-changing.
- There is a danger that the net effect of commercial pressures will be to rob children of the thing we should cherish the most – childhood itself.
- The demonisation of children has become a major issue for our society.
- We are failing to tackle serious and growing public health problems that are affecting our young people – a failure that can only lead to a destructive, self-perpetuating cycle of ill-health and social malaise.
- Internationally we are at the bottom of the league table of developed countries for the well-being of our children.

Key Action Points

- We all have a role to play in challenging and confronting inappropriate marketing to children.
- Much greater involvement of adults in the lives of children and young people is needed.
- We should celebrate the achievements and successes of children and young people.
- We should encourage the media to promote positive images of children and childhood.
- We should understand the important changes taking place in the public health of our children and young people.

4. DO CHILDREN AND YOUNG PEOPLE GET A 'GOOD DEAL' FROM THE SERVICES PROVIDED FOR THEIR CARE?

In the little world in which children have their existence…there is nothing so finely perceived and so finely felt as injustice.

Charles Dickens, *Great Expectations* (1861)

Children have a right to good quality health care, to clean water, nutritious food, and a clean environment, so that they will stay healthy.

UNCRC: Article 24

All organisations concerned with children should work towards what is best for each child.

UNCRC: Article 3

Despite the gloom and despondency that might be created by the research reports alluded to in the previous chapter on the overall well-being of children and young people, countless English children and young people are loved by their families, are working hard to achieve their educational attainments and contribute to society, and have opportunities undreamed of by their grandparents. Nonetheless, we cannot evade the fact that significant numbers of children and young people are living in poverty, experiencing social exclusion and are not having their needs met by current services. This chapter examines the experiences and life chances for many children and young people as they grow up in England in the 21st century. Have they really 'never had it so good' as the older generation repeatedly tell them, or do we as a community choose to ignore the plight of a significant proportion of our children and young people?

The continuing legacy of poverty

Box 2: The health consequences of being born into poverty

It is generally accepted that children born into poverty are:

- more likely to born premature or underweight;
- less likely to be breast-fed;
- more likely to be exposed to tobacco smoke;
- more likely to die in the first year of their life than their better-off neighbours;
- much more likely to die in childhood of an accident
- twice as likely to die by middle age than women and men from advantaged backgrounds.

Few would disagree that children in England today are hugely better-off than their Victorian counterparts. However, the inequalities of wealth and health which were so conspicuous in the 19th century have not been entirely eradicated. Indeed, in many ways these inequalities have become more stubborn and difficult to reach. The sense of moral outrage which drove the social reformers of the Victorian era to overcome the obvious horrors in their midst, has been replaced today by something approaching a smug complacency – a feeling that the demons of want, ignorance, hunger and disease have been slain. Martin Narey, the Chief Executive of Barnardo's, was outspoken in his lecture at the 2007 annual meeting of his organisation on the loss of a moral compass in contemporary society for the care of its most vulnerable children and young people, and the ongoing failure to eradicate child poverty.

Large parts of England are still scarred by the ill-effects of inequalities. So much so that there is now an emerging 'underclass' of children whose members have never experienced the security and stability of family life, with parents in work and earning a decent income. It should come as no surprise to learn that substantial numbers of these children are afflicted by illness and disease, and often find themselves sucked into a world of drug abuse, petty criminality, violence and early imprisonment – just as in Dickens' day. The extent of the health divide in Britain was exposed when the former chief medical officer, Sir Donald Acheson, published his seminal report into health inequalities in the UK in November 1998.[57] His report made grim but compelling reading. And, although much credible effort and work has been done by government since Sir Donald's report was published, there is still much more to do. It is also noteworthy that the End Child Poverty

coalition of voluntary organisations has been a refreshing example of advocacy for disadvantaged children, reminiscent of the campaigns of the 18th century social reformers. Acheson's Inquiry established a clear, empirical link between poverty and ill-health (see also Box 2). In addition, it highlighted that children are the ones most affected by these inequalities. In Britain in the mid-1990s, though a quarter of people were living below the poverty level, the figure for children was one in three.

We have one of the largest economies in the world and yet we are plagued by some of the highest levels of poverty of any modern, advanced society, as evidenced by the recent UNICEF report[58] into the well-being of young people in the 21 richest countries of the world. Child poverty in Britain more than doubled during the 1980s. It continued to rise, if a little more slowly, in the 1990s. It is only since 1998, through serious effort by the New Labour government that this situation has begun to improve – but even now, that picture is patchy.[59] The Acheson Inquiry identified that many people on low incomes did not have enough money to buy the items and services necessary for good health, meaning that money for food was often used to meet emergencies. Mothers were sometimes forced to go without food as a result, and many pregnant women on Income Support had inadequate diets, especially single women under 25 years of age.

While the majority of people ate balanced diets across the country there were 'food deserts.' These were in inner-city estates where access to affordable fresh food was difficult because of poor public transport links. The Inquiry also noted that babies whose fathers were in lower social groups were on average 130 grams lighter than those with fathers in the top social groups. Low-weight babies are more likely to suffer from coronary heart disease, high blood pressure and related illnesses in later life. Infant mortality is an important proxy for social disadvantage, and England has one of the highest rates in the developed world. The Inquiry found that poor women were more likely to be obese than more wealthy women, with 25% of women in lower social classes being diagnosed as obese compared to 14% of professional women. The children of mothers who are overweight are much more likely to suffer coronary heart disease as adults, and are also more likely to be obese.

There are key risk factors occurring during childhood and adolescence which research suggests increase the likelihood that disadvantaged children will fare worse in later life.

These are:

- poor early development
- poor school attendance
- being 'looked after' by a local authority

- contact with the police
- drug misuse
- teenage parenthood
- non-participation in education, employment and training between the ages of 16 and 18.

Many of these factors are linked – for example, young women in care have repeatedly been shown to be at higher risk of teenage pregnancy and teenage parents are more likely to drop out of education early. The wide range of these 'risk factors' shows the scale of the challenge that policy-makers face. And, in some cases, the ability of government to influence key risk factors – such as the growth of poor lone-parent families – may be limited.

In England in 2003 there were around 40,000 conceptions to girls under 18 years of age. Of these nearly 60% resulted in live births.[60] Rates in the UK are higher than in any other country in Western Europe, although there is some very recent evidence that the rate may have fallen somewhat. Nonetheless, rates of teenage pregnancy are highest in the poorest areas of the country and among the most vulnerable young people such as those in care or those who have been excluded from school. This matters for the health of our children. Why? The death rate for the babies of teenage mothers is 60% higher than for babies born to older mothers.[61]

Of considerable concern is the existence of 'hidden harm', with an estimated 800,000 children living in households with an alcohol abusing carer, and a further 300,000 in households experiencing substance misuse. Children of some parents with some mental health disorders may compound the harm, coupled with the fact that many children themselves act as carers of sick siblings and parents. These children and young people are severely disadvantaged by the stress of the burdens placed on their young shoulders, this being compounded by bullying for being a carer and the failure of some schools to know of the social predicaments of their students.

Services to support parents

It is clear that against a backdrop of change – both in terms of changes in family structures and changes in society (as outlined in Chapter 3) – good parenting becomes increasingly important. Parenting is the most important and yet, at times, the most difficult job in the world. Many people are catapulted into this position with little preparation or training. While the majority of parents care for and love their children, a significant minority are failing their children. The consequences of poor parenting are felt

for years to come not only by the children themselves but also by our wider society. Surely investing in parents, parenting and families must be the bedrock for an effective political policy agenda? We need to re-examine the evidence from John Bowlby on the crucial importance of the attachment of the baby to its mother and build it into government policy.

"Surely investing in parents, parenting and families must be the bedrock of an effective policy agenda?"

Parents, carers and society as a whole have a responsibility to ensure that we do all we can for children so that they are able to:

- be healthy;
- stay safe;
- enjoy and achieve;
- make a positive contribution;
- secure economic well-being.

These are the five key outcomes that children and young people believe to be vital to their well-being, as identified in the Green Paper *Every Child Matters*.[62]

To achieve these positive outcomes we need to ensure that children are cherished and nurtured. As mentioned previously, the nurture of children demands love and care, physical contact, warmth and comfort, security and stability, good nutrition, safeguarding and protection from harm, play, exploration, encouragement, managed risk, moral boundaries, expectations and purpose in life coupled with effective education. Parents and carers must be supported by accessible, appropriate, evidence-based and needs-led services to ensure that children are nurtured and able to reach their full potential. Although society has conflicting views about the government's role in influencing parenting practice, it seems to me essential that we focus attention on those children who do not experience adequate parenting. A health-led parenting support project is currently underway as part of the Every Child Matters programme. It aims to target young vulnerable mothers during pregnancy and for the first two years of their children's lives. This is an important step in our attempts to reduce social exclusion, and robust research analysis is needed to prove or disprove its value.

Are we meeting the health needs of our children and young people?

We have seen in Chapter 2 that many children and young people have significant health needs. Clearly services are required to prevent the onset and the escalation of problems through the delivery of effective interventions. But all too frequently these services, which should be designed to meet the particular needs of children and young people, are not available. Three areas of special importance are highlighted below.

Services for young people

Of particular concern to me is the provision of health services to our young people. On almost any indicator – obesity, suicide rates, emotional dysfunction, sexual health, mental illness – young people in England today are being let down by the adults who are charged with their care (see Box 3). It is noteworthy that the UK, in contrast to other countries such as the USA and Australia, has not developed the medical subspecialty of adolescent health – why?

A study undertaken by the British Medical Association (BMA) in 2003[63] found that the problems experienced by young people are being fuelled by an increasingly impoverished diet, insufficient exercise, excessive alcohol and drug consumption, and tobacco smoking. Less than 15% of girls aged 13 to 15 years of age eat the recommended amount of fruit and vegetables. Almost a quarter of 15- and 16-year-olds will have smoked cigarettes in the past week. A fifth will have taken an illegal drug in the last month. Perhaps one of the most worrying findings of the BMA study is that the sexual health of adolescents is deteriorating. A further report from the Health Promotion Agency in 2006 echoed these concerns.[64] It found that young men and women aged 16 to 24 were a crucial population for targeted sexual health promotion as rates of HIV, chlamydia, syphilis, genital herpes and genital warts diagnosis have continued to rise in this group. The English National Chlamydia Screening Programme found that one in ten young people tested positive for chlamydia, which can lead to infertility and difficulties during pregnancy. Between 2001 and 2005 the diagnosis of chlamydia has increased by 81% in young men aged 16 to 19 and by 47% in young women of the same age.

It comes as no surprise to learn that following the publication of its report, the BMA called for a comprehensive plan to tackle the root causes of deteriorating teenage health. Vivienne Nathanson, the BMA's head of science and ethics, said at the time: "Services targeting the needs of adolescents are almost non-existent. We must invest properly in sexual health and provide services that young people feel comfortable using if we are to

reduce the burgeoning levels of sexually transmitted diseases."[65] Dr Nathanson also said that the behaviour of teenagers poses "an extraordinary threat to an entire generation". She added: "It is also a threat to all of us – how can the NHS be funded to deal with that kind of health crisis? … We need to ensure that young people do not fall in the gap between services for children and those designed for adults." Sadly, the gaps are still there and young people are still falling through them.

Box 3. Teenage health behaviours in England[66]

- 20% of young people aged 13 to 16 are overweight.
- 25% of 15- and 16-year-olds smoke.
- One in five adolescents may have had psychological problems.
- 10% of teenagers between 16 and 19 may be infected with chlamydia.
- 3% of women conceive under the age of 20.
- 15% or fewer girls aged 13 to 15 eat recommended amounts of fruit and vegetables.
- 11% of those between 11 and 15 in England have used drugs at least once in the last year.
- 10.5 units of alcohol are consumed each week on average by those aged 11 to 15 in England who drink.
- 4% of young people aged 11 to 15 say they have used class A drugs in the last year.
- 13 of every 100,000 people aged 15 to 19 commit suicide each year.
- 26% of 16- to 19-year-old women first had sexual intercourse before the age of 16, compared with 30% of men of the same age.

There remains an urgent need to re-structure some services for young people. For example, a recent report from the Office of the Children's Commissioner and the mental health charity YoungMinds that reviewed inpatient services for young people with mental health problems highlighted the totally unacceptable use of adult inpatient wards for the care of young people, some as young as 12 years old. The report, *Pushed into the Shadows*,[67] describes the shocking reality of the experiences of these young people in age-inappropriate wards, through being exposed to physical and sexual abuse, drug misuse and being denied their entitlements of education and contact with their families. Why are the managers responsible for these services not thoroughly ashamed of the way in which these vulnerable youngsters have been treated?

The transition from adolescence to adulthood generates formidable obstacles for young people with physical and learning disabilities, chronic medical conditions and mental health problems as they fall between the silos of paediatric and adult health services. This is often coupled with a failure to provide effective education and social care support. Many of these unnecessary difficulties reflect cultural attitudes in our professions as well as a failure to see the world through the young person's eyes by asking them what they need. There is now an irrefutable case for an urgent policy and investment focus on young people's health, and improvement in the design of services to meet their needs. Why is this important? It is important because, by the time children reach adolescence, they are reaching a stage where the behaviour patterns they learn can become set for life. It is also important because adolescents, frequently so cruelly misrepresented in the media, are the most neglected group in health service thinking. That things are starting to change will be highlighted in Chapter 6.

Disabled children and young people

A further example of the ambivalence of our society to children and young people is that until recently disabled children and young people were almost invisible when it came to policy and resource allocation. Who cares about the disabled children in our society?

In 2002 it was estimated that there were approximately 770,000 disabled children in the UK.[68] One in 20 children under 16 years old is disabled. Between 1992 and 2002 there has been a 62% increase in the number of children with disability, due in part to the increased ability of paediatric medicine to prolong the survival of extremely prematurely born infants, and save the lives of children suffering diseases that hitherto would have led to early death. In addition, we have improved techniques to diagnose and recognise certain forms of disability. As more than 98% of disabled children are cared for at home, families with disabled children are particularly susceptible to poverty as low income is compounded by high costs. Estimates of the number of households with a disabled child who live in poverty range from 29%[69] to 55%.[70] Influential reports including *Still Missing Out?*,[71] which show that, despite better disability benefits, many of Britain's disabled children and young people are still "entrenched in poverty". Children from lower-income households are more likely to report longstanding physical and mental health problems.[72, 73]

Finding out what life is like for these families is not easy. But some have tried. Gabrielle Preston, for instance, has written a moving study which provides both the empirical evidence of the scale of the problem, while giving voice to the parents, children and young people themselves. In her report *Helter Skelter: Families, Disabled Children and the Benefit*

System,[74] she reveals just how difficult it can be to have a child with 'special needs'. The author quotes one mother who said: "Everybody kept telling me this is a child with special needs…but nobody actually told me that I was entitled to help – my health visitor, my GP, my social worker – I'm on good terms with all of them but they didn't tell me." The relentless stress of caring for a child with special needs or disabilities without adequate support imposes a huge strain on relationships. Many of the women, and it is invariably women caring for disabled children, said that they have always felt like lone parents, largely because their husbands have found it difficult to cope with the children.

It is interesting that the government is again emphasising that work is the primary route out of poverty; in spite of government initiatives to draw mothers – specifically lone parents – into paid employment, combining working (or studying) and caring for a sick or disabled child remains extremely difficult.[75] However, Preston cites a survey undertaken by the Council for Disabled Children which shows that 85% would like to work at least part-time. The government is also committed to social inclusion and yet schools are often reluctant to admit and quick to exclude children with severe problems. A recent Audit Commission report[76] that investigated half of all local education authorities in England and Wales found that children with statements were three times more likely to be permanently excluded from school than other children. The most troubling aspect of these figures is that no-one knows what happens to the children that are excluded – nor do we have any reliable, quantitative information about the number, type, severity and combination of their difficulties, or the extent of social exclusion among their families. In our target-obsessed age, where is the place for children with special needs in the national performance tables? Like so many other young people with disabilities, or adolescents with mental health problems, they are all but invisible.

If we are to judge policy on how it provides for the most vulnerable, then the treatment of children with special needs is nothing short of appalling and shameful. Read *Henrietta's Dream*[77] by a mother, Henrietta Spink, who describes her family's worst possible journey in trying to gain access to the services to support her two profoundly disabled sons. As the authors of *Disabled Children in Britain*,[78] the first detailed analysis of disability in Britain since 1984, conclude: "Disabled children are one of the most vulnerable groups in society yet we have less statistical information about them than any other group, including the homeless. …If the government's rhetoric about the importance of combating poverty and social exclusion is to be realised, then this scandalous lack of basic information will have to be made good."

There is now some light in the tunnel for children with disability, in that the campaign Every Disabled Child Matters is now having considerable impact with parliamentarians

and policy-makers. I find this campaign especially important since it shows for the first time for many years how the science of effective advocacy can deliver a real change in government thinking. Thus, the recent parliamentary review of disability has given powerful support through a series of hard-hitting recommendations for children with a disability to be given much greater policy focus and resource allocation. It may well be that the forthcoming Comprehensive Spending Review and its Public Service Agreement indicators will at last give a long-term commitment to improving the lot of children and families with disability. But why has it taken so long for anyone in power to grasp this particular nettle? It is worth remembering that any family can produce a child with a disability. The children themselves have certainly not asked to be born with a disability. Where is society's compassion for their plight?

Child and adolescent mental health

The 2004 survey of children's mental health[79] confirmed that one in ten children have a clinically recognisable mental disorder. The prevalence of mental disorders was greatest among certain groups of children such as those:

- in lone-parent (16%) compared with two-parent (8%) families;
- in reconstituted families (14%) compared with families containing no step-children (9%);
- whose interviewed parent had no educational qualifications (17%) compared with those with a degree or equivalent qualification (4%);
- in families with neither parent working (20%) compared with those in which both parents worked (8%);
- in families with a gross income of less than £100 per week (16%) compared with those with an income of £600 or more (5%);
- in households in which someone was receiving disability benefit (24%) compared to those that received no disability benefit (8%).

Clearly those children living in disadvantaged circumstances were more prone to mental health problems.

Four per cent of children and young people were found to have an emotional disorder. Among the young people aged between 11 and 16, those with an emotional disorder were much more likely to smoke, drink and use drugs than other young people. Among this group 28% of young people said they had tried to kill or harm themselves. Six per cent of children and young people had a conduct disorder. Fifty-nine per cent of children

with a conduct disorder were rated as being behind with their schooling and about half were considered by their teachers to have special educational needs. Among young people between 11 and 16 years of age who had conduct disorder, 21% said they had tried to kill or harm themselves.

The problems facing adolescents with mental health problems are rarely addressed in the media, but the young people themselves are regularly caricatured as anti-social creatures; what, in the tabloid press and elsewhere, are disparagingly called 'yobs'. When we examine the backgrounds of young people between 15 and 20 years of age who are in prison, the percentage who are estimated to have diagnosable mental health problems, substance misuse problems or both jumps to a staggering 90%.[80] The government's guidelines on dealing with anti-social behaviour identify the need for proper assessment, but a recent study by the British Institute for Brain Injured Children found that 35% of under-17-year-olds who had been given an Anti-Social Behaviour Order (ASBO) had a diagnosed mental disorder or an accepted learning difficulty.[81] Where was the help for these individuals? These findings may actually be rather conservative, since many learning and communication problems in young people may go undiagnosed for a long period of time.

The advocates of the 'Respect' agenda could do worse than look at the Mental Health Foundation's research which shows that the mental health needs of young offenders are "clearly not being met by existing services within England and probably across the UK".[82] The Foundation also argues that "expertise and resources are lacking within custody in particular, but also in other types of provision across all the agencies involved (social services, youth justice and probation)". It comes as no surprise that when young offenders fail to get the services they need, they go on to re-offend and their mental health problems worsen, even to the point of suicide. Why do we have so many young offenders, and who cares about their emotional well-being, psychiatric health and educational needs, particularly when imprisoned?

There is incontrovertible evidence that many of today's most troubled children and young people have not been getting a 'good deal' from the services set up to look after their best interests. What is being done and what more should be done are the subjects of the following chapter.

Key Learning Points

- Increasing numbers of children find themselves in a world of drug abuse, petty criminality, violence and early imprisonment.
- We have some of the highest levels of poverty of any modern, advanced society.
- Investing in parents, parenting and families must be the bedrock for an effective political policy agenda.
- On almost any indicator, including obesity, suicide rates, emotional dysfunction and mental illness, young people in England today are being let down by the adults who are charged with their care.
- Disabled children are one of the most vulnerable groups in society yet we have poor statistical information about them.
- 35% of under-17-year-olds given an Anti-Social Behaviour Order (ASBO) have a diagnosed mental disorder or an accepted learning difficulty.

Key Action Points

- There must be ongoing political pressure to address poverty.
- We need to increase the awareness of the public of the impact of poverty on the health and well-being of children and young people.
- Adolescent care must be recognised as a distinct discipline and given the resources and leadership to develop services.
- We need to increase the awareness of the public of the impact of disability and child mental health on the health and well-being of children and young people.

5. WHAT HAVE BEEN THE DRIVERS OF CHANGE?

Healthcare services for children are still generally fragmented and uncoordinated. Children have been treated as small adults who simply need smaller beds and smaller portions of food.

Professor Sir Ian Kennedy, *Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984–1995* (2001)

Governments should ensure that children are properly cared for, and protect them from violence, abuse and neglect by their parents, or anyone else that looks after them.

UNCRC: Article 19

Children have the right to good quality health care.

UNCRC: Article 24

Children who have been neglected or abused should receive special help to restore their self-respect.

UNCRC: Article 39

The United Nations Convention of the Rights of the Child

Following the First World War, the indomitable reformer Eglantine Jebb and the emerging Save the Children organisation first articulated the need for children to have rights. This was reinforced by the inspiration of Janusz Korchak in Poland who was deported to his death in Treblinka holding the hands of his orphan children. In 1991 the UK government ratified the UN Convention on the Rights of the Child (UNCRC) (1989).[83] This

convention with its 42 key Articles (see Appendix) protects children's rights by setting standards for protection, provision of care, and the participation of children in decisions that affect them. By agreeing to undertake the obligations of the Convention the government is committed to protecting and ensuring children's rights and has agreed to be held accountable before the international community for their implementation.

Despite this commitment, after its assessment in 2002 the UN Committee was highly critical of the failure of government to implement many of the UNCRC Articles. Especial criticism focused on the reservation on the application of the UNCRC to children seeking asylum, and the plight of children in the youth justice system. Regular reports from the Children's Rights Alliance for England[84] continue to document ongoing failures to address the implementation of the Articles. Furthermore, research has shown that only 23% of children and young people asked were aware of the fact that the UNCRC existed.[85] Of greater concern is anecdotal evidence that even professional staff who work with children are unfamiliar with the UNCRC Articles. The government has failed to "make the convention known to parents and children" (Article 42).

It is important to highlight that the UK government will be under the microscope of the UN Committee on the Rights of the Child again during 2008, and I anticipate that there will be commendation for much good progress since 2002, but coupled with ongoing criticism of the failure to embed the 42 Articles in government policy and practice. I find it sad to note, for example, that the UNCRC is scarcely mentioned in Every Child Matters. I argue that while this policy framework is to be applauded for focusing on improving outcomes, nonetheless the UNCRC is a moral compass for how children should be regarded by society. It is salutary to note how Sweden, one of the top countries for the well-being of children, has a government department whose sole function is to monitor the application of the UNCRC in every aspect of emerging parliamentary legislation and budget. Why cannot we have a similar body in England, to child-proof the rights of children in developing new parliamentary bills?

Irrefutable evidence that services have not been meeting the needs of England's children

Any illusion that we give priority to children and young people was shattered at the start of this millennium with the publication of two damning and cataclysmic reports into the care of some of our most vulnerable citizens – children with life-threatening conditions, and children who are the victims of abuse. I refer, of course, to the Kennedy[86] and Laming[87] reports. The repercussions of Professor Ian Kennedy's forensic inquiry into the care and management of children with serious heart conditions at Bristol Royal Infirmary

were felt far beyond the southwest of England. Likewise, the shock waves from Lord Laming's investigation into the tragic death of eight-year-old Victoria Climbié in London, reverberated in social services departments across the country. Between them, these two reports had and still have profound implications for the way we provide a wide spectrum of services for children and young people, and reading the reports should be mandatory in the training of young professionals in all the disciplines supporting children and young people. It is sad to see, several years now after their publication, how few professional staff engaged in children's services know of or have read these reports.

The Bristol Inquiry 2001

The terms of reference of Professor Kennedy's inquiry required him to consider the paediatric cardiac service provided at the Bristol Royal Infirmary from 1984 to 1995. The inquiry discovered that in the four years from 1991 to 1995 a substantial and statistically significant number of excess deaths, between 30 and 35, occurred in children under one year of age. The term 'excess deaths' is a statistical term which refers to the number of deaths observed over and above the number that would be expected if the unit had been typical of other paediatric cardiac units in England. So what went wrong?

Kennedy found that these 'excess' deaths took place in a unit where mortality at the time for children aged under one was probably double that for England as a whole, and even higher for neonates. Around a third of the children who underwent open-heart surgery at Bristol, he declared, received less than adequate care. But Kennedy was also clear there were no bad people in this story: everyone was doing their best. It was the system that let them down. What Kennedy identified was a flawed system of care with poor teamwork between professionals, too much power concentrated in too few hands, and surgeons lacking the insight to see that they were failing and that they should have stopped operating. Most importantly at Bristol – and, as we shall see, across the country – there was no system for auditing clinical outcomes. The hard facts that chronicled the story of their poor performance were available; but not in an accessible format. Professor Kennedy found that Bristol was awash with data from one source or another. What was lacking was information – some understanding of what the data meant.[88] But no-one was looking, no-one was collating, no-one was comparing the doctors' performance against an accepted and acceptable standard. As a consequence, no-one was telling the parents, who were consenting to what were high-risk operations. He describes a mindset of "professional hubris". The inquiry discovered that senior management at the hospital were close to an "old guard" of clinicians and would support them. There was a "club culture", with insiders and outsiders. The style of management had a punitive element, and the environment did not make openness and candour safe or acceptable. This, to

me, goes to the very root of the problem. We can change the structures and operating procedures, we can design hospitals and theatres with the child in mind, but nothing will fundamentally change in the NHS without a revolution in the way we think about children and young people and how we deliver services.

"Nothing will fundamentally change without a revolution in the way we think about children."

Kennedy extended the brief to look at the specific issues in Bristol to a nationwide examination on the standing and status of children's health services. His conclusions were indeed cataclysmic. His quick legal mind identified with forensic skill the key issue at the heart of the scandal, namely, he noted "what seems to be a difficulty on the part of policy-makers and health service managers to accept that the healthcare needs of children and young people are different to those of adults". He continued:

It seems so obvious that it hardly needs to be said: just as children differ from adults in terms of their physiological, psychological, intellectual and emotional development, so they differ in their healthcare needs.

They experience and see the world differently. Children are in a constant state of growth and development that creates particular needs and demands which are of a different order from those affecting adult patients.

Their relative physical and emotional immaturity, in comparison with adults, has implications for both the treatment which they receive and the physical environment in which they are cared for.

Children communicate their thoughts and feelings in a very different way from adults. Effective communication with children as patients (often through a combination of play, one-to-one interaction, and by communication with parents) is seen by professionals involved in paediatric healthcare as crucial to the child's physical and psychological well-being. Thus the ability of staff to care appropriately for children is crucial. Skills, understanding and knowledge are required which are different from those of staff who mostly care for adults.

Instead, Kennedy found a failure to recognise the need for the kind of holistic, child-centred approach to the care and treatment of children which had been advocated for the past 40 years. The report's conclusion was blunt: "The NHS is still failing to learn from the things that go wrong and has no system to put this right. This must change. Even today, it is not possible to say, categorically, that events similar to those which happened at Bristol could not happen again in the UK – indeed, are not happening at

this moment." Kennedy stated that he had written his report in a state of 'some anger' at the way seriously ill children had been cared for. Why was this? What angered Sir Ian, beyond the immediate failings he discovered in Bristol, was a sense that governments of all persuasions had been alerted to the needs of children down the decades – but that these warnings had always gone unheeded. In his concluding remarks he cites from the following reports:[89]

Greater attention needs to be paid to the emotional and mental needs of the child in hospital, against the background of changes in attitudes towards children, in the hospital's place in the community, and in medical and surgical practice. The authority and responsibility of parents, the individuality of the child and the importance of mitigating the effects of the break with home should all be more fully recognised.

Platt Report, 1959[90]

The special needs of children which arise from the fact that they are growing, developing persons should be reflected in the facilities that are provided for them and, perhaps more important, in the training of those who care for them. We want to see a service which is child-centred and we believe that this must be a service in which the professional staff are adequately trained and experienced in the special needs of children.

Court Report, 1976[91]

Children have special health care needs because they are physically and emotionally different from adults… . The root cause of hospitals failing to apply the principles is often a lack of attention of many clinicians, managers and other staff to these special needs and the needs of children's families.

Children First: A Study of Hospital Services, 1993[92]

At present health services for children do not always consider the specific need of children. Children's health services… are too often based on traditional custom and practice or indeed on professional self-interest. Children's health services must be needs led, not based on historical patterns or the self-interest of provider groups.

'Hospital Services for Children and Young People', Health Select Committee, 1997[93]

All of these had urged that the needs of children and their parents should become the central principle informing arrangements for children's healthcare services. But as Kennedy says: "Remarkably, some would say scandalously, despite the consistency of these recommendations over such a long period of time, there has been an equally consistent failure fully to implement these fundamental principles, a failure which continues to this day." Such was the political fallout from the Bristol inquiry that the government, and many of the professional bodies who were indirectly targeted by

Kennedy, were forced to take a critical look at what they were doing. A revolution was underway.

Increasing professional anxiety

At this time a consultation exercise was also underway in the Department of Health to draw up a new national plan for health – The NHS Plan. Although this Plan, together with increased funding for the NHS, was welcome, paediatricians were dismayed at the inadequate voice for children and adolescents in the modernisation action teams that were then taking forward the definition of the Plan. Sensing that the moment was right to make a move, a group of leading paediatricians published a joint paper in the *British Medical Journal*[94], pointing out that only one registered children's nurse and a health visitor had been appointed to be custodians of the interests of all children and young people in defining health policy in the taskforces being set up. The paper's authors asked the government a very simple but profound question – who is speaking for the needs of children and adolescents at the policy level? It had become increasingly clear to many senior health professionals working with children and young people that England's children were all but invisible to key policy- and decision-makers.

In England, despite the government's signature to the United Nations' Convention on the Rights of the Child, there had been no national or governmental body or person appointed to protect the rights of children, or to assess the impact on children of the policies emerging from individual ministries. Within the NHS, improving the health of children and adolescents was not defined as a key target. Children were mentioned only in passing in the reforms of funding for research and development, and, with some exceptions, improving child health had not been a high priority for local service delivery. In addition, few English health authorities had health purchasing commissioners dedicated exclusively to children. So who was fighting for the needs of children?

The paper's authors also found that children's needs were reflected in just 16% of health improvement plans, and that only one in ten health authorities had any specific policies on adolescent physical health. They added that there was "currently a dismantling in some districts of services that have been well integrated and commended in the House of Commons select committee's report on the state of children's health. Finally, specific services for children are still not available in 40% of the country."

It was argued in 2000 that if the benefits to children and adolescents in England from the current financial and policy reforms were to be realised, then several fundamental cultural and organisational changes were needed. These included:

- an explicit recognition that children have fundamental human rights for which protection is needed;
- an acknowledgment that children have special requirements for health and should not be regarded as small adults; and
- specific authority, delegated to individuals and bodies to be responsible for defining strategy for children and adolescents and for integrating care within the health service and between sectors.

To implement these changes would require the effective advocacy of the interests of children and young people at all levels from central government to local communities.

The Climbié Inquiry 2003

The view of children as invisible, voiceless and without representation was substantially reinforced by Lord Laming's damning report into the death of eight-year-old Victoria Climbié.[95] The former Chief Inspector of Social Services began his inquiry in April 2001 and published his 400-page report in January 2003.

Victoria Climbié was part of a large, loving family living in the Ivory Coast. Her parents had agreed she could come to Europe in order to be educated. This was not about giving Victoria away; it was about giving Victoria an opportunity. All they wanted, as any parent would, was for their daughter to have the best education. Instead, she suffered the worst cruelty. Victoria arrived in Britain with her great-aunt, Marie-Therese Kouao, in April 1999. Within a year she was dead, murdered by the people who had taken the principal responsibility for caring for her: Kouao and her boyfriend, Carl John Manning. Both are now serving life imprisonment. Manning told the trial that Kouao would strike Victoria daily with a shoe, a coat hanger and a wooden spoon. She would hit her toes with a hammer. Victoria's blood was found on Manning's football boots. He admitted hitting her with a bicycle chain. Victoria's final days in the depths of winter were spent living and sleeping in a bath in an unheated bathroom, in her own urine and faeces, bound hand and foot in a bin bag. Victoria died of hypothermia, after months of abuse, on 25 February 2000 at St Mary's Hospital, Paddington. She had 128 separate injuries to her body.

Lord Laming himself, speaking after the publication of his report, had this to say: "During this gruelling Inquiry our increasing familiarity with the suffering experienced by Victoria did not make it easier to endure. I will not dwell on it. … In [the space of] a few months this once lively, bright and energetic child had been reduced to a bruised, deformed and malnourished state in which her life ebbed away because of the total

collapse of her body systems." What is most tragic about this case, as Lord Laming goes on to say, is that at almost any point in her rapid journey into hell, the caring professions could have averted her death. "One of the most striking features of Victoria's case," Lord Laming says, "was the sheer number of occasions when the most minor and basic intervention on the part of the staff concerned could have made a material difference to the eventual outcome… . In some cases nothing more than a manager reading a file, or asking a straightforward question about whether standard practice had been followed, may have changed the course of these terrible events."

Children, as Professor Kennedy had said and now Lord Laming was confirming, were all but invisible. Like stealth aircraft, they seem to show up on no official radar screens. But how could this little girl be so invisible? Despite being known to a range of statutory services in the ten months between 26th April 1999 and 25th February 2000, no radar identified a serious problem. According to Lord Laming what transpired during this period can only be described as a "catalogue of administrative, managerial and professional failure by the services charged with her safety". Lord Laming concluded: "The dreadful reality is that although Victoria was in contact with all of the key services, at the end, little more was known of her needs than when she was first seen in Ealing some ten months earlier. None had any idea what a day in the life of Victoria was like."

Kennedy and Laming exposed serious systemic failings in the way we provided services and care for children and young people. In brief, what they found was:

- care is always subordinated to the demands of adults
- a lack of concern for vulnerable individuals
- an ignorance of rights which demand protection
- a quality of care which falls far short of what it should be
- a fragmentation of services and a lack of responsibility
- a lack of effective planning
- a failure to listen to patients and carers
- a lack of effective leadership.

Both these inquires found that the failings discovered in Bristol and London were more than just isolated incidents. Indeed, Lord Laming concluded that "many of the concerns identified in Victoria's case are replicated elsewhere in the country". He said he had heard nothing to persuade him that "the deficiencies identified should be viewed as unique or that their significance extends no wider than the area of North London in which Victoria lived". As we have seen, there is much common ground between Kennedy and Laming. Both inquiries found that the needs of children were subordinated to the needs of adults.

Both inquiries found a distinct lack of leadership in the running of children's services, and a failure to engage in asking children and young people and families what they think about services. These criticisms were especially searing to me. How could I, a senior academic children's physician, have allowed these cultures and deliveries to have happened under my nose? Why had my profession and the bodies set up to promote its interests failed so dismally those we took such pride in serving? What do we have to do in the training of all staff engaged with children to make sure they read, understand and take note in their everyday working lives the lessons spelled out so graphically in these seminal inquiries?

The key challenge posed by both these inquiries is for a fully integrated, joined-up approach to children and young people across various departmental responsibilities – from health and social care to education – which truly puts children and the needs of children at the centre of all decisions and services. In Chapter 6, I consider how current policy initiatives are addressing the needs of children and young people today. Of crucial importance is the need for professional staff to be more effective advocates for the needs of the children they are serving. In my view, advocacy is just as much a science as effective research. What is the cause being advocated for? What are the key facts to justify the importance of the issue? How can the facts be brigaded to produce an incontrovertible argument? Who are the key movers and shakers to target the information to? Are professional staff and parents and carers aligned to a common purpose? How can the media be drawn in to support the cause?

Key Learning Points

- Professionals need to be familiar with the content and importance of the UN Convention on the Rights of the Child.
- There is concordance between Kennedy and Laming about the reasons that services have failed children and young people.
- Nothing will fundamentally change in the NHS without a revolution in the way we think about children and young people and how we deliver services.
- Children are too often all but invisible. Like stealth aircraft, they seem to show up on no official radar screens.
- Advocacy is a science that deserves academic rigour and study.

Key Action Points

- All staff working with children should read the Kennedy and Laming reports.
- Staff working with children should receive sufficient training to ensure they are not afraid to address deficiencies and contentious issues in service provision.
- All organisations and services must identify an individual with responsibility for children and young people.
- To implement these changes would require the effective advocacy for the interests of children and young people at all levels, from central government to local communities.

6. IS CURRENT GOVERNMENT POLICY ADDRESSING THE HEALTH NEEDS OF CHILDREN AND YOUNG PEOPLE?

We want to see all children and young people achieving the best possible physical and emotional health and well-being, both in childhood and into adulthood.

Change for Children – the National Service Framework for Children, Young People and Maternity Services, 2004

Children who have any kind of disability should have special care and support, so they can lead full and supportive lives.

UNCRC: Article 23

In the preceding sections I have attempted to demonstrate the pressures which face our children and young people, and their invisibility in terms of the way society has responded to their needs. Belatedly that situation is beginning to change: children and young people are at last being seen by policy-makers, even if their 11.8 million voices are still not adequately heard. Indeed, the recent Prime Minister, Tony Blair, made it clear that children must become a national priority. In September 2002, on the eve of his party's annual conference, he boldly declared that his government's goal was nothing less than "to make sure that every child of the next generation has the opportunity to flourish, regardless of where they are born, where they grow up and where they are educated". And Mr Blair has not been alone in calling for a change in the way adult politicians regard the needs of children. The then Chancellor, Gordon Brown, gave a similarly impassioned speech two years later when he addressed the Joseph Rowntree Foundation in July 2004. "Children," Mr Brown said, "may not have votes or the loudest

voices...or at least their voices are not often heard in our politics – but our obligation is, if anything, greater because of this. We need to understand that these children are not just someone else's children and someone else's problem. For, if we do not find it within ourselves to pay attention to them as young children today, they may force us to pay attention to them as troubled adults tomorrow."

These are clear statements of intent and much commendable work has been done to turn these intentions into reality. We are experiencing a period of unprecedented national government policy development for English children and young people. More has been done in the last seven years to improve their lives and health through policy development than in the last 30 years. These provide major opportunities, but also pose fundamental challenges for the professions working with children and young people.

There is no doubt that the present New Labour government has introduced a raft of policies and initiatives for children that are much admired overseas. Within seven years the government had created a Minister for Children, a cross-government Directorate for Children, Young People and Families nested in the Department for Education and Skills (now the Department of Children, Families and Schools; see Chapter 7), a National Children's Taskforce in the Department of Health and a massive range of policy initiatives under the banner of Every Child Matters. These include a new National Service Framework for Children, Young People and Maternity Services,[96] Youth Matters, a template for young people's services, a Social Exclusion Action Plan, and, crucially, an act of Parliament, the Children Act 2004 that not only created the new independent post of a Children's Commissioner, but provided legislation for a new framework of local services reorganisation through the creation of Children's Trusts and the appointment of Directors of Children's Services in all Local Authorities. These people are charged with the responsibility for the design and delivery of integrated children and young people's services predicated by local needs.

New guidance and policy directions continue to be generated and released to the field almost to the point of overload, and it is difficult to find any aspect of need that hasn't been thought of. Financial investment in Sure Start, new Children's Centres, new schools and children's hospitals and in workforce capacity is unprecedented and welcome. How are such policies developed and by whom? What can be learned from a case study of the production of a major policy statement?

Insights into the development of health policy – the National Service Framework for Children, Young People and Maternity Services

In 2000 I was invited to chair a new Children's Taskforce in the Department of Health, and I immediately recruited a team of some 30 of the nation's most knowledgeable minds on children's health, drawn from the academic, statutory and voluntary sectors and supported by a number of enthusiastic and politically wise officials from a range of Departments of State. At its first 'away day' in January 2001, its immediate and most important action was to formally request of the Secretary of State for Health permission to develop a National Service Framework (NSF) for children and young people. We were aware of the proceedings of the Kennedy Inquiry, and indeed a number of us had given evidence to it. We sensed that the moment was right to seek a major commitment from Government to develop a holistic and innovative policy direction for children's services. In February 2001, Alan Milburn granted our request to develop a National Service Framework for Children, Young People and Maternity Services, known more generally as 'The Children's NSF'. News of this development was greeted by acclaim from the field, which saw at last an opportunity to make real change for children. They gave their support for its development, although this was perhaps accompanied by an unreal expectation of what could be delivered.

National Service Frameworks were new instruments of government health policy designed to set standards of care for improving important areas of health service delivery. A number had been published or were in development, including NSFs for Cancer, Coronary Heart Disease, Mental Health and Older People, and their power to effect rapid change in priority and service design were becoming apparent. The Children's Taskforce expected its NSF would follow the pattern established by previous national frameworks. It understood that there would be hypothecated (protected) money for the implementation of standards. There would also be hard targets and performance indicators, and the various sectors would be given 'must-dos' and a strict timetable for implementation. This expectation was shared out in the field where it was realised that setting hard targets was the key mechanism which could guarantee the level of change required to make the NSF work.

The development of the NSF was fundamentally influenced by the findings from the Bristol Inquiry that was published in July 2001. As Kennedy perceptively pointed out: "We are in no doubt that there must be a fundamental shift in attitude and approach, so that action to improve children's healthcare services is taken at every level of

policy-making and of management… . There is still a continuing lack of recognition of the need for a holistic, child-centre approach to the care and treatment of children which has been advocated for the past 40 years." In the government's formal response to Kennedy the Department of Health made a firm commitment to improving children's services and to ensuring that children, like adults, were entitled to high-quality, safe services designed to meet their particular needs. In addition, the new post of National Clinical Director for Children was created in the Department of Health, to ensure that a named individual was responsible for developing policy for children's services. I was appointed to this position in July 2001.

The taskforce's bold ambition was for the Children's NSF to cover not only the interface between children's health and social care, but also to recognise that children spend much of their time in school – so the interface with education was of paramount importance. It was also clear to us that various elements of the NSF, such as child and adolescent mental health and maternity, merited frameworks of their own. But such an approach would fragment what we intended to be a holistic response to services which, we believed, were intrinsically linked. Children and families, we argued, cannot be neatly compartmentalised into different categories. The aim was to show throughout the NSF that it would only work if, in its implementation, it recognised the need for a multi-disciplinary, multi-agency approach to services for children and young people. The inclusion of maternity services in the brief was controversial, some practitioners arguing that these services demanded a separate NSF. The taskforce's view was that their inclusion cemented the crucial relationship between patients, maternity services and child health.

What we saw in the Victoria Climbié Inquiry was the failure of services to look into the 'journey' that she had made before she arrived at each different caring organisation. That is why, in the NSF, the aim was to try and describe the journey every child makes from conception through pregnancy to birth and beyond into childhood and adolescence, coupled with its needs at each milestone through the illness or adversity. The purpose of this approach was to give mothers and their children the best possible start in life. Given the determination to put the child's journey at the core of the team's thinking, it was inevitable that the various working groups should focus on the transitions that mark milestones in a child's life – from fetus to baby, from baby to toddler, from toddler to school age, and from adolescent to adult. It was universally agreed that this last transition was particularly important and one in which there are significant shortcomings in service delivery. There was, therefore, a consensus that there should be a standard on growing up which drew together a wide range of interventions aimed at smoothing the transition between services and at improving adolescent health. Of particular concern was that the

needs of those children who were more likely to have poor outcomes – such as those born into poverty, looked after children and young people, children who suffer from sexual exploitation, children exposed to domestic violence or family conflict, teenage parents – in other words 'children in special circumstances', should be emphasised. The thinking of this NSF working group was that it should not treat this as a separate standard. After all, the very idea of the NSF was to look at ways of helping vulnerable children and their families. Instead, these issues run like a thread through the whole of the NSF.

In addition, we were determined to address the lack of research into medicines for children and young people. Children have been denied effective treatment by the failure of government, professional bodies and the market imperatives of the pharmaceutical industry to ensure that the use of medicines is informed by hard scientific evidence of efficacy and safety. It was decided to create a standard devoted entirely to children's medicines. As early as 1997, the Health Select Committee had highlighted the lack of licensed medicines for children.[97] The government and other administrations had started to take this issue more seriously, but in February 2006, the House of Lords was still reporting that too many children's drugs had not been properly tested. A report claimed that 90% of medicines for newborn babies and 50% of those aimed at children are untested after collating evidence from doctors.[98] Because of this failure to recognise their needs and to perform appropriate research, children are still denied access to information that adults would demand as a fundamental right.

From 2001 until the full publication of the NSF in the autumn of 2004, over 300 colleagues from across England were recruited to sit on Expert Working Groups, each chaired by eminent authorities respected by the field. A massive process of consultation took place, including seeking the views of children and young people themselves, who proved to have penetrating insights into how services should be designed around their needs. A core philosophy emerged, built around three fundamental and challenging concepts:

- putting the child or young person (and mother in the case of maternity services) at the centre of services, and seeing services through their eyes
- designing services around the needs of the child, young person and carer
- the interweaving of health, social care and education to reflect the child's life and not just its health.

As the taskforce's work evolved, however, it became clear that, unexpectedly, the ground was shifting under its feet. Fast as it was working, the government was heading in a

different direction through the publication of *Shifting the Balance of Power*[99] in 2002. This new policy pronouncement switched the responsibility for health services delivery away from central prescription to local authorities and other local agencies. This at first glance commendable shift in emphasis in recognising that the needs of children in, say Bradford, are completely different to those in Norwich, had profound implications not only for the structure of the NSF, but of much greater importance, its implementation and delivery. Hard targets were reduced to broader aspirations. What had started out as a powerful tool for change had been weakened to the point where, potentially, the credibility of the NSF was seriously compromised. Indeed, the members of my taskforce expressed their fury and frustration over the change to what had been expected, and this was reflected by the reactions from the health sector and children's workforce across the country. My back is still scarred from the meetings I attended where it was alleged that my taskforce had betrayed children yet again by failing to provide effective levers for change.

The implementation was 'sold' by emphasising that all standards would be expected to be implemented within ten years, that every primary care trust, strategic health authority and hospital would have a 'senior' person responsible for the implementation of the NSF, and that the voice of parents and children would be strengthened, particularly through the crucial overseeing of the inspection of services by the Healthcare Commission – a body set up following the Kennedy Inquiry to ensure rigorous scrutiny of services in every healthcare setting. But we now had the situation where the NSF contained not mandatory standards, but aspirations. The new emphasis on localism meant that the NSF was in danger of being seen not a 'must-do' document, but simply one of a number of approaches that could be taken to ensure better provision for children and young people.

It has to be said, however, that this document, which took three years to produce, quickly became a benchmark of a government's approach to children's health for practitioners across the world, and I was invited to many countries to describe its genesis and content.

The NSF in its final form defines the following sets of standards:

1. Promoting health and well-being, identifying needs and intervening early
2. Supporting parents
3. Child, young person and family-centred services
4. Growing up into adulthood
5. Safeguarding and promoting welfare of children and young people
6. Children and young people who are ill

7. Children and young people in hospital
8. Disabled children and young people and those with complex needs
9. Mental health and psychological well-being of children and young people
10. Medicines for children and young people
11. Maternity services.

Each standard was supported by evidence-based analysis of the research literature, and a toolkit, including four-minute video clips of children's experiences in healthcare settings, was offered to staff to help get their thinking around a new way of designing services, namely the concept of the 'Child's Journey'. We urged them in every setting to take a child's condition or circumstance and then define:

- milestones expected
- needs of child and carers at each milestone
- competencies to meet the needs
- information and evidence of best practice
- current services
- design of appropriate services and their configuration
- workforce, budget and safety.

If the creation of the NSF was a massive undertaking, implementing it will require a commensurate, if not greater, effort. As we have seen, there are a number of key challenges that we face already. By shifting the balance of power back down to local level, there is a real risk that implementing the NSF will be patchy; at best some localities will see it as a vital tool to bring about real improvements, while others will simply park it on a shelf and carry on with business as usual. While it is vital that there is local ownership of these initiatives, the concern must be that cash-strapped, over-stretched local authorities will see this as just another central government impost – to be carried out grudgingly, if at all. These worries are reinforced by the practical consequences of ongoing structural reorganisation in the NHS, with contraction in the number of strategic health authorities (SHAs) and primary care trusts (PCTs) and the emergence of new patterns of healthcare. These include the creation of Foundation NHS Trusts with much greater autonomy and independence to set their own priorities and practices. The concern must, therefore, be that history will again repeat itself and that at some date in the future another seminal report will be published in which the Children's NSF is added to the list of those initiatives whose recommendations were never fully implemented.

My concern over effective implementation was reinforced by visits across England to see for myself the standing of children's services in 'adult-centric' organisations. I found

repeatedly that there was an astonishing lack of understanding in many chief executives, chairs and board members of why services for children were different to those for adults. Indeed, staff in children's services told me in some localities that neither its local chair nor chief executive had ever been to see for themselves the unique challenges of providing and delivering effective services, especially those for the non-acute services. I also found not only in the Department of Health but in other organisations that children's issues were not 'mainstreamed' in the everyday matters preoccupying the organisation. Of special concern, no-one experienced and authoritative was charged at board level to speak for the needs of children, young people and families. Despite this, everywhere I have been to I have seen much excellent work being done by motivated staff to improve the lives and health of children. We have an outstanding workforce for children driven by passion for their needs. If everything that I have seen that is good was done everywhere, then we would have no difficulties. However, the obstacles to implementation are real and include cultural aspects of delivery such as territorialism, tribalism, traditionalism, tunnel vision, timidity, 'targetitis', tiredness, exhaustion, and deep cynicism coupled with an unreal timescale.

"The task is to identify and encourage the innovators and change-makers."

The task is to identify and encourage the small numbers of innovators and change-makers, and to help them really make a difference. This way, others may be persuaded to follow by example. If the benefits of the NSF to service delivery can be showcased, the sceptical and the agnostic might be convinced that it is a route worth following. But, where carrots will not work, we should not shirk from naming and shaming those authorities who are failing to meet the needs and aspirations of children, young people, their families and carers. We need, also, to be sure that the proliferation of initiatives designed to help children and young people do not create confusion. The risk is that too many agencies will be charged with the same or similar tasks. Turf wars could then break out, and the needs of children could then be lost in the fog of political battle. A policy as wide-ranging and ambitious as the NSF inevitably comes with a price tag. But the resource implications go beyond money and involve the supply of skills and staff. Again, a concern must be that as pressure grows on government to reduce spending, the political commitment to a group which lacks the power to vote could vanish as rapidly as it emerged.

Nevertheless, the NSF, now embedded in the wider Every Child Matters: Change for Children programme, with its key outcomes of being healthy, staying safe, enjoying and achieving, making a positive contribution and securing economic well-being presents an

unrivalled opportunity to secure the profile of services for children within mainstream policy thinking and development. However, fine words by themselves will do nothing. Change for the better will only occur if there is the political will and drive from government to make it happen, backed by local understanding, support and involvement, and above all, by investing in the science of change management itself. The sheer scale and scope of the work programme, and the priority being given to improving the life chances for children, shows there is an opportunity to drive forward a massive cultural change in the way services are prioritised and delivered. The challenge is to make sure that every child really does matter. Despite the shifts in public policy which make the implementation of the NSF more problematic, the framework itself has become recognised internationally as one of the most innovative and exciting policy statements from any government on quality standards for improving the lives and health of children, young people and mothers, and this is gratifying.

Kennedy, in his lecture in the autumn of 2006, described his perspective of change five years after his inquiry. He acknowledged that much excellent progress had been made in policy for healthcare delivery overall, and applauded the developments for children and young people including the production of the Children's NSF. Although acknowledging that the implementation of the NSF was still in its infancy, Kennedy highlighted special concern for the slow progress in improving services for disabled children, the continuing impact of poverty, failure to progress improvements in the public health of children, and continuing deficiencies in the mental health of children and young people. Other evidence is now emerging to document the very slow improvement in services. Thus the Healthcare Commission in its report on services for children in hospital,[100] published in 2007, describes how some progress has been made, but serious difficulties persist in a significant minority of acute hospitals, particularly in the safety of children who are critically ill, a failure to develop effective child protection policies, and in meeting the broader needs of the child.

Even as this monograph was in preparation, a new publication released by the Department of Health[101] states that "policy makers and healthcare providers are responding to the challenges and shaping the child health agenda by making significant changes to the way health services are planned and delivered". This is undoubtedly true, and there is welcome evidence of some progress. However, let there be no doubt of the enormity of the mountain still to be climbed if all children and young people in England are to receive the care and health services that they need to achieve the best outcomes in their lives. We cannot afford complacency or the emergence of a view that the box has now been ticked.

What needs to be done now to implement policy and accelerate change for children will be discussed in the following chapter. Suffice it to say at this point that the views of children and young people of the services being provided to meet their needs is a crucial and further major cultural challenge to adult-centric philosophies and practices. When, for example, will children and young people be involved in the appointment of senior nurses, doctors or administrators charged with responsibility for their services?

In December 2007 the government published its Children's Plan which sets out its proposals for a ten year programme of work together with very substantial funding to improve many aspects of the lives of children. This plan is exceptional in the way in which children have at last been brought into the very heart of cross-government policy-making. It confirms that a tipping point has been passed in recognising the central importance of children and young people in our society today.

Key Learning Points

- More has been done in the last seven years to improve their lives and health through policy development than in the last 30 years.
- Every Child Matters and the NSF are widely respected for the way the standards and outcomes were developed.
- What had started out as a powerful tool for change had been weakened by changes in overall government policy and reorganisation of the NHS to the point where the credibility of the NSF may be compromised.

Key Action Points

- It should be mandatory for all staff working with children and young people to read *Every Child Matters* and the children's NSF.
- Continued effective local advocacy for implementing NSF policy is essential.
- The rigorous ongoing inspection of children's services is essential for momentum to be maintained.

7. WHAT ARE THE KEY FACTORS NEEDED TO ENSURE EFFECTIVE IMPLEMENTATION OF RECENT INITIATIVES?

In the end, Tipping Points are a reaffirmation of the potential for change and the power of intelligent action. Look at the world around you. It may seem like an immoveable, implacable place. It is not. With the slightest push, in just the right place – it can be tipped!

Malcolm Gladwell, *The Tipping Point* (2000)

All organisations concerned with children should work towards what is best for each child.

UNCRC: Article 3

We have seen that the development of children's services has been compromised repeatedly by poor leadership and advocacy and a lack of professional responsibility in recognising the best interests of children. It is fair to say that these fundamental issues have been compounded by a lack of knowledge and a lack of information about the real factors that will influence good outcomes for children and young people.

Leadership, responsibility and change management

A lack of effective leadership and the failure to identify individuals within services to take responsibility for children, has again and again been shown to lead to poor practice in the delivery of services to children. At the very mildest end of the spectrum this has led to the delivery of poor quality services which are not designed to be responsive to the

needs of children; at the very worst this has led to children dying as a result of poor practice. We now face unprecedented changes in children's services and have a real opportunity to make fundamental improvements for children. However, it is even more vital during these times that we have individuals who are confident and competent leaders to drive this change and that the lines of accountability and responsibility are crystal clear at all levels of service delivery. One danger of the recent changes in service configuration is that previously established relationships between sectors will become fragmented, lines of communication will become broken and that there will be a loss of emphasis on identified individuals with responsibility for children. We must not allow this to happen. We must not return to a situation that mirrors provision prior to the Kennedy and Laming reports.

I am greatly influenced by the teaching of Don Berwick from the Institute of Health Improvement in Boston, and by his description of the Innovation and Change Cascade Theory,[102] which I have modified in the light of my own observations in England. The change cascade does not happen by itself. It is led by people.

- Innovators – these are key people, reflecting around 2% of the workforce, who may not be the most important influencers; indeed they may often be disruptive in the light of their frustration, born of certainty of knowing what must be done.
- Early Adapters, and Spreaders and Disciples – these really are the key people, not more than around 15% or so, but through their commitment and passion they will be the leaders and the change innovators.
- Followers – it is a sobering fact that the majority of us (around 50% to 60%) are followers and not leaders. We will follow gladly when the way forward has been shown to be effective by the early adapters, spreaders and disciples.
- Agnostics and Recalcitrants (around 15%) – a substantial number of potentially dangerous colleagues are those who are agnostic to the cause and are recalcitrant in being dragged to the table.
- Saboteurs and Wreckers – these are the most dangerous of all, who will do everything in their power to prevent change and undermine its implementation. In my experience this may be around 5% of colleagues.

The challenge for local leaders, therefore, is to identify the small number of people who will deliver change, and to give them the toolkits, support, resources and time to do the job properly. I argue that a fundamental problem for government is that it is not investing nearly enough in the change management process. It has become clear that we

need to encourage staff to think differently, to look at service provision through the eyes of the child and their family. As Sir Ian Kennedy says in his report,[103] the big challenge is to get professional staff to examine the competencies required to meet these needs, rather than remaining trapped in their professional bunkers.

Chapter 5 described how the needs of children and young people have been neglected again and again with potentially appalling consequences. Thankfully there are now many examples where change is happening, where practitioners are beginning to really design services that are appropriate for children and young people. One of the best examples of where staff have changed the way they deliver services is in speech and language therapy. Until recently, the shocking fact was that a child of two could expect to wait two and a half years for a speech and language therapy assessment in London. That is disastrous for a child who is unable to communicate properly when she or he starts school. Recently, however, in parts of London, as I have seen for myself, the waiting time is down to zero. This was achieved because staff learned to think differently. They began to look at the service from the child's perspective. They asked themselves some hard questions about why children were coming to them. Could they be grouped together, could competencies be pooled to provide a better, more effective service?

Learning to think in new ways is often the most difficult of options. Too many of us live within our own comfort zones. All we see is the view from the bunker. We are too timid to change, too bound by tradition to think of new ways of doing things, too loyal to our tribe to seek the help of others, too protective of our territory to break down boundaries, and too focused on targets to see the bigger picture. But change in thinking has to come if the plight of children and young people is to improve. As mentioned above, the task now is to identify those people, the 15 out of every 100 NHS staff who, given the time, resources, the toolkits and the support, will help bring about the change in thinking that is required to transform the way we care for children and young people. This demands political commitment as well as improving the capacity to think in this challenging way.

New tools for change

If the government is to reach its goal of reducing inequalities in health outcomes it may find the use of local health 'maps' very helpful. Such an instrument has been developed over the past few years in Vancouver, where it is being used to great effect to improve the health and well-being of young children. The Early Child Development (ECD) Mapping Project began in February 2000, when Dr Clyde Hertzman of the Human Early Learning Partnership (HELP) led a population-wide assessment of nursery children in the city.[104] A questionnaire known as the Early Development Instrument (EDI) was introduced to

measure the development of nursery children. The results were collated in the form of maps to gain a clearer picture of how community and neighbourhood factors might be influencing the development of the young child. The mapping process helped communities to:

- assess their children's readiness to participate in and benefit from school activities (school readiness)
- reveal differences in children's development across neighbourhoods
- assess how well their community was doing in supporting young children and families.

Before the advent of such mapping there was no way to monitor early child development, and no way to understand how local circumstances might be changed to improve the life chances of children. Using the EDI data from across the region has enabled researchers to establish a provincial average or baseline of children's school readiness. School districts and communities can make comparisons with others across the province. Combined with the mapping of community assets, the EDI data can also help school districts and communities assess where services are most be needed.

By mapping information at the micro- or neighbourhood level, researchers have gained a better understanding of how various factors influence a child's development and health. This information enables policy-makers and community members to develop effective policies to help children get the best possible start in life. Maps created by the ECD Mapping Project can reveal important differences in child development. Specifically, they can:

"Mapping information at the neighbourhood level gives us a better understanding of what influences a child's development."

- heighten awareness of the importance of early child development
- prompt new community policies
- show where children and families live, where programmes and resources are, and how accessible these programmes are to those they were designed to support
- help identify large neighbourhood differences in the number of children who are healthy and ready for school
- reveal where the gaps are in children's development and where change is needed.

I believe that the Canadian experiment is of universal application, because the first six years of any child's life are fundamental for learning, behaviour, physical health and well-being throughout life. That is why I believe that there is much we could learn from this pioneering experiment. It comes as no surprise that the researchers in Vancouver have found that child development outcomes correspond very closely to socio-economic levels and patterns of neighbourhood disadvantage. Routinely available data, including budgets and spending from education, health, social care and local government, are now being collated to produce operationally effective maps to underpin the targeting of resources and designing new ways of delivering services.

Belatedly we are realising here in England that mapping might enable us to identify the neighbourhood differences in socio-economic status that could profoundly influence a young child's early development. It may sound like a statement of the blindingly obvious, but the Canadian studies have provided compelling evidence that children who grow up in safe, supportive neighbourhoods with abundant resources do better, on average, than those children who grow up in disadvantaged and resource-poor neighbourhoods. The implementation of Sure Start facilities in similar deprived neighbourhoods offers a real chance to address these issues in England, and Government should not be deflected by short-term research studies that might well fail to demonstrate dramatic improvements.

As the social cartographers become more sophisticated, the usefulness of their maps increases. In Vancouver, for instance, they can now identify those neighbourhoods and communities that would benefit most from additional resources. As part of this project, they obtained data on the average cost of purchasing a range of nutritious groceries (referred to as the 'Nutritious Food Basket') for a family of four. These costs were then analysed as a proportion of household income. What they found was a six-fold difference in the ratio of 'income-to-food-needs' across the city, with the cost of purchasing a nutritious food basket ranging from a low of 11% to a high of 66% of household income!

Mapping processes are now being developed in England. An annual mapping of child and adolescent mental health services was initiated in 2002 and patterns and trends are beginning to emerge.[105] The results are encouraging and show some progress towards meeting the standards set out in the National Service Framework. Increased numbers of services are now saying they are accessible to those with a learning disability, those in crisis and those young people aged 17 to 18 years who had previously fallen in the gap between child and adult services. These are positive findings, but it should be remembered that they do not provide an insight into the quality of service provision. A project is underway to develop a profile of children's health services in England.[106] The National Child Health and Maternity Services Mapping project is intended to be an

annual data collection exercise based on a survey of the commissioning and provision of children's health services within primary care trusts and secondary care providers. As with the Canadian mapping project, its ultimate aim is to improve the outcomes for children and young people by supplying better information about the nature of current provision. In doing so, the project help direct services where they are most needed and will have the biggest impact. The project is a joint exercise by the Department of Health and the former Department for Education and Skills and was formally launched by Dr Stephen Ladyman as part of the implementation programme for the Children's NSF and Every Child Matters.

As already noted, one of the biggest concerns is whether local teams will have the capacity, skills and motivation to meet the rigorous demands of the NSF. This particular instrument is just one of a number of tools that is being developed to help local services do just that. A pilot phase across 34 sites, reflecting a broad range of geography and commissioning and provision arrangements for children, is now complete. Although there have been previous mapping exercises of this type in adult mental health and child and adolescent mental health, this is a first for children's health services. The focus of the first year's data collection and pilot exercise is upon health and its interface with education and social care. The contours of the maps will then be widened to include social care and education, and the interface between health and extended schools, children's centres and teenage pregnancy strategies.*

Thus far, however, some 19 service categories have been charted in the first maps, from health visitors to postnatal services. Although provisional and incomplete, the pilot revealed a remarkably wide range of health spending per child across the country from a low of £27 to a high of £415. This excessive variation may reflect genuine inequalities in provision between areas, in which case this information will help to identify where budgets may be insufficient. It seems more likely that the range presented here reflects difficulties in collecting consistent data between primary care trusts. In 2006, the Association of Public Health Observatories published its first ever attempt to collate and map the indicators for child health across the nine English Government Regions.[107] It concluded by saying that despite the plethora of data available on aspects of child health and well-being, there remains a serious lack of current data on the health of the most vulnerable groups of children in our society. There is, clearly, a major need for new investment into the research and evidence base upon which to build national as well as local health policies for children.

* Current information on mapping can be found at www.childhealthmapping.org.uk

Nonetheless, what the health cartographers have discovered for certain is that mapping brings with it key benefits. When fully developed it will enable us to:

- establish a baseline of current service provision. This is crucial at a time when services are undergoing a radical change agenda for children
- provide a common template across the country. This could prove a vital tool for ensuring consistency in implementing national policy, thus minimising the risk of post-code provision and patchy local implementation
- develop a powerful diagnostic tool which will help identify key issues to be addressed
- provide practitioners and policy-makers with a complete inventory of children's health services by PCT, local authority and strategic health authority. This must be drilled down to what is available and where, a staffing profile and vacancy rates
- provide answers to some key policy questions. For example, we need to know the numbers of school nurses per cluster; the time spent in public health activities; the training background of nurses; paediatric accident and emergency facilities; waiting times for therapy; choice in childbirth; and the number of cots and beds.

If this approach is to succeed, the maps must contain consistent and reliable data. This must, for instance, include information on the amount spent on children's health services by PCT, local authority and strategic health authority. We need also to turn the microscope on the commissioning arrangements that are in place in each PCT. Some will be very good; others may be poor. We need to know strengths and weaknesses. Crucially, this data must also include the leadership arrangements that are in place, the status of needs assessment, and the extent to which the trusts have embarked upon multi-agency working. Without the latter, the NSF will remain trapped inside professional silos.

Working for children in changing times

Having accurate and reliable maps is one thing; having people who are willing and able to read them is another. On my tours of the country as the National Clinical Director for Children, I found the response to the NSF to be patchy at best. Some local authorities and strategic health authorities have seized upon the NSF as a valuable tool for accelerating change which had already begun, but the challenge is how to make a 'locality-based' approach work effectively. Obtaining accurate information is vital. The mapping process is a key part of that. But we also need information that stretches across time. We need data from epidemiological studies and we need a clear understanding of

the demography of need and the provision of service. We also need to know what resources – staff, skills, training, voluntary and civic social capital – we have available, and where there are gaps. This, at least, will give us a sense of the bigger picture. It might enable us to see where the needs of children are greatest and where they are being met the least. This kind of information can then be used to assess the various strategies that the localities devise to meet these needs.

One of the most important changes created by the Children Act in 2004 was the appointment of Directors of Children's Services in all 150 Local Authorities in England to be responsible for the integration and management of local children's services. In 2007 a new professional organisation, the Association of Directors of Children's Services, was created to support their interests. The power and authority of these new key individuals is much to be welcomed, and offers a tantalising prospect of serious action being taken at last to address the central challenges of Kennedy and Laming. An important ongoing challenge remains, however, which is to integrate the health dimensions of new Children's Trusts into the cultures and services in education, social care and local government.

It is one thing to draw up a Local Children and Young People's Strategic Partnership and to establish a Children's Trust[108] – it is something else to make them work. What is happening – or should be happening – in children's services across England is nothing short of a revolution. Old boundaries are being broken down. Old ways of thinking are being challenged as never before. But we should not underestimate the powers of tradition and conservatism. Hostility to change is rife in the system. The human tendency is for people in positions of power and authority to cling to their territory, for people who work for them to display tribal loyalty to the old ways of doing things. Many people are wedded to tradition, not dedicated to change which is threatening the status quo. Our task, as noted earlier, is to identify the innovators and the early adaptors and disciples who will be the engines of change. These are the ones who will make things happen – some of them will be in the health sector, others in education and many will be in the voluntary sector, which is often much more flexible and less bureaucratic.

What is needed – according to the Children Act – is for strategic health authorities and PCTs to work with local authorities, schools and voluntary groups to improve the well-being of children. It is a big task, but the prize is greater. Ideally, these groups and agencies should coalesce in Children's Trust arrangements which will play a key role in co-ordinating and integrating the planning, commissioning and delivery of local health, social care and education services. This task would be difficult even if there was some stability in the system. But there isn't. In both the NHS and in our state schools, the

government is intent on a radical change programme, which can only make implementing these new policies all the more hazardous and fraught. The amalgamation of PCTs, for instance, could throw a large spanner in the works of the mapping programme. By changing the geographical and demographic boundaries of the PCTs, these changes will make it all but impossible for us to make meaningful comparisons between earlier and later data sets. We will, in short, be measuring different things.

Alongside the amalgamation of PCTs, the emergence of academies and trust schools – as identified in the recent White Paper on education[109] – could lead to the virtual abolition of local education authorities and the establishment of semi-autonomous trust schools, which could put much of the locality-based reform process in jeopardy. The guiding principle of the Children's Trusts – which are working to a ten-year timeframe – is to integrate frontline services. Yet, if another arm of government seems bent on making integration all the more difficult, it is hard to see how that goal can be achieved. As the Core Standards document of the NSF says: "Full implementation of the standards will take time. There are examples of good practice already in services in many areas of the country, but delivering all aspects of the standards in all areas requires a long-term programme of change." The important phrase to note here is 'long-term programme of change'. For this to work, the system requires stability and consolidation of the progress that has been made. It must allow the time and the chance for changes to bed in and become accepted by those at the local level who are charged with implementing it.

It will be hard enough to get people to accept the need for change in a stable environment. If people sense that these changes will be swept away by another set of new policies that are heading out of Whitehall at this very moment, then they will do nothing and the much needed process of change will stall. We must not let that happen. However, the recent publication of the *Commissioning Framework for Health and Well-being*[110] is a much-needed stimulus to one of the most important levers for change, the commissioning of services. It is very welcome indeed to see the high profile in this document given to children and young people's services, and it represents a sea change in cross-government thinking. Opportunities are also being provided through the new integrated inspection processes for children's services in schools, social care and in health. It is important that the findings from inspection are not seen as a threat, but rather as a tool for continuous improvement.

Key Learning Points

- The importance of effective leadership and allocated responsibilities cannot be underestimated.
- Fine words of policy by themselves will change nothing.
- Mapping instruments can act as powerful diagnostic tools that will help identify key issues to be addressed.
- Individuals and organisations need help in developing new ways to deliver services.

Key Action Points

- Greater investment is needed to develop leaders and support those responsible for children's services.
- All staff should understand the essence of current policy directives and see their own services in the light of the overall picture.
- Public Service Agreement (PSA) targets for children's services should be included in all government spending reviews.
- Maps must contain consistent and reliable data.

8. CONCLUDING OBSERVATIONS

The child is father of the man;
And I could wish my days to be
Bound each to each by natural piety.

My Heart Leaps Up, William Wordsworth

A child's spirit is like a child; you can never catch it by running after it; you must stand still and, for love, it will soon itself come back.

The Crucible, Arthur Miller

Children have the right to say what they think should happen when adults are making decisions that affect them, and to have their opinions taken into account.

UNCRC: Article 12

The writing of this book started immediately after the delivery of the Queen Elizabeth the Queen Mother Lecture in 2006. Its gestation has been much longer than expected, not least because of the breathtaking pace of change driven by government policy for children and young people. It has been difficult to maintain an up-to-date perspective, and even as I attempt to draw the commentary to a close, there has been a change in Prime Minister and in the machinery of Government. Gordon Brown, who as Chancellor of the Exchequer gave so much support to recognising the importance of children for our future success, has become Prime Minister. Of serious significance is the appointment of his trusted lieutenant Ed Balls to be the very first Secretary of State for Children, School and Families, sitting at the heart of government as a cabinet minister. His much-welcomed appointment gives him the responsibility for leading on children's issues across government, and already there is evidence of emerging impact and effect. Of special significance is the changing mood and expectation of staff working with children who sense that there are now, at last, serious

prospects for improving the lives and health of our children. It is also noteworthy that the other political parties are now focusing their rhetoric increasingly on the importance of children and families. Across the United Kingdom, the devolved administrations in Scotland, Wales and Northern Ireland are in their own ways making important changes to the lives of children and young people.

However, despite the welcome changes in political temperature, we still face real challenges that need to be reiterated. English society is undergoing dramatic changes: becoming more egocentric, multicultural, and consumer-driven, with changing family dynamics, increasing parental separation and lone-parenthood, a falling birth rate and changing skills needed for successful employment. There is an increase in vulnerable children needing protection (including those looked after by the state), in the number of refugees and young prisoners and those being exploited through prostitution, pornography and substance misuse. The UK has worsening outcomes for adolescent health, with one of the highest teenage pregnancy rates in Europe, increasing numbers of sexually transmitted infections, worsening levels of obesity, and emotional and mental health difficulties. As I have argued earlier in this book, the majority of children and young people in England today are loved, cared for, healthy and successful. But the evidence that we looked at also makes it clear that there are increasing numbers of children and young people who are not sharing in the benefits enjoyed by the majority. Even the healthy majority are facing new and in many ways even more pernicious threats to their well-being.

From all of the evidence there is a stark and uncompromising conclusion, namely that as a nation we have not been giving all of our children the care and nurture they need to become competent and successful young adults. Too many children have fallen through the safety nets of the statutory and voluntary services, and repeated commentaries have shown serious deficiencies in the capacity, competence and quality of services to support their needs. The challenge is to ensure that all children and young people enjoy the benefits of living in one of the richest countries in the world and receive the nurture in families, in communities and in society to fulfil potential while being respected as citizens of today. I reiterate that, to achieve full potential in life, children need love and care, physical contact, warmth, comfort, security and family stability, effective healthy nutrition, safeguarding and protection from harm. This needs to be coupled with play that promotes exploration, encouragement and managed risk together with understanding moral boundaries, and the expectation of a purpose in life.

All of these components of nurture should be supported by accessible, appropriate, evidence-based and needs-led services. The responsibility for delivering them cannot be

solely that of government, although policy and legislation are key levers. Effective parenting, support from the public, local communities and schools, and adequate numbers of highly trained and experienced professional staff working in partnership are fundamental prerequisites for change and success. Inevitably, the focus of this commentary has been on the way children's health is affected by the society they live in and the attitudes of adults to their needs. Social conditions – poverty, joblessness, poor educational attainment, inadequate housing – also affect the life chances of young people and those who care for them. To the government's credit (and to the credit of voluntary organisations in providing effective advocacy) it has put the eradication of child poverty at the very heart of its economic and fiscal ambitions. This, in itself, should have a significant impact on the health and well-being of young people. But we must caution against any complacency. All governments can find themselves knocked off course by events. Even the most competent of ministers can find themselves the victims of changing political fashions and shifting Cabinet allegiances. We must ensure that no matter how often the leadership of government in No. 10 Downing Street or a Department of State may change – whether it is Children, Schools and Families, Health, or the Treasury – the interests of children remain a constant. Never again should they be allowed to slip off the political radar screens. Never again should there be a Laming report which describes children as being invisible.

We have seen all too clearly the effects that the media, increasing commercial pressures and the explosion of technology are having on children and young people in England today. We need to value the benefits of modern society, but we must strive to ensure that children and young people are not being shamelessly exploited – to this end we must see that all the regulatory levers, even those in the hands of industry, are pulled to the best effect. We also need to learn to celebrate our children. Sadly, there is often little reference, if any, to the contributions that children and young people make to society. To change the culture away from that of demonisation and fear of children and young people will be a gargantuan, but not impossible, task. Recognising that there is a problem is the starting point.

It is now nearly 20 years since our government made a promise to children and young people through endorsing the UNCRC. The Articles that were signed up to are laudable and yet again and again we seem to be breaking these promises, and I look to government to do much more to promote the UNCRC. Despite this, as we have seen, over the last seven years there has been an impressive policy cascade to address the needs of vulnerable children and young people, leading to an historically important 'tipping point'.

This has been driven by a number of factors:

- the focus from New Labour on social inequalities and the economic capital of children
- the fury of parents in Bristol who demanded a public inquiry into the poor outcomes of infant cardiac surgery
- the conclusions of two public inquiries into the scandals of health and social care provision for children
- political impatience over continued failures in the systems of child protection, and the personal commitment of the previous Prime Minister and Chancellor of the Exchequer.

The challenge facing government now is the implementation of this internationally admired raft of legislative and policy changes. There is no quick fix and change will take time, especially against the practical obstacles to change that include the territorialism, tribalism and traditionalism endemic in the cultures of children's service providers. Ongoing commitment from all political parties for the cause of children and young people is essential, together with the sustained provision of adequate resources, particularly through the mechanism of the Treasury's Comprehensive Spending Reviews and the levers of its associated Public Serviced Agreement indicators.

"The challenge facing government now is the implementation of this internationally admired raft of legislative and policy changes."

Throughout this book I have given examples of the appalling consequences of not listening to children and young people. A pattern that has its roots in history has been repeated at family, service and policy levels and has led to unnecessary deaths, inappropriate service provision and mental and physical illness. Key to the successful implementation of policy and the renewal of services is to ensure that services address the needs and requirement of children and young people. It will be vital to make sure that the views, interests and needs of children and young people themselves are taken seriously. Young people may not have the right to vote, but they are passionate, articulate, forthright, intelligent, critical, quizzical and questioning. Their voices must be heard and their rights must be respected. They must be asked for their views and their opinions listened to, heard and respected. The enormity of the changes needed in the attitudes of adults to the proposition that children should be asked and listened to should not be underestimated.

There is a growing impatience at the pace of change, and at the persistent and continuing failures in child protection. A precious window of opportunity has opened in which to embed real change for children. The challenge for all of us – parents, communities, professionals working with children and young people, planners and policy-makers – is to make the best use of this moment: do not pass it up. Make it clear where you stand on the importance and policy priority for children and young people.

I now sense a very different atmosphere in the children's sector recently, as a result of the changes I have discussed above. There are outstanding political policies, with ministers and countless committed and knowledgeable officials in several departments of state, but particularly in the new Department for Children, Schools and Families, who are passionate about developing and delivering the agenda of Every Child Matters. The children's workforce is being increasingly led by effective directors of children's services, and individual practitioners continue to elect to work with children because of their dedication to the most vulnerable in society. The contributions from the voluntary sector need to be celebrated and built on. I do believe we have passed a 'tipping point' in the recent history of childhood in England. Social historians of the future may well look back in awe at what has happened in such a short time. Immense challenges remain, but I look forward to a society developing in England where children and young people will be actively involved in shaping all decisions that affect their lives, are supported to achieve their full potential through the provision of appropriate services, and will live in homes and communities where their rights are respected and they are loved, safe and enjoy life.

If children are our future, we are their present. Let us not fail them, and they will never fail us. So what are you going to do, friend, to make this happen?

REFERENCES

1. The 1000 Family Study website can be found at: www.ncl.ac.uk/plerg/Research/1000F/1000history.htm
2. Matthew and Laurie Taylor (2003) *What are Children For?* Short Books.
3. UNICEF (2007) *Child Poverty in Perspective: An Overview of Child Well-being in Rich Countries, Innocenti Report Card 7. UNICEF.* Innocenti Research Centre.
4. Every Child Matters: the overarching government policy for children informed by the Green Paper of the same name. Department for Education and Skills (2003) *Every Child Matters*. The Stationery Office. See: www.dfes.gov.uk/everychildmatters/
5. Hillary Rodham Clinton (1996) *It Takes a Village*. Simon and Schuster.
6. DeMause L. (1976) *The History of Childhood*. Souvenir. See also Aries P (1986) *Centuries of Childhood*. Peregrine.
7. Nicholas Orme (2001) *Medieval Children*. Yale University Press.
8. William Shakespeare (1599) *As You Like It*. Act II, Scene vii.
9. Maurice Cranston (1957) *John Locke, A Biography*. Reprinted 1985. Oxford University Press.
10. Jean Jacques Rousseau (1974) *Emile or On Education*. Translated by Barbara Foxley. J.M. Dent and Sons Ltd.
11. John Locke (1979) *An Essay Concerning Human Understanding*. Oxford University Press. See also Cleverley J and Phillips DC (1986) *Visions of Childhood – Influential Models from Locke to Spock*. Teachers College Press.
12. Friedrich Froebel (1782–1852), a German educationalist, is perhaps best known as the originator of the kindergarten system.
13. Maria Montessori was the first female physician in Italy. In 1906 she gave up both her university chair and her medical practice to work with a group of 60 young children of working parents in the San Lorenzo district of Rome. It was there that she founded the first Casa dei Bambini, or Children's House. What ultimately became the Montessori method of education developed there, based upon Montessori's scientific observations of these children's almost effortless ability to absorb knowledge from their surroundings, as well as their tireless interest in manipulating materials. Every piece of equipment, every exercise, every method Montessori developed was based on what she observed children to do 'naturally', by themselves, unassisted by adults.
14. Gillian Wagner (2004) *Thomas Coram, Gent*. 1668–1751. Boydell & Brewer Ltd.

15. Gillian Wagner *Thomas Coram, Gent*. 1668–1751.
16. James Walvin (1982) *A Child's World: A Social History of English Childhood 1804–1914*. Penguin Books.
17. James Walvin *A Child's World: A Social History of English Childhood 1804–1914*.
18. Allan Gallop (2003) *Children of the Dark*. Sutton Publishing.
19. Charles Kingsley (1863) *The Water Babies*. Macmillan.
20. Jeannie Duckworth (2002) *Fagin's Children: Criminal Children in Victorian England*. Hambledon and London.
21. Office for National Statistics (2006) *Health Statistics Quarterly no. 31. Autumn 2006: Infant and Perinatal Mortality 2005*.
22. Edward M. Brecher and others (1972) *Licit and Illicit Drugs*. Little Brown and Company. He reports that Godfrey's Cordial was a mixture of opium, molasses for sweetening, and sassafras for flavouring which was especially popular in England. In mid-19th-century Coventry, ten gallons of Godfrey's Cordial – enough for 12,000 doses – was sold weekly, and was administered to 3,000 infants under two years of age.
23. Elizabeth Barrett Browning (1974) *The Complete Poetical Works of Elizabeth Barrett Browning*. Houghton Mifflin Company.
24. Generally considered the greatest author of the Victorian period. Dickens' works are characterised by attacks on social evils, injustice and hypocrisy. He had also experienced in his youth oppression, when he was forced to end school in early teens and work in a factory. Dickens' good, bad and comic characters, such as the cruel miser Scrooge, the aspiring novelist David Copperfield, or the trusting and innocent Mr Pickwick, have fascinated generations of readers.
25. Charles Dickens (1840) *The Old Curiosity Shop*.
26. Great Ormond Street Hospital's motto is 'The Child First and Always'. What is now the internationally famous centre for child healthcare started from modest beginnings in 1852, in a converted 17th century townhouse on the corner of Powis Place. A survey in 1843 revealed that, of some 2,400 patients in all the London hospitals, only 26 were children under ten years of age; of 51,000 people dying that year in the capital, 21,000 were children under ten. It was generally assumed that children were 'expendable', and better off staying with their mothers even when seriously ill.
27. Jeannie Duckworth *Fagin's Children: Criminal Children in Victorian England*.
28. 'Respect' agenda: a cross-government strategy to tackle bad behaviour and nurture good behaviour. Established in 2005. See www.respect.gov.uk
29. Social Exclusion Task Force (2006) *Reaching Out: An Action Plan on Social Exclusion*. Cabinet Office. Sets out the work across government to improve the life chances and opportunities of the most disadvantaged and hard-to-reach people. The plan aims to reduce and prevent the harm and cost caused by social exclusion. See www.cabinetoffice.gov.uk/social_exclusion_task_force
30. Such authors include Neil Postman (1981) *The Disappearance of Childhood*. Delacorte; Phil Scratton (1997) *Childhood in Crisis*. UCL Press; Sue Palmer (2006) *Toxic Childhood*. Orion Books.
31. Greg Critser (2003) *Fat Land*. Houghton Mifflin Company.
32. Williams R (2000) *Lost Icons – Reflections on Cultural Bereavement*. T & T Clark.
33. Susan Linn (2004) *Consumer Kids – The Hostile Takeover of Childhood*. The New Press.

34. Martin Lindstrom (2003) *Brand Child – Remarkable Insights into the Minds of Today's Global Kids and Their Relationship with Brands.* Kogan Page.
35. Juliet Schor (2004) *Born to Buy*. Scribner.
36. These figures are quoted by Baroness Howe of Idlicote in a House of Lords debate on direct marketing to children on 14 January 2004. See www.publications.parliament.uk/pa/ld200304/ldhansrd/vo040114/text/40114-09.htm
37. The figures are taken from the *International Journal of Advertising and Marketing to Children*, November 2002.
38. James U. McNeal 'Tapping the Three Kids' Markets', *American Demographics*, April 1998.
39. David Siegel, Timothy Coffey and Gregory Livingstone (2004) *The Great Tween Buying Machine: Capturing Your Share of the Multibillion-dollar Tween Market*. Dearborn Trade Publishing.
40. *Let's Talk Sex*. Channel 4, 20–22 March 2006.
41. *Health Survey for England 2004. Updating of trend tables to include childhood obesity data*. 2006 See www.ic.nhs.uk
42. Department of Health (2006) *Forecasting Obesity to 2010.* The Stationery Office.
43. Greg Critser *Fat Land*.
44. Joint Health Surveys Unit National Centre for Social Research (2003) *Health Survey for England, 2002.* The Stationery Office.
45. Blake Morrison 'Life After James', *The Guardian,* 6 February 2003. See also Blake Morrison (1997) *As If*. Granta Books
46. Blake Morrison 'Life After James'. See also Blake Morrison *As If*.
47. Franklin B and Petley J (1996) 'Killing the Age of Innocence: Newspaper Reporting of the Death of James Bulger' in Pilcher and Wagg (eds) *Thatcher's Children: Politics, Childhood and Society in the 1980s and 1990s.* Falmer. See also Garland D (2001) *The Culture of Control: Crime and Social Order in Contemporary Society*. Oxford University Press.
48. See: www.crimereduction.gov.uk/violence12.htm
49. See the official Bichard Inquiry website at www.bichardinquiry.org.uk
50. *The Times*, 4 August 2007.
51. Bernard Hare (2005) *Urban Grimshaw and the Shed Crew*. Sceptre.
52. *Kidulthood*. Film released on 22 May 2006. Revolver Entertainment.
53. See Lord Herman Ouseley's report into race relations in Bradford. The former head of the Commission for Racial Equality spoke of a city 'gripped by fear', with communities segregated along racial, ethnic and religious lines and schools doing little to promote race relations. He warned that "There is a fear of people talking openly and honestly about problems because of possible repercussions, recriminations and victimisation. There is the fear of challenging wrongdoing because of being labelled racist." The full report, *Community Pride not Prejudice*, can be obtained at http://www.bradford2020.com/pride/
54. Michael Lamb's book *The Role of the Father in Child Development* (Wiley, 2004) is an excellent compendium of the research evidence of the importance in fathers in the upbringing of children.

55. Candace Currie and others (eds) (2004) 'Young People's Health in Context. Health Behaviour in School-aged Children (HBSC) Study: International Report From the 2001/2002 Survey' in *Health Policy for Children and Adolescents*, No. 4 2004. WHO. The full report can be found at www.euro.who.int/eprise/main/WHO/informationsources/publications/catalogue/20040601_1
56. UNICEF (2007) *Child Poverty in Perspective: An Overview of Child Well-being in Rich Countries, Innocenti Report Card 7*. Innocenti Research Centre.
57. Acheson D (1998) *Independent Inquiry into Inequalities in Health*. The Stationery Office. See: www.archive.officialdocuments.co.uk/document/doh/ih/contents.htm
58. UNICEF *Child Poverty in Perspective: An Overview of Child Well-being in Rich Countries*.
59. Bradshaw J and Mayhew E (eds) (2005) *The Well-being of Children in the United Kingdom*. Save the Children.
60. Teenage Pregnancy Website: www.dfes.gov.uk/teenagepregnancy
61. Brian Ferguson and others (2006) *Indications of Public Health in the English Regions: Child Health*. Association of Public Health Observatories.
62. Department for Education and Skills (2003) *Every Child Matters*. The Stationery Office. See: www.dfes.gov.uk/everychildmatters/
63. British Medical Association (2003) *Adolescent Health.* Full report available at www.bma.org.uk/ap.nsf/Content/AdolescentHealth
64. The UK Collaborative Group for HIV and STI Surveillance (2006) *A Complex Picture. HIV and other Sexually Transmitted Infections in the UK: 2006.* Health Promotion Agency, Centre for Infections.
65. See: www.bma.org.uk/ap.nsf/Content/AdolescenthealthPU
66. British Medical Association (2003) *Adolescent Health*. Full report available at www.bma.org.uk/ap.nsf/Content/AdolescentHealth
67. Children's Commissioner for England and YoungMinds (2007) *Pushed into the Shadows: Young People's Experience of Adult Mental Health*. Office of the Children's Commissioner.
68. Office for National Statistics *Living in Britain: Results from the 2002 General Household Survey.*
69. Department for Work and Pensions (2003) *Households Below Average Income 1994/95–2003/04.* See: www.dwp.gov.uk/asd/hbai/hbai2004/contents.asp
70. David Gordon (2000) *Disabled Children in Britain: A Re-analysis of the OPCS Disability Survey.* The Stationery Office.
71. Neera Shama (2002) *Still Missing Out? Ending Poverty and Social Exclusion: Messages to Government from Families with Disabled Children.* Barnardo's.
72. Joint Health Surveys Unit National Centre for Social Research (2003) *Health Survey for England, 2002*. The Stationery Office.
73. Green H and others (2005) *Mental Health of Children and Young People in Great Britain, 2004.* Palgrave Macmillan. Summary report available at www.statistics.gov.uk
74. Gabrielle Preston (2005) *Helter Skelter: Families, Disabled Children and the Benefit System. CASE paper 92.* Centre for Analysis of Social Exclusion, London School of Economics.
75. Gabrielle Preston *Helter Skelter: Families, Disabled Children and the Benefit System.*
76. Audit Commission (2002) *Special Educational Needs: A Mainstream Issue*. Audit Commission.
77. Henrietta Spink (2004) *Henrietta's Dream*. Hodder and Stoughton.

78. David Gordon *Disabled Children in Britain: A Re-analysis of the OPCS Disability Survey.*

79. Green H and others (2005) *Mental Health of Children and Young People in Great Britain, 2004.*

80. Lyon J, Dennison C and Wilson A (2000) *Tell Them So They Listen: Messages from Young People in Custody*. Home Office Research Study 201. The Home Office.

81. British Institute for Brain Injured Children (2000) *Ain't Misbehavin': Young People with Learning and Communication Difficulties and Anti-social Behaviour.* See: www.bibic.org.uk

82. The Mental Health Foundation (2002) 'The Mental Health Needs of Young Offenders', *Updates* Volume 3, Issue 18.

83. Office of the United Nations High Commissioner for Human Rights (1989) United Nations Convention on the Rights of the Child.

84. See CRAE website at: www.crae.org.uk

85. Office of the Children's Commissioner (2006) Ipsos Mori poll available at www.ipsos-mori.com/polls/2006/occ.shtml

86. Kennedy I (2001) *Learning from Bristol: The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984–1995.* HM Government UK. See www.bristol-inquiry.org.uk/

87. *The Victoria Climbié Inquiry.* The Stationery Office, 2003. www.nationalarchives.gov.uk/ERO/records/vc/1/1/index.htm

88. See the BBC's Health Correspondent Daniel Sandford's reflections on why Kennedy was so important to the future of the NHS at http://news.bbc.co.uk/1/hi/health/1443081.stm

89. www.bristol-inquiry.org.uk/final_report/report/sec2chap29_4.htm

90. Ministry of Health, Central Health Services Council (1959) *The Welfare of Children in Hospital*. (The Platt Report). HMSO.

91. *Fit for the Future: Report of the Committee on Child Health Services* (Cmnd 6684) (The Court Report). HMSO, 1976.

92. The Audit Commission (1993) *Children First: A Study of Hospital Services*. Audit Commission.

93. *Hospital Services for Children and Young People, House of Commons Health Select Committee, (Session 1996–97) Fifth Report*, 1997. HMSO.

94. Aynsley-Green A and others (2000) 'Who is Speaking for Children and Adolescents and For Their Health at the Policy Level?', *British Medical Journal* 321; 229–232.

95. *The Victoria Climbié Inquiry*. The Stationery Office, 2003. www.nationalarchives.gov.uk/ERO/records/vc/1/1/index.htm

96. Department of Health (2004) National Service Framework for Children, Young People and Maternity Services.

97. The Health Committee (1997) *The Health Committee: Second Report. The Specific Needs of Children and Young People. Volume One*. The Stationery Office.

98. See BBC report at http://news.bbc.co.uk/2/hi/health/4672948.stm

99. Department of Health (2002) *Shifting the Balance of Power: The Next Steps*. The Stationery Office. www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4008424&chk=JxswvF

100. Commission for Healthcare Audit and Inspection (2007) *Improving Services for Children in Hospital*. Commission for Healthcare Audit and Inspection.

101. Shribman S (2007) *Children's Health Our Future – A Review of Progress Against the National Service Framework for Children, Young People and Maternity Services 2004*. Department of Health.
102. The work of Don Berwick at the Institute for Healthcare Improvement can be found on www.ihi.org/ihi
103. Kennedy I *Learning from Bristol: The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984–1995*.
104. The Human Early Learning Partnership (HELP) is an interdisciplinary research partnership that is directing a world-leading contribution to new understandings and approaches to early child development. HELP is a network of faculty, researchers and graduate students from British Columbia's four major universities. See: www.earlylearning.ubc.ca/
105. Miranda Wolpert and Bob Foster (2005) 'CAMHS in England 2005: A Picture of Progress?' *YoungMinds Magazine* 78.
106. This is an annual data collection exercise, initially focusing on children's health services provided by primary care trusts, secondary and tertiary care providers, although some information is asked of the voluntary and independent sectors. See www.childhealthmapping.org.uk/
107. Association of Public Health Observatories (2006) *Indications of Public Health in the English Regions 5: Child Health*.
108. Children's trusts – these will bring together all services for children and young people in an area, underpinned by the Children Act 2004 duty to co-operate, to focus on improving outcomes for all children and young people. People will work in effective multi-disciplinary teams, be trained jointly to tackle cultural and professional divides, use a lead professional model where many disciplines are involved, and be co-located, often in extended schools or children's centres.
109. Department for Education and Skills (2006) *Higher Standards, Better Schools for All*.
110. Department of Health (2007) *Commissioning Framework for Health and Well-being*. Department of Health.

APPENDIX

The United Nations Convention on the Rights of the Child: Articles 1–42

The Convention has 54 Articles in all. Articles 43–54 are about how adults and governments should work together to make sure all children get their rights.

Article 1: Everyone under 18 years of age has all the rights in this Convention.

Article 2: The Convention applies to everyone, whatever their race, religion, abilities; whatever they think or say, whatever type of family they come from.

Article 3: All organisations concerned with children should work towards what is best for each child.

Article 4: Governments should make these rights available to children.

Article 5: Governments should respect the rights and responsibilities of families to direct and guide their children so that, as they grow, they learn to use their rights properly.

Article 6: All children have the right to life. Governments should ensure children survive and develop healthily.

Article 7: All children have the right to a legally registered name and nationality. Also the right to know and, as far as possible, be cared for by their parents.

Article 8: Governments should respect children's right to a name, a nationality and family ties.

Article 9: Children should not be separated from their parents unless it is for their own good. For example if a parent is mistreating or neglecting a child. Children whose parents have separated have the right to stay in contact with both parents, unless this might hurt the child.

Article 10: Families who live in different countries should be allowed to move between those countries so that parents and children can stay in contact, or get back together as a family.

Article 11: Governments should take steps to stop children being taken out of the country illegally.

Article 12: Children have the right to say what they think should happen when adults are making decisions that affect them, and to have their opinions taken into account.

Article 13: Children have the right to get and to share information as long as the information is not damaging to them or to others.

Article 14: Children have the right to think and believe what they want, and to practice their religion as long as they are not stopping other people from enjoying their rights. Parents should guide their children on these matters.

Article 15: Children have the right to meet together and join groups and organisations as long as this does not stop people from enjoying their rights.

Article 16: Children have a right to privacy. The law should protect them from attacks against their way of life, their good name, their families and their homes.

Article 17: Children have the right to reliable information form the mass media. Television, radio and newspapers should provide information that children can understand, and should not promote materials that could harm children.

Article 18: Both parents share responsibility for bringing up their children and should always consider what is best for each child. Governments should help parents by providing services to support them, especially if both parents work.

Article 19: Governments should ensure that children are properly cared for, and protect them from violence, abuse and neglect by their parents, or anyone else who looks after them.

Article 20: Children who cannot be looked after by their own family must be looked after properly by people who respect their religion, culture and language.

Article 21: When children are adopted the first concern must be what is best for them. The same rules should apply whether the children are adopted in the country where they were born, or if they are taken to live in another country.

Article 22: Children who come into a country as refugees should have the same rights as children born in that country.

Article 23: Children who have any kind of disability should have special care and support so that they can lead full and independent lives.

Article 24: Children have the right to good quality healthcare, to clean water, nutritious food and a clean environment so that they will stay healthy. Rich countries should help poorer countries achieve this.

Article 25: Children who are looked after by their local authority, rather than their parents, should have their situation reviewed regularly.

Article 26: The Government should provide extra money for the children of families in need.

Article 27: Children have a right to a standard of living that is good enough to meet their physical and mental needs. The Government should help families who cannot afford to provide this.

Article 28: All children and young people have a right to a primary education, which should be free. Wealthy countries should help poorer countries achieve this. Discipline in schools should respect children's human dignity. Young people should be encouraged to reach the highest level of education they are capable of.

Article 29: Education should develop each child's personality and talents to the full. It should encourage children to respect their parents, and their own and other cultures.

Article 30: Children have a right to learn and use the language and customs of their families, whether these are shared by the majority of people in the country or not.

Article 31: All children have a right to relax and play, and join in a wide range of activities.

Article 32: The Government should protect children from work that is dangerous, or might harm their health or their education.

Article 33: The Government should provide ways of protecting children from dangerous drugs.

Article 34: The Government should protect children from sexual abuse.

Article 35: The Government should make sure that children are not abducted or sold.

Article 36: Children should be protected from any activities that could harm their development.

Article 37: Children who break the law should not be treated cruelly. They should not be put in prison with adults and should be able to keep in contact with their families.

Article 38: Governments should not allow children under 16 to join the army.

Article 39: Children who have been neglected or abused should receive special help to restore their self-respect.

Article 40: Children who are accused of breaking the law should receive legal help. Prison sentences for children should only be used for the most serious offences.

Article 41: If the laws of a particular country protect children better than the Articles of the Convention, then those laws should stay.

Article 42: The Government should make the Convention known to parents and children.