

Welcome



I am very pleased to welcome you to the February 2013 edition of Childhood Remixed—the first online interdisciplinary journal emerging from University Campus Suffolk (UCS). This exciting and innovative production seeks to investigate and explore many aspects of childhood and bring together people from different areas, backgrounds and interests to share ideas and explore various aspects of childhood.

Whilst children make up one third of all humanity, up until quite recently they have not featured centrally in academic study and we know surprisingly little about them. The aim of Childhood Remixed is to capture emerging debates about children and engage intellectually with a range of topics relating to children.

The contributions to Childhood Remixed span across three of the five schools within UCS. The examinations of childhood within this edition of the journal embrace a variety of interdisciplinary approaches, the journal will open up discussion about childhood and children's lived experience. The aim of the journal relates closely to the wider vision of UCS where staff and students in areas such as science, art, business and education can interact in new ways to help to establish UCS as a recognized and respected force in this area.

Professor Simon Hallsworth

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A note on referencing

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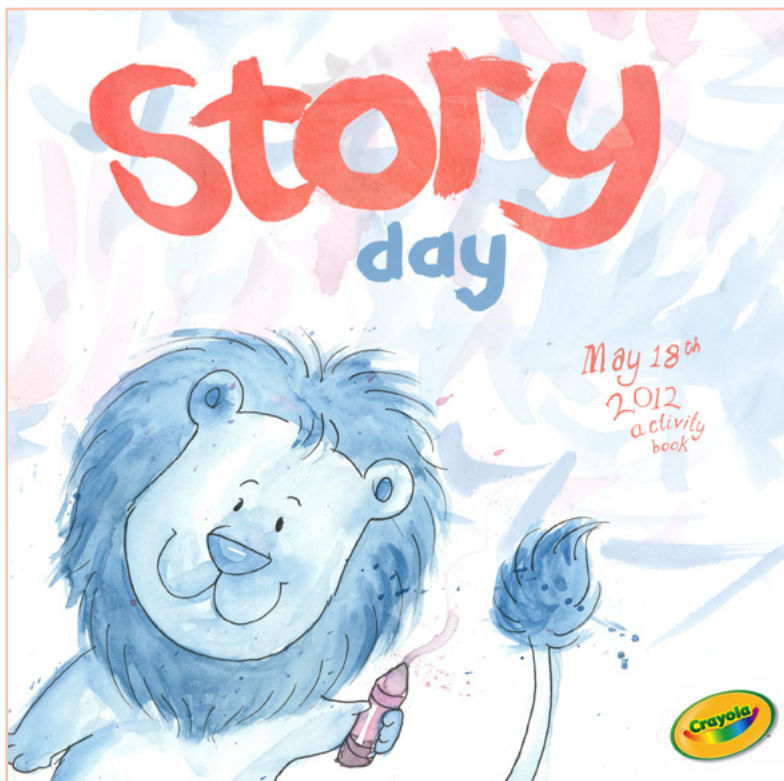
Jade Redford School of Arts & Humanities

Jade Redford is a third-year student of BA (Hons) Graphic Design (Graphic Illustration). She has a particular love for illustration, with her own work usually involving ink or watercolour. Having a popular online following, she regularly receives commissions from admirers of her work. Jade has contributed to IP1 magazine, and has been featured in public displays and exhibitions at UCS. With a strong interest in children's and book illustration, she hopes to develop her skills and style into a career as an illustrator.

Story Day

Abstract

As a student of (BA Hons) Graphic Design (Graphic Illustration), much of my course focuses on solving problems through the medium of drawing and design. At Level 5 we were given a 12-week project brief to create our own commemorative day, so I began by researching into the most well-known days, such as Birthdays, Christmas Day, memorial days etc. However the freedom of the project allowed me to explore something I am very interesting in, which is children's book illustration. It is an enjoyable way to make images and tell stories, co-operating with the text to teach and entertain children as well as adults. From this idea, I began creating my own commemorative day for story books, simply called 'Story Day'.



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As a child, my favourite books were 'Mog the Cat' and 'The Tiger Who Came to Tea', both by Judith Kerr. A big part of it was the illustrations and how she captured the expression of the characters, and books like that influenced me to start drawing. When researching commemorative days, I came across ones such as Roald Dahl Day, World Book Day and Children's Book Week, which inspired me to take the opportunity to explore children's illustration and something educational. I decided to create a commemorative day for children's storybooks, which is to promote reading and being creative. To do this I had to decide through my research, three or four final outcomes to promote this day. My main product was of course, a storybook, but it also doubled as a small activity book for children intended to be given out to primary schools. I also made a hand-drawn animation, an A2 poster and a website, which all linked with each other through matching design and illustration. The intended audience for this day would be early readers (aged around 4 – 7), their parents and school teachers, considering it is meant to be something that is set in school.

To help make 'Story Day' memorable and recognisable, particularly to children, I set upon creating a mascot. I began using popular and well-loved animals amongst children, such as dogs and cats, but I wanted to use something less domestic and more imaginative. I tried experimenting with designing a fantasy creature, such as a dragon and gryphon, but that went too far the other way. After rejected ideas and receiving feedback, I ended up with an animal from wildlife; a lion. A lion seemed appropriate because I noticed children's character's had similar traits; they were usually anthropomorphised animals (animals with human characteristics). To draw upon a few: Winnie the Pooh, Tom & Jerry, Donald Duck, Elmer the Elephant and The Cat in the Hat. I believe this is simply because children see animals, even a lion, as 'cute', interesting, and they have a good imagination. They can also make for more interesting, diverse character designs, and be appealing for both boys and girls.

This is Lester the lion. He lives in the Savannah, a large land with lots of grass, and the weather is very hot.

One morning, Lester was resting under a tree to get some shade from the sun. Soon, the sun was so bright he decided to get up and go for a walk.



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To illustrate the character, I took inspiration from some great children's illustrators, such as Quentin Blake, who illustrated the Roald Dahl books. I felt that watercolour had a soft, textured and human quality that would appeal to children, and since the day is about stories and being creative, a digital approach would seem to contradict it. The lion is blue because I found this to be a popular favourite colour amongst children, and even though it can be more associated to boys, the tone of the character is not too masculine. The title 'Story day' is red to contrast the blue.

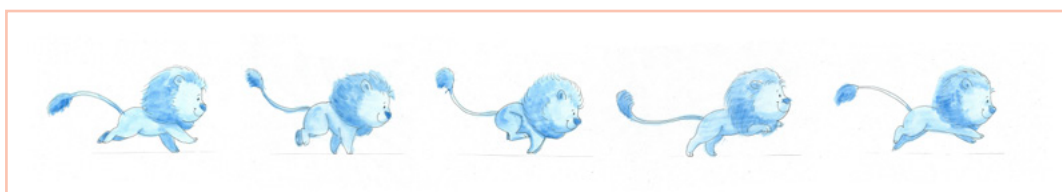
The actual book itself is something that would be given to school teachers to hand out to the children on this particular day. The cover of the book has the lion character holding a crayon, once again enforcing the element of drawing and writing. Also, it relates to the day's 'sponsor' Crayola, who I thought would make a good partner for the day because their products are all about creating images, and are directed at a similar age group. The book itself is just 16 pages long, the first half being a story and the second being small activities. The story is very simple, and I took inspiration from books such as Elmer the Elephant, and it is essentially the lion character stumbling upon some blue paint amongst the middle of a yellow Sahara. I chose a narrative that is easy to follow and includes the theme of colour and mark-making, relating to the creative aspect of the day.

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The secondary product of 'Story Day' was a very short animation, designed to be something that could be shown on TV or as an internet advertisement. Once again I used the lion mascot to keep with the continuity, and hand-drew each frame with watercolour as I had done with all the images. My main inspiration for the animation was from Roobarb and Custard; I liked the rough, innocent and child-like manner of the illustrations which were made with marker pen. The lines were constantly moving, which is called 'boiling.' This style of animation is something I thought I could achieve and would be appropriate for a short sequence. In the animation the lion runs across the screen, so I had to research into animal running sequences, and my main reference was actually a Disney run cycle for a dog as it required just 5 frames. It still took many attempts before I managed to get it right.

The strongest points of this project are the book and animation, since they were the most time consuming to complete. The weakest was the website, as I spent the least amount of time on it. However, the website was focused almost solely on appealing to the adults who visited it while still keeping the identity of the day, so it doesn't quite fit with the rest of the products as well as it could have. I think the end result of the project successfully did what I originally planned, which was to promote 'Story Day'; the branding of the logo and mascot remain the same in all the products which makes them recognisably linked. 'Story Day' was to commemorate storybooks and inspire children to be creative, so I hope I managed to reflect that important and fundamental part of childhood.



Sue Middleton School of Applied Social Sciences

Sue graduated from UCS in 2007 with a degree in Early Childhood Studies with Psychology, and is currently studying on the MA Childhood & Youth Studies course at UCS. She had ambitions to pursue a career in the nursing profession but family commitments lent themselves well to part-time undergraduate and post-graduate studies instead. Sue is a qualified counsellor and has a wealth of experience of working with a number of different client groups, ranging from the RNIB; the Ipswich Women's Refuge; Bath Health Authority with adults with complex needs; Anchor Housing for the elderly and with young children with disabilities.

Sue has a personal interest in the holistic management of life-limiting and progressive illness and has been a volunteer with St. Elizabeth's Hospice in Ipswich for nearly 3 years. Recently, she joined their Home Visiting team and visits patients and their families in the community post referral, who are in need of social support in dealing with their situation. For her MA dissertation, she is researching sibling experiences of having brothers and sisters with a life-limiting or life-shortening diagnosis.

With support from EACH, the children's hospice network in Suffolk, she is currently undertaking a phenomenological study of the lived experiences of siblings, through which their voices can be heard and their lives from their perspectives, understood.

To what extent are the rights of the child acknowledged and realised within the diagnosis and treatment of life-limiting illness within the UK?

Abstract

Since the United Nations Convention on the Rights of the Child [UNCRC 1989], children's rights have become more visible within academic sociological studies of the contemporary agentic child, and their lived childhood experiences. However, acknowledgement of children as bearers of rights can be considered challenging against a backdrop of post-modern discourses, together with associated historical and social ideologies. This paper considers the rights of the child and the extent to which they can be realised in the diagnosis / treatment of life-shortening and progressive illness. Difficulties can be observed in terminology of UNCRC vocabulary such as "best interests", and also in the conflicting yet dominant discourses

of both parents and professionals. Thus, the status of the unwell child is considered within the overarching rights convention, together with dichotomies of their perceived competence or incompetence, lack of advocacy and whether they are permitted to 'be' if their futurity, their transition to adulthood is unlikely. The paper concludes that whilst the rights of a child with a life-shortening diagnosis can be realised to some extent, acknowledgement of children's participatory rights and as active participants living with illness is key to developing future practice to reflect the child's perspective, thereby giving children a voice independent of its situated familial context.

Recently, a mother's refusal to consent to the accepted treatment for her son Neon Roberts, diagnosed with a second medulloblastoma brain tumour dominated the news. Undoubtedly, such a condition with or without treatment is considered both life-threatening and life shortening. However, the focus has remained upon the mother's refusal to subject her son to high levels of radiotherapy to prolong his life. Her decision was overruled in the High Court, where professional and legal evidence concluded the treatment was essential. Occasional references of ensuring Neon's 'best interests' are recognised have been made, yet his voice has been apparently absent from the on-going battle between parent and state, private and public. This specific context lends itself to further consideration of the extent to which the rights of the child can be realised within the diagnosis and treatment of life-limiting conditions (henceforth LLC's) within the UK. The ways in which children have been ascribed power and agency yet denied both by adults has been demonstrated widely (Green, 2010), and may prevail under the guise of "parental protectiveness" (Young et al., 2008, in Green 2010: 81) and conceptions of 'childhood' which positions children as requiring welfare and protection are frequently apparent (ie: Children Act 1989). Subsequently, this discussion considers children's rights within aspects of paediatric palliative care (henceforth PPC), the primary aim of which is to preserve both the child's dignity and quality of life throughout an incurable illness.

The subjective terms 'quality of life' and "best interests" of the child are considered within the framework of the United Nations Convention on the Rights of the Child (1989, henceforth UNCRC), together with other rights conventions where applicable. Children with LLC's can be classified into four varying groups; (i) life threatening conditions where curative treatment may be feasible but can fail, (ii) conditions where premature death is inevitable, and there are long periods of intensive treatment aimed at prolonging life, (iii) progressive conditions without curative options where treatment will be exclusively palliative and (iv) irreversible but non-progressive conditions leading to health complications and possible premature death (International Children's Palliative Care Network

henceforth ICPCN 2011, online).

The government paper, “Better Care; Better Lives” (DOH, 2008) negates issues of children’s rights but identifies its vision as a ‘children first’, needs-led, problem solving approach, focusing upon healthcare, education, children’s services and voluntary sector to meet the needs and rights of children with LLC’s requiring PPC to facilitate the child leading a full life. In reality, the range of illnesses and symptoms are considered problematic in terms of predicting and planning for individual care needs. Whilst emphasis remains upon the needs of the child herein, the child is located within the family and this assumption is reflected in plans for future integration of services, to meet the needs of families for who support with their child’s complex care issues will not reduce over time.

Current post-modern discourse concerning children and childhood underpins the discussion hereafter, considering historical and social ideologies resulting in the emergent paradigm of social constructionism where children are considered active social agents, competent and capable in exerting influence over their changing circumstances (Robb, unpublished in Foley et al., 2001). Recognition of the child as a social actor underpins modern Western discourses of childhood and is essential to their constitution within the sociological study of children and childhood. The child is no longer the passive recipient of social processes or structure (Smith, 2010).

Children actively participate in society and influence decisions, relationships, and the mechanisms of “social assumptions and constraints” (Mayall, 2002 in Qvortrup et al., 2011:34). Fundamental to their active participation are their relationships with wider social structures which present both opportunities and limitations. Thus, a revised paradigm has emerged which concedes to their agency and changing position within society (James, 2009, in Qvortrup et al., 2011), and to a “competence paradigm” within which the child is no longer regarded through the lens of inadequacy or incompetence (Hutchby and Moran-Ellis, 1998:8).

Issues of competence within children with LLC’s were debated at the ‘Rights of The Child’ Conference by Kidson, who concluded that ‘competence’ remains ambiguous and subjective (see ACT, October 2011, online). The assumption that the child is becoming competent should facilitate their role within any decision-making process relating to them (Richardson, 2011, in Brykczynska and Simons, 2011) and therefore, the inclusion of children within the decision-making process shapes their lives and has potential to reduce helplessness and powerlessness (Attig, 1996, in Roderiguez 2009). Of interest here is the underlying sense that children, such as Neon Roberts, are denied their role within the decision making process of treatment, thereby challenging the academic and child rights agenda of competence and autonomy.

Notions of 'being' or 'becoming' dominate modern discourses of children and childhood. Referring to children as 'becoming' suggests "a journey towards a clear and knowable destination", to adulthood, and thereby relegates childhood to a mere phase of transition (Lee 2001:7). Such a view conceptualises children as incomplete, unfinished, and dependent, thereby alluding to reliability upon the competence of others. For the LLC child, the nature of their illness implies the journey will not be complete, and the destination of stability, independence and competence associated with adulthood is unachievable. Arguably, if an incurably ill child is truly in a state of 'being' not 'becoming' then issues of futurity are threatened, as a healthy progression towards adulthood seem unlikely.

However, children can be competent without being independent and they should be assisted in making valid contributions to the relationships which affect their lives (Leeds, 2005 in Loreman, 2009). The Children's Rights Alliance for England (CRAE, 2010) suggest that the perceived vulnerability of children has facilitated the drafting of a human rights treaty by the international community between 1979-1989 encompassing numerous 'substantive rights' including economic, political, social, cultural and civil. The outcome was UNCRC bespoke in prioritising the rights of children. However a decade later, a review by the House of Lords Joint Committee 2008-2009 declared "a general climate of intolerance and negative attitudes" towards children prevails within the UK (CRAE 2011, online).

Indeed, both UNICEF and CPAG suggest child rights are neither promoted nor respected adequately within the UK. Burman (1996, in Montgomery 2009) posits that the UNCRC concedes every child has the right to liberty, shelter and freedom of expression. Yet such notions of children as autonomous competent individuals originate from Western, liberal humanist philosophy and are therefore incongruous with other societies. Subsequently, whilst 194 countries ratified the UNCRC, this 'universal' convention emerges as culturally relative. Undoubtedly, UNCRC is a comprehensive convention emphasising the importance of children as full human beings in ways the Declaration of Human Rights (1948, online) overlooked. Nevertheless, the criticism that UNCRC implicitly upholds western cultural values, portraying them as universal and demonstrating little regard for other cultures seems justified.

As a convention encompassing 54 Articles relating to every aspect of life for a person under 18 years, UNCRC emphasises protection, provision, prevention, and participation, thereby acknowledging a shift from child needs to child (human) rights (Kehily 2004), and from "human body to social beings" [Williams 1991, in Qvortrup et al., 2011;377]. Indeed, UNCRC has been described as an advocacy tool, promoting children's welfare through the lens of justice not charity (Veerman 1992; 184). However, the accomplishments and short-comings of UNCRC (1989) in meeting

expectations and improving the lives of children in the 21st century must be examined alongside the extent to which the convention can empower the lives of children with LLC's portrayed as vulnerable, innocent, dependent and incompetent human beings.

Participation is fundamental within UNCRC. Article 12 purports to give every child the right to express their views in relation to all issues that affect them. This Article recognises the inherent worth of children, advocating respect, dignity and participation within the context of decision-making. In 2009, the committee on The Rights of The Child, commented on the child's right to be heard, concluding a child rights approach to participation ensures children are placed at the forefront of initiating action and change. However, children often face barriers which impact upon their decision-making such as levels of understanding, circumstances, social status or even their individual vulnerabilities which will inevitably impact upon their ability to participate effectively.

Recently, Bluebond Langner (ACT Rights of the Child conference 2011, online) emphasised the need to focus upon the children and families at the centre of PPC. She questioned how children can be effectively involved in decisions affecting their care and what role should they take. Their involvement, despite the complex and emotionally difficult issues, is widely agreed, and is supported by the General Medical Council (online); "You should encourage young people to involve their parents in making important decisions but you should abide by any decisions they have the capacity to make themselves."

Bluebond Langner (2011, online) proposed professionals should focus upon maintaining a meaningful engagement with both the child and family according to the social and cultural contexts in which the decision is being made, whilst allowing for the child's capabilities and understanding of their illness. The child is considered as capable of weighing up the options and making an informed decision. The 'best interests' of the child are protected, paternalism prevails, and the concept of 'child' is portrayed as a rational human being. Nevertheless, this view is essentialist and fails to consider the rights of the child, especially participation. Alternatively, a preferred context for decision-making is where the child is recognised as a social actor, capable of demonstrating social agency.

Empowering children via their participation in decision-making processes has potential to be harmful in situations where children may choose less beneficial options regarding their treatment and therefore jeopardise the necessary pathway for their illness. Nonetheless, Bluebond Langner (2011, online) suggests what usually happens is that children exercise autonomy but tend to defer to their parents thereby participating in what could be perceived as a decision taken by the family amidst anxiety that through their sole participation the child may choose badly. However, evidence suggests children tend to defer to their parents, thinking they

may know best and make the same decision (Bluebond Langner 1979, Alderson 2000). This does not mean that the decision is not autonomous. Social conforming does not equate to non-autonomous but it is indicative of social relationships being the biggest predictor of decision-making. The child/parent relationship must be respected; the child can have a role within the decision-making but the decision should not be theirs alone. Alderson (2000:114) refers to UNCRC, and English law in respecting children as the 'main decider' in personal decisions if they understand the relevant information and can act in their 'best interests'.

Conversely, for the LLC child who is not competent to play a role in the decision-making process it is very different. Kidson (2011, online) speaks of the difficulties in assessing competence in such children within a decision-making capacity and also in terms of acting in the child's 'best interests', fundamental to UNCRC and outlined in Article 3. Still, Alderson (2000) suggests a child too unwell or too young to contribute verbally to personal health care decisions may exert influence through body language and emotional expression. Undoubtedly, one of the core principles of UNCRC is its devotion to the 'best interests' of the child and this consideration is reflected widely (UNICEF 2011, online). The GMC (2007) states doctors should always act in the 'best interests' of children and young people' but acknowledges identification of 'best interests' is problematic, especially where suggested treatments may not be proven or in cases where treatment is refused despite being considered in their medical interests. Article 3.1 reflects Children Act 1989 where the child's welfare is of paramount importance, yet throughout UNCRC, 'best interests' are presented as a requirement not a right, through "maximising and unfeasibly demanding language" where definitions of 'best' remain vague (Archard, 2009:62). Thus, 'best' for the child is in reality a question of moral relativism, resulting in the 'best interests' principle appearing subverted and problematic.

Traditionally, a child's 'best interests' have been viewed from adult's perspectives in terms of what is 'best' (Lansdown 2000). Children are not expected to make serious decisions and balance out risk with benefits, yet Alderson (2000) and Butler (1998, in Alderson 2000) show children are able to process thoughts critically and logically, and demonstrate complex thinking in some instances.

Research shows it is rare for a child to go against adult advice (Alderson, 1992 in Mayall, 1994), but of overall importance is consideration of the child's competence, and the extent to which they want to be involved and informed. Nonetheless, Lansdown (2000) recognised significant implications in giving utmost consideration to the child's 'best interests' in terms of decisions affecting individual children, the nature of their treatment, its application and side effects. Clearly, UNCRC challenges health professionals by imposing obligations and standards which ensure

its principles are promoted. Children's rights generate obligations and responsibilities which must be honoured if the child is to be regarded as a bearer of rights and included in the decision-making process.

Whilst the new social studies of childhood theoretically affords children an evolving status of citizenship thereby recognising their emergent social, moral and political competence, ensuring the participation of children with LLC's can be challenging for professionals and parents as their participation is dependent upon diagnosis, communication issues and the health of the child (Council for Disabled Children 2011). Fundamental to UNCRC, Article 12 acknowledges children with the right to be heard yet there is no obligation in health legislation to listen to the children and take account of their views (Lansdown 1994). Presiding over the Gillick case (1985), Lord Scarman noted parental rights yield to the child's rights to form their own decisions when they reach sufficient understanding, intelligence, and competence assumed to be 16 (Kidson, 2011) but even where a child is considered competent, their understanding of the circumstances cannot be objectively observed only implied (Shaw 2001). Nevertheless, Article 12 is ambiguous in suggesting children are given the right to express their views with "due weight", as competence should not be an issue if the right is unconditional (Alderson and Montgomery, 1996).

Therefore, the sharing of information with children to encourage cooperation, participation and gain their informed consent is of fundamental importance as Alderson (1993:13) explains, "self-determination is the key to all rights". The right to choose is crucial to being a rights holder yet paradoxically, if a child refuses consent to treatment, the decision can be overridden by the parents and the courts if necessary in order to promote the child's welfare, as recent events have demonstrated. For children with LLC's and their families, their lives are uncertain and often lived in an isolating cycle of crisis and survival unlike other families. Following diagnosis, they face the reality of living with a LLC including an acute deterioration of the child's condition as the disease reveals itself as "relentless" (Menezes 2010 : 44). Subsequently, services responsible for the delivery of PPC should aim to achieve for the child a good life and a good death.

Within existing literature, child perspectives are absent and only limited explorations in capturing how young people with LLC perceive their lives are available (see Taylor et al., 2008 and Rodgeriguez 2009). Whilst many key articles in UNCRC are implicitly reflected within the literature, complex issues are further complicated by ethical considerations and individual circumstances within which a dominant discourse does not emerge and the rights of the child outlined in UNCRC within this context can only be realised to a limited extent. As discussed here UNCRC has the potential to impact upon LLC children, but the situation can be only be improved with further qualitative research to comprehend the needs

of the children with an LLC from their perspectives. Existing studies consider the child as a passive recipient of health care provision, not as the 'being' agentic child, and one of the primary difficulties emerging from the literature is the difficulty in obtaining the child's perspective, possibly because of the nature of their illness restricts their participation. The ability to communicate successfully with non-verbal and/or cognitively impaired children must be considered and reflected further (EAPC, 2011).

It would seem UNCRC functions as an organising framework, but conflict between the 'best interests' for the child and those of the family and professionals are evident, together with limited opportunities for participation. Unquestionably, children are located within their family, their unit of care (EACP, 2007), therefore palliative care teams address holistically the physical, psychological, emotional, spiritual and social needs of the child and family. For the child with an LLC, their interaction with health care provision and PPC is entirely dependent upon the decisions of adults; their location within the family experiencing a myriad of emotions including denial and grief leaves them powerless with very few real choices, thereby suggesting difficulty in regarding the impact of UNCRC as a positive influence within their lives.

Thus, it seems the conclusion must be one which concurs with early socio-historical theories of childhood where children were marginalized and invisible within their families, in need of protection and provision. For the children living with an LLC, their treatment is holistic and multi-disciplinary, limited proof of their ability to exercise agency or control within their lives is apparent. Thus, evidence suggests reliance upon parents to report on and represent their child reflects perceived doubt in children's abilities. Children's involvement with their PPC tends to be limited, although there is some evidence which demonstrates both their insight and perception. Tebbitt (2007) recognises the importance of involving both family and child in care plans, but argues research would be better informed if the voices of children were heard formally or informally via child-appropriate methods of feedback and collated into statistical and qualitative data generated providing it is ethically robust. Thus, it seems children's rights can be realised only to a limited extent, but PPC is a relatively recent phenomenon and, as the interest in fostering meaningful participation with children in the shifting research paradigm grows, with further child-centred research there is scope for the situation to progress, and improve the situation for children like Neon Roberts.

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I graduated from University Campus Suffolk achieving a grade of a 2:1 in BA (Hons) Early Childhood Studies in 2012. I am now studying at the University of Essex for a Masters in Sociological Research within the Department of Sociology. I am hoping to move onto PhD study next year and my research interests are in the sociology of the debate around the sexualisation of childhood and the perceived loss of innocence. I currently work part time in the UCS Ipswich library. My eventual career goal is to become a lecturer/researcher. This article was adapted from a final year essay, written in March 2012.

Education in transition: A critical analysis of the transition from communism to capitalism after the end of the cold war, how has it impacted on the education system in Russia?

This article explores the education system in Russia, concentrating on pre-school and primary education. The system is evaluated on a historical and contemporary comparison between today and under communist rule during the Cold War. The twentieth century was dominated by an ideological battle between Communism and Capitalism, after World War II this battle intensified and resulted in the Cold War. The Cold War was an ideological battle of East versus West, the world's two 'Superpowers,' the USA and the USSR were in ideological opposition (Heywood 2011: 38).

The Cold War was considered 'cold' because the ideological tensions did not result in a full scale military war; although there was a fear of nuclear war, the height of this was the Cuban Missile Crisis in 1962. The Cold War officially ended in 1990 and in 1991 the Soviet Union collapsed (Heywood 2011: 41).

In the mid-twentieth century there was a powerful upsurge in the Russian education system which raised it to a world-leadership position (Andreev 2009: 20). Throughout this period the education system was very effective in reforming the outcomes of the Russian people by eradicating

illiteracy, training a work force, growing the scientific potential of the country, and providing universal education (Borisenkov 2007: 6). The Soviet School system focused on natural sciences and mathematics as vital to future success; consequently by the 1960s the system was considered world-leading for the outcomes it produced (Borisenkov 2007: 7). The Soviet system was considered world-leading not only for educational outcomes but also in terms of the attention it gave to the upbringing of children which was viewed as a state responsibility, this can be seen through its excellent pre-school education and provision (Borisenkov 2007: 7).

Soviet rule came into effect in 1917 after a revolution which overthrew the Tsarist autocracy; the perception is that prior to this was a period of 'darkness' with near total illiteracy, with the period after 1917 being categorised as a "flowering of enlightenment" and the Soviets are often wholly credited with these reforms (Andreev 2009: 21). However prior to this there were educational reforms taking place; in the 1880s there was a drive to teach literacy to 'peasants,' by 1889 there was over nine-thousand peasant schools demonstrating a rapid period of development (Andreev 2009: 24). Andreev (2009: 24) argues that this paved the way for education reforms in the Soviet era and acted as a 'revolution before the revolution'; therefore the cultural revolution of Russia cannot be attributed purely to Soviet rule.

Borisenkov (2007: 7) acknowledges the many successes of the Soviet school system but also pays consideration to the discerning contradictions in the systems development; arguing that there was total domination over the administration of the schools, indoctrinating the communist ideology in the teaching and upbringing of its children. Education was one of the ways the common people were indoctrinating into the benefits of the communist system (The Stalin Project 2008). The education system was not set up with the aim of encouraging individuality but of universal averaging and unification of thought to accomplish the social mandate (Holowinsky 1985: 139)

Borisenkov (2007: 8) further argues that although the education system provided people with knowledge it did not teach practical skills, which meant that graduates lacked initiative and independence. Soviet education was designed to promote uniformity and until 1988 was subject to a strict curriculum that offered no flexibility in pedagogy and was orientated towards a 'typical' child with no room for differentiation depending on individual abilities or needs. This philosophy extended through all the levels of the education system (Borisenkov 2007: 8; Holowinsky 1985: 139). From 1962 to 1985 pre-school education was compulsory through the "Program of Upbringing in the Kindergarten" which set to instil communist morality from an early age (Borisenkov 2007: 8). The aim of pre-school education was the indoctrination to collectivism and promoted collective activity through play, thought to be children's

‘work’ (Holowinsky 1985: 139).

From the mid 1980s onwards the education system underwent rapid reforms; indoctrination aspects of the system reduced to allow greater flexibility of the curriculum, freedom of ideological expression, the introduction of independent fee-paying schools, and individuality and creativity were encouraged (Borisenkov 2007: 9). However the reforms destabilised the system and created a feeling of crisis within educational institutions. The move toward freedom from school uniformity was welcomed, but resulted in a loss of control of the Ministry of Education; this, coupled with a funding crisis meant that teacher’s salaries were not paid and the system fell into a state of near collapse (Borisenkov 2007: 10).

After the end of the Cold War in 1991, Russia experienced a period of transition and a program of reforms continued in order to attempt to restore and stabilise the education system (Borisenkov 2007: 11). However financially things were still extremely difficult; schoolteachers became one of the lowest paid sectors; an inability to replace failing equipment and provide resources for learning had a profound effect on the quality of provision and the outcomes for children (Borisenkov 2007: 11).

These reforms continued for many years, and suffered from further budget cuts and a lack of clear direction resulting in many education professionals feeling undervalued and dissatisfied (Borisenkov 2007: 12–13). These reforms introduced a westernised attainment based approach to education which was heavily opposed by the Russian people (Borisenkov 2007: 12–14).

The reforms in the 1990s did not just affect the Education System, there was a complex interaction between Political will of the time and the Economic crisis that Russia faced. The reforms were pushing Russia into capitalist markets and resulted in Russia playing ‘catch up’ with the rest of the world (Nikandrov 2008: 59). They led to a deep recession whereby public spending fell sharply and directly impacted the quality of life of Russian citizens, the effects of which are still being felt with Russian life expectancy ranked 111th in the world, in line with countries such as Iraq (Nikandrov 2008: 59). This demographic issue is a cause for concern for President Putin; it poses a direct threat to the Human Capital of Russia and is reflected in low living standards and inequality (Nikandrov 2008: 59).

Russia then began to experience a period of economic growth and relative stability compared to recent years; this is due to the production of raw materials and high oil prices which affected Gross Domestic Product (GDP) which was growing at a rate of 6-7% a year and the Russian people hoped this would improve living conditions through greater expenditure on public services (Nikandrov 2008: 59). This is reflected by UNESCO (2008) who found that expenditure on education was 3.5% of GDP which is similar to other G8 countries.

However this period of economic growth came to a sudden stop with the worldwide recession; leading the OECD to predict hard times ahead for the Russian people as public spending was predicted to fall once again (BBC 2009).

Nonetheless President Putin actually promised an increase in public spending on education of 1.6% of GDP occurring after the next election; however sceptics view this as a vote-winning policy and are doubtful of this happening in reality (Forbes 2012).

In contemporary Russia the education system is structured as a three-tiered approach; Kindergarten education (ages three to six), followed by Primary education (ages six to ten), and basic secondary education (ages ten to fifteen). Following from basic secondary school is a choice between further education or vocational options (Ministry of Education and Science (MES) 2012a).

Pre-school education is not compulsory and free provision is not guaranteed by the state; however when children join primary school they are expected to have mastered certain skills (Oberemko 2006: 38). The responsibility for ensuring that children have achieved the necessary development rests with the family and is therefore dependent on socio-economic status (Oberemko 2006: 38). There are limited free places for Russia's most deprived children, but accessing these are challenging, many parents spoke of having to give 'bribes' to the administrators in order to secure places (Oberemko 2006: 39). The alternatives are a professional nanny (only for the most affluent), or taught at home by parents, which the majority of less wealthy families opt for; this in itself raises concerns about the quality of provision that parents are able to provide, dependent on their own education (Oberemko 2006: 39).

This differs greatly to preschool education in the Soviet era; the kindergarten movement took shape under Soviet rule and was seen as a vital link in the education system (UNESCO 2007: 4). The pedagogy of Soviet preschools was world-leading with such theorists as Vygotsky being influential in Russia and many other countries (UNESCO 2007: 4). The Kindergarten movement in Russia was heavily influenced by pioneers such as Froebel and Montessori and some of these practices remain today (UNESCO 2007: 2).

However despite the importance placed upon preschool development, after the removal of compulsory attendance only 57% of children had completed kindergarten when they entered formal schooling (Holowinsky 1985: 139). This figure is similar to present day Russia whereby around 60% of children attend kindergarten before formal schooling (UNESCO 2011).

The curriculum for Primary education in Russia aims to develop literacy, numeracy and general academic ability including theoretical thinking and 'self-control' (UNESCO 2011). A framework curriculum for

general education was adopted in 1993 and affords the flexibility for regional variance and institutional differences (UNESCO 2011). The core learning areas of the curriculum are Russian language, literature, arts, social studies, natural sciences, mathematics, technology and physical education (UNESCO 2011). Technology as a key component in the curriculum reflects the growing global trend of the salience of technology for the future development of societies.

The principles that underpin the education system, according to the Ministry of Education (MES 2012b) value holistic approaches to education, unification of cultural identity, universality, secularisation, freedom and autonomy. Furthermore the education system is said to be underpinned by principles of equality and inclusion, stating that formal education is provided universally regardless of race, nationality, language, gender, health or wealth (MES 2012b). However these notions are representing political ideology and the rhetoric, and may not reflect the reality of the situation for the Russian people

In fact the Ministry of Education then goes on to contradict itself in a very shocking and extreme way by describing it's approaches to children with additional needs stating that special conditions are provided "to correct the abnormalities of their development, and to become socially adapted" (MES 2012b). This statement is contradictory of the previous statement on equality and inclusion, and is scandalous for those who value inclusion and diversity in the classroom.

The underpinning notion of education unifying a national cultural identity is not completely dissimilar to the notion of indoctrination to particular cultural and ideological values experienced under Soviet rule (Borisenkov 2007: 7). Nevertheless the education system today is very different on the basis of economic factors; contemporary Russia has struggled financially to support the education system and the modernisation that formed part of the collapse of the communist economic system.

There are some environmental issues which impact the provision of education; Russia is a vast country and sparsely populated in places; the quality of provision of rural schools has been disputed (Gurianova 2006: 58). Under Soviet rule the practice was to create a standardised provision regardless of location; however today's practice is more flexible to allow differentiation of regional difference and access, to ensure the universality of education (Gurianova 2006: 58–60). Nonetheless education is moving back toward standardisation with the influence of globalisation.

The outcomes that the system produces today are inferior to the results produced under the Soviet system. Throughout the Cold War, the USSR was considered a Superpower in terms of its defence capability, its political influence and its economic stability (Heywood 2011: 39). This was reflected in education which produced highly educated citizens and

scientific prowess as demonstrated by Russia's contribution to the 'Space Race' (Andreev 2009: 20). Conversely there have been concerns about the quality of education in contemporary Russia over the knowledge, skills, abilities, and creative development of its citizens (Zhlokov 2010: 42). This is resulting in a lack of social mobility, putting further financial strain on the government; Russia lacks the Human Capital to drive its development in line with other westernised countries (Zhlokov 2010: 43).

Dronov and Kondakov (2010: 77) suggest that the future of the Russian education system is going to rely on further modernisation and reforms, arguing these reforms need to move beyond economics and involve an overhaul of socio-cultural aspects. This will produce a new administration, resulting from complex interactions between social, economic and political relations (Dronov and Kondakov 2007: 77). This is beginning to be addressed by a national initiative named "Our New School" which among socio-cultural and economic changes is introducing national examinations to ensure greater quality and accountability (Lebedev 2010: 3–4).

Inequality in provision has resulted in a lack of opportunities; investment into education and human capital is not effective, resulting in high poverty rates and low economic output (Nureev 2010: 3). Investment in Human Capital is seen through investment in education, by creating an educated workforce, citizens are able to provide for themselves putting less strain on the economy and creating economic productivity, ultimately resulting in a growth of GDP (Nureev 2010: 4–6).

Education is now a top priority for national projects as seen by the "Our New School" reform; however the details of such reforms have been highly debated and contentious. Particularly debateable is national examinations and whether these reforms are indicative of the influence of globalisation (Filippov 2011: 3). Arguments in favour of the reforms and a 'globalised model' are in favour of the democratisation and accessibility of the system (Filippov 2011: 4). Conversely Filippov (2011: 4) argues that this will result in standardisation at the expense of quality and flexibility of valuing student's unique abilities. Filippov (2011: 4) suggests that these reforms fit into a framework of a global socio-cultural trend of 'McDonaldisation' as described by Ritzer, which has spread into a number of social spheres, including education. There are four basic criterion of McDonaldisation; efficiency, calculability, control of quality and predictability (Filippov 2011: 4). Globalisation of public services means that they are a part of a society focused on mass consumption (Filippov 2011: 4). The goals of education fit into the four requirements of McDonaldisation; it has to be efficient to achieve the results quickly; this is seen through standardised testing and acquisition of academic knowledge purely to pass the examination. It is calculable, seen as a quantitative economic based calculation as reflected by the Human Capital Model, the 'investment' in

education has to be meaningful by producing self-sufficient employed citizens (Filippov 2011: 5). There is control of quality which is reflected in curriculum documents and the standardisation of testing and there is predictability in the results (Filippov 2011: 6). Filippov (2011, p.8) argues against these criteria for reforms saying that it deprives education of variation, culture and creativity. However the globalised model is seen in most Westernised countries and is considered a vital part of integration with Western culture (Fillippov 2011: 9). Despite these reservations Fillippov (2011: 10) argues that Russia needs to adopt a McDonaldised model of education in order to provide universal accessibility of quality provision in order to compete in global markets, bolster GDP and create greater social-mobility. Furthermore Onokoi (2005: 51–60) suggests that Russia is on a path of European integration in regards to education, but innovations must be carefully considered towards the progressive development of the education system without the destruction of its national, cultural and pedagogical traditions.

This article has reviewed the education system of Russia under Soviet Rule and has seen that it was effective and classed as world-leading in terms of universality and increased rates of literacy. Soviet education valued not just academic ability but also general childhood care and upbringing which was a role for the state. However this article has demonstrated that the political will behind the education system was of indoctrination into a communist worldview and morality. Communist rule was focused on a unified Russia, with no room for individuality, valuing society as a collective.

This article has evaluated the current education system which has seen ongoing reforms since the 1980s. These reforms took education into a more individualised, holistic approach. There have been economic issues which have seen public spending on education fall, bringing the system to a brink of near collapse. Further to this there have been concerns over the quality of provision of education which is not allowing for social-mobility and not increasing human capital.

The latest reforms are moving Russia back into an education system based upon standardisation; this is reflected in the national initiative “Our New School” and the introduction of standardised testing. This is marking a change to a globalised McDonaldised model of education that Ritzer described whereby standardisation is creating better accountability with the aim of improving the quality of provision and boosting Human Capital to ultimately boost GDP. Nevertheless the globalisation of education in Russia has come under criticism as it does not value cultural or individual diversity.

Overall the Russian education system has seen many changes over the last thirty years. The influences on the education system are multi-faceted and complex. Economics have played a major part in the reforms of the system with historically a severe lack of funding; however public

expenditure is now in line with the rest of G8. Political will and ideology has had a major impact on the system, moving from communist collective rule to a more westernised approach valuing capitalist ideology. Furthermore the need for Russia to compete in global markets has led to ongoing cultural and education reforms, with a goal of increasing human capital and allowing for upwards social mobility.

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November 2012)

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I am a final year English student and wrote 'Innocence' last year as an assignment for my Short Story module. The rationale was very open: to write an original short story, incorporating the techniques we had learnt over the course of the module. We could choose any subject we wanted and the variety of stories produced was huge. The inspiration from my story came when my friend told me that she was in the process of making a summer fruits pie and that her hands were stained with the juices i.e. her hands were red. I'm not sure why this then led me to thinking about killing and cutting up dead bodies in a kitchen, but the result was 'Innocence'! I had no real guidelines for the story other than it had to be between 2,500 and 3,000 words.

After completing my English degree in the summer, I am hoping to start a PGCE course and go on and become a Primary School teacher.

Innocence

Her hands were blood red and sticky; a knife lay on the counter. There was a knock on the door.

'Shit,' she said aloud and looked around for something to wipe her hands on. The person at the door knocked again, longer and louder.

'Ok ok, I'm coming.'

Kath surveyed the mess in the kitchen, grabbed a towel and made her way to the front door, closing everything behind her as she went. When she reached the front door, she took a deep breath and opened it. Standing in front of her was a little girl from down the road holding a box.

'Can I help you?' Kath positioned herself in such a way that made it clear she had no intention of inviting the girl in.

'I'm raising money for my school...can I have some money, please?'

'Oh...sorry...I haven't got any money in the house.'

The girl looked surprised at Kath's response and shifted awkwardly on her feet. Kath could sense the girl's uneasiness and smiled down at her.

'I promise I'll give you some money if you come back tomorrow.'

She moved and closed the front door abruptly, hoping the girl would get the hint to go away. Kath stayed where she was and looked through the peep hole in the door; she watched the girl walk down the path. When she'd gone through the gate and was back on the pavement, Kath breathed out and made her way back into the kitchen and the mess she'd left behind.

Standing in the doorway, she took in what was in front of her. Knives lay discarded around the room. A saw was lying in the middle of the floor. Most shocking though, was the smell that hit her. It filled Kath's

nostrils and took her breath away; even after all these years, the stench of a decomposing body never failed to turn her stomach.

'Get a hold of yourself,' she said aloud as she moved into the room. The odour would remain in the house for weeks after the body had been disposed of, but that was the least of Kath's worries at the moment. Disposal of the corpse and the clean-up of the murder room were more important right now.

Working methodically, Kath moved around the kitchen bagging up the body, part by part. Within 30 minutes, she'd managed to place everything into black bin bags and piled them up by the back door. She'd have to wait until dark before moving them into the shed at the bottom of the garden.

The body in the bag was the third person Kath had killed this year; her seventh in total. It wasn't like she enjoyed killing people. She had no control over her actions when the voice in her head was at its strongest; the voice which had been with her for the last ten of her 42 years.

The murdering had begun with small animals and insects; 'Nothing wrong with that', the voice had told her. 'Everyone kills spiders and ants and beetles.' Within a couple of years though, the spiders and ants and beetles had become neighbours' cats and dogs. Three years ago, Kath killed her first human.

She always made sure that the people she killed wouldn't be missed by anyone as it meant there was less attention when they disappeared. The last thing she wanted was for a major police investigation. She didn't fancy answering questions and being under suspicion because she knew the victim. Picking 'nobodies' made things a lot simpler; the voice liked things to be simple.

*

It wasn't until much later that Kath felt it was dark enough to move the bags down to the shed. During the intervening three hours, Kath had thoroughly disinfected the kitchen, cleaned and returned the knives and saw to their usual hiding places and even managed to catch up on the goings on in 'Eastenders'. That was the thing; as soon as the killing process was over; Kath returned to her usual self and continued living a normal day to day life. No one would ever suspect that the middle aged woman living at 67 Red House Lane led a double life.

As she opened the back door, the noise made next door's cat jump off the fence, startling them both.

'Bloody thing,' Kath muttered as she stepped out and made her way down the garden. Using a wheelbarrow, she dumped the bags in front of the shed door; she reached into her pocket and found the three keys needed to unlock the padlocks that hid her secret. Once unlocked, Kath began her

routine. Light switched on. Bags placed next to the chest freezers. Door closed and bolted. It was as though she was operating on auto-pilot. Freezer lid opened. Bags untied. Piece by piece moved from the bag, into the chest, joining the umpteen other frozen body parts that had accumulated over the course of three years. Quite a collection, really. Kath smiled to herself as she closed the lid. She then performed the earlier routine in reverse and five minutes later, was back inside the warmth of her house.

*

Just as Kath sat down to have her lunch; there was a knock on the front door. Taking a quick bite from her sandwich, she went to see who it was. Standing on the doorstep was the girl who had called yesterday evening, asking for money. Kath had completely forgotten she'd told her to come back today. She smiled at the young girl, trying to make up for her rudeness from yesterday. The smile seemed to settle the girl and she visibly relaxed.

'Oh hi,' Kath said. 'I'd forgotten you were coming back. I've got some money for you today though, so don't worry.'

As she said this, a cat darted in through the door, making both her and the girl jump.

'Oh, Storm! I'd wondered where you'd got to!'

'That's your cat?' the girl asked. 'She's been playing in our garden but we thought she was a stray 'cos she didn't have a collar. She loves being played with.'

Kath still felt embarrassed about her behaviour towards the youngster yesterday and realised the cat could be the perfect way to make up for it.

'Do you want to come in and feed her? She seems to like you!' As she said this, Storm was weaving her way in between the girl's legs, clearly wanting to be made a fuss of.

'Would that be ok? I love cats. One of ours went missing last year and we never found it. Ziggy was my cat. I loved her lots.'

A look of sadness passed across the girl's face as she bent down to stroke Storm, making Kath start. She thought back to her victims from last year. There had been a few cats mixed in with the humans, but she never thought about the killings after they'd been done. She remained completely detached from the things she killed. The voice had always told her that remaining cold and distant was the best way to behave. They were dead. There was nothing she could do now. They couldn't be brought back. End of.

The sight of the girl making a fuss of Storm sent a chill through Kath. What was happening? She'd never felt like this before. Guilty. She didn't like it. It unsettled her.

'You alright?' The question snapped Kath back into reality.

'Yes, yes. Sorry. Was just thinking back to when Storm was a kitten. That's all.' She tried to smile but the look of pain on the girl's face had disturbed her. She couldn't shake the image from her mind.

Kath moved to allow the girl into the house, with Storm leading the way into the kitchen. She closed the door and followed them.

'Get a grip, woman,' the voice told her as she moved through to the back of the house. 'You've come too far to start getting emotional. I won't let you.'

*

The girl, who Kath had discovered was called Emily, hadn't stayed for long, much to Kath's relief. She'd given her £10, smiled and waved her goodbye and was immensely relieved when she was finally alone again. Just as she'd done yesterday, Kath watched Emily leave through the peep hole in the door. When she was certain she'd gone, Kath locked the front door, went into the sitting room and sat on the sofa, staring into space. She still couldn't get rid of the feelings of guilt and she couldn't work out why she was feeling like this over a bloody cat. It made no sense. She couldn't even remember what the cat had looked like. She'd never had any feelings of guilt or remorse before. So why now?

Over the course of the next week, the feelings slowly subsided and before long, another week had passed and Kath hadn't even thought about Emily or her cat.

Kath continued to live as she'd always done: rarely speaking to her neighbours, rarely leaving the house, rarely making contact with anyone in fact.

*

It was precisely a month after she had first visited, that Emily returned to 67 Red House Lane. Kath was in exactly the same situation. Blood splattered the worktops. Knives lay haphazardly around the kitchen.

The knock on the door made Kath jump. She remembered what had happened last time she was interrupted. That couldn't happen again.

She remained motionless but could feel and hear her heart beating. She hoped whoever it was would realise no one was in and leave. No such luck. There was another knock.

Again, Kath stayed stationary, this time praying whoever it was would go away. A drop of blood from the knife fell down onto her shoe. Kath didn't even notice it.

Another knock. Another desperate prayer for the person to bugger off. Another drop of blood fell, this time onto the floor.

No knock followed and Kath breathed out in relief. She lowered the

knife onto the worktop and took in what was in front of her. The knock had interrupted her flow and she had to try and remember what bit came next.

A noise outside made her look up and what she saw made her scream. It was Emily. Standing outside the kitchen window. Looking in. Rather than screaming though, Emily smiled. Both stood staring at each other; Kath in bewilderment, Emily in amazement. Getting caught mid-cutting process had always been Kath's worse fear, and now it had happened.

Not quite sure what to do, Kath attempted a smile. Maybe she can't see inside. Maybe she's smiling because she's found me. Thoughts ran through Kath's head as she tried to make sense of the situation. A half dismembered body lying in her kitchen and a young girl standing outside, looking in. What the hell was she going to do?

Emily moved from the window towards the back door and Kath watched as the handle moved downwards. Shit. She couldn't remember if she'd locked the door. She hadn't. Emily walked in.

Kath was frozen to the spot, completely unable to move. Emily looked silently around the room, taking in everything in front of her.

'What you doing?'

Kath had no idea how to reply. She opened her mouth but nothing came out.

'Are you making dinner?'

Again, Kath's mouth opened, but nothing came out.

'Can I help? I haven't got anything to do and I'm bored at home.'

This time Kath's mouth opened in shock. Here was a young girl, maybe 10 years old, asking if she could help 'prepare' dinner. How could she not realise what was going on inside the kitchen?

'I help my mum with dinner normally, so I know what to do. I promise I won't get in the way. What you making?'

How do I reply to that? Kath asked herself. And what do I do now?

Without realising what she was doing, Kath moved to the kitchen door and reached for a spare apron. She passed it to Emily who smiled and put it on. The situation was beyond surreal, but Kath had stopped trying to analyse it.

'I've just about finished cutting the...the...meat,' Kath managed to say. 'Do you want to help me tidy up?'

Emily nodded and smiled again. She looked genuinely happy to be here.

*

For the next hour, the two worked together to tidy the kitchen. Kath still couldn't believe what was happening. Emily chatted away, oblivious to what she was really doing. Fortunately for Kath, most of the body had been

placed into black bags before she'd been interrupted. The odd pieces of flesh that had been left out could easily be mistaken for steak.

Kath glanced up at the clock and noticed how late it was.

'Don't you need to be getting home for dinner, Emily? It must be past your tea time.'

Emily shook her head and continued to spray the disinfectant.

'Nope. I ate before I came round to see you.'

'Won't your mum be wondering where you are?'

'Nah. She knows I'm here with you. She said she's happy for me to be here 'cos she trusts you.'

Kath raised her eyebrows as she wiped where Emily had sprayed.

Another hour passed before the kitchen was completely clean. The bags had been piled into a heap by the back door, ready to be moved when darkness arrived.

Kath, who had managed to calm down over the last couple of hours, had actually enjoyed herself. The voice, which usually appeared and kept her company whilst she chopped and tidied up the body, had disappeared, much to Kath's surprise. It had been nice to spend time with someone else and to have a conversation. She hadn't realised just how lonely and isolated she'd become.

By the time Emily left, it was dark enough to move the body down to the shed. Kath threw the bags into the wheelbarrow she'd left next to the back door and wheeled them to the bottom of the garden. When she reached the shed, she pulled out the keys, unlocked the padlocks and entered. The usual routine followed and ten minutes later, she was sitting on the sofa with a cup of tea.

*

Months passed and Emily became a frequent visitor at Kath's. She clearly enjoyed helping Kath clean up the murder room. She never asked any questions about where the bin bags went after she left and Kath never told her. There was no need to complicate things. They worked slowly, talking to one another about every day, mundane subjects. It didn't really matter what they spoke about; it was the company that Kath enjoyed. It was a relief in some ways to know that someone else knew what she was doing, but that they wouldn't tell anyone.

It was their third clean up together and were just ten minutes into the process when there was a knock on the door. They both froze. They looked at one another in silence. There was another knock. Emily opened her mouth but Kath shook her head, silencing the girl.

They carried on standing. Kath was waiting for another knock. It didn't come. She breathed out and relaxed. Emily did the same but the look of terror on her face remained.

Kath gave a reassuring smile to Emily. It was as much for her own sake as Emily's. Why couldn't people just leave her alone?

The pair resumed their cleaning. Neither said anything.

Ten minutes passed and there was another noise which made them both stop suddenly. What now? Kath thought. Then she realised what the sound was. It was the latch on the side gate being opened.

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Addressing health inequalities of non-English speaking families

Health Inequalities: There is evidence to suggest that people from the black and minority ethnic (BME) population suffer with poorer health and reduced life expectancy when compared to the white British population (Department of Health (DH), 2003). People from BME groups are more likely to present late in pregnancy (DH, 2007) and with chronic illness and yet use emergency telephone numbers and attend accident and emergency departments inappropriately (Local County Council et al. 2007). The Pakistani and Bangladeshi populations have the highest rates of limiting long standing illness (Acheson, 1998). Babies of mothers who were born in Pakistan or the Caribbean have infant mortality rates that are double the national average (Acheson, 1998). Women who are living in the United Kingdom (UK) but who were born abroad are disproportionately suffering maternal mortality and morbidity (Lewis, cited by Mastrocola and Nwabinell, 2009). The Department of Health (2007b) has recognised that women from black and ethnic minority groups often miss antenatal screening tests as they are more likely to book late with maternity services and that refugees and asylum seekers may have difficulty accessing maternity care. People from BME groups suffer with poor health, premature deaths and chronic ill health and this is partly due to socio-economic status, environmental and employment conditions and partly due to poor quality of services, lack of information and negative experiences (Knight Jackson, 2007).

Problem: It was recognised locally that non-English speaking mothers were disadvantaged in accessing health and childcare support due to their language barrier and a lack of understanding of services available. Many of these women were unable to afford English tuition and single women on income support, women on spouse visas and asylum seeking women were not eligible for free English tuition. Childcare is not provided with government funded English classes and women are not allowed to attend English classes with their babies or children.

Approach: The project management guide provided by NHS Institute for Innovation and Improvement (2010) was used as a framework in the development of the following intervention. A link role was formed between the health visiting service and the local voluntary and statutory sector that were providing a service to refugees, asylum seekers and migrant workers. A focus group consisting of service users was then arranged and the findings were applied to a SWOT analysis. It was then decided that there was a need for a health promotion group combined with English tuition and crèche facilities. A pilot group was organised. It was held within a centrally located children's centre and consisted of five sessions. Each session consisted of one hour of English tuition followed by an hour of health promotion with multi-agency input. The facilitator liaised between the English teacher and health promotion speaker so that the language taught was specific to the topic that followed. Topics included: introduction to the National Health Service, oral health, healthy eating, family planning and personal and home safety. All sessions maintained a visual focus and included a variety of teaching methods that included role play. Written translations were provided where possible. Language line was used to answer questions. Crèche facilities were provided, however, most of the mothers chose to keep their babies with them in the class.

Results: The pilot group evaluated well. The group was attended by fourteen women who all stated that they would like the group to continue. Eight of the women said that they felt more confident in being able to make a GP appointment and many of the women indicated that they would like to use other services being offered by the children's centre such as stay and play sessions. The women reported that they liked the fact that their babies could stay with them. None of the women had accessed a children's centre before. The group is currently being rolled out on a regular basis within a town centre children's centre and continues to be well attended.

Conclusion: Reducing health inequalities is a priority of the government agenda (Marmot, 2010, HM Government, 2010). As leaders of the Healthy Child Programme (DH, 2009), health visitors have an important role in identifying marginalised population groups who may not be accessing preventive health and childcare services and adapting service provision to meet their needs with the aim of reducing health inequalities.

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The value of health visiting in meeting the needs of the 'looked after child'

Abstract

During my time delivering the Health Visiting service I have developed an interest in the needs of Looked After Children. Researching for this case study highlighted to me further what a hugely vulnerable group they are. These vulnerabilities only increase if the care they receive within the care system does not meet their needs. I have since become more determined than ever to provide a holistic service to these children and their foster/ adoptive families, ensuring that health reviews are thorough, multi-agency working is seamless and their needs are met in a supportive and reassuring manner.

It should not be assumed that just because they are in care that they are no longer suffering, in fact, the insecurities that this change presents can have a profound effect on young children who often lack the understanding to process why it is happening. I hope my case study makes other professionals think twice when providing a service to this vulnerable group of children.

Case study

This case study examined an individual case requiring health visitor involvement. It demonstrated the value of health visiting and the various levels of intervention required to meet the individual needs of the child. The focus was on achieving successful outcomes for children looked after by the local authority. A synopsis of the client's history and professional involvement were introduced. The role of the health visiting service in relation to the case was analysed, with critical evaluation based upon observations made in practice and within the research base.

This child's case had been complex from the beginning and there were a vast amount of issues for discussion. However, due to word limitations a few selected topics for analysis were chosen due to their significant impact on the child's well-being. All names in the case study were changed or

removed to protect confidentiality in accordance with the NMC Code of Conduct (2008).

Lucy was a 2½ year old girl in foster care. Her mother Nicki was 17 years old homeless and a smoker. She had been sexually abused as a child. She had met Lucy's father Dan, an 18 year old drug user who had grown up in the care system. Their relationship was brief and they split up before Lucy was born, with Dan having little contact. Nicki failed to attend many antenatal appointments and housing remained an issue. She was recognised as vulnerable and her unborn child identified as at possible risk from harm. She was put on a child protection plan before birth. After Lucy was born they were placed in a joint mother and baby foster placement where they remained until Lucy was 8 months old. Nicki was bonding well with Lucy, sharing positive interactions and good attachment. Breastfeeding well Lucy's child protection plan moved to that of a child in need and they moved into a privately rented house.

There was gradual deterioration in the home environment and Nicki's care of Lucy over the next 10 months. The health visitor updated Lucy's health needs assessment, Lucy's poor sleep pattern was discussed and less positive interactions between mother and daughter were noted. The house was chaotic with frequent male visitors and there were concerns around drug use within the home. At aged 23 months Lucy was admitted to the children's ward with a vaginal injury that was deemed non-accidental. With no explanation for the injury Lucy was placed into foster care and became a looked after child.

The term 'looked after child' was introduced by The Children's Act 1989 and describes children in England and Wales in the care of the local authority. In Lucy's case this was as a consequence of a court order. The threshold of 'significant harm' had been established so parental responsibility was granted to the local authority in partnership with the birth parent. Looked after children are amongst the most socially excluded of our child population, their health may not only be jeopardized by abusive and neglectful parenting but public care itself may fail to repair and protect health and may even exacerbate damage and abuse (Hall and Elliman 2006). The Statutory Guidance on Promoting the Health and Wellbeing of Looked after Children (DH 2009) emphasises that children often enter care with a worse level of health than their peers due to the impact of poverty, abuse and neglect. It highlights the need for effective joint working between local authorities and health organisations to address these needs.

Research is growing into the effects of early intervention and prevention strategies to improve the later outcomes for children, particularly those seen as vulnerable or in need of additional support. The Health Visitor is in a vital position to offer this intervention. They identify, assess and monitor children at risk from harm as part of their role within public healthcare. It is how they manage and communicate this risk to other

agencies and services that is so vital in their safeguarding role. Children are placed on a Child Protection Plan in one of four categories, Physical abuse, Emotional abuse, Sexual abuse or Neglect. Lucy was put on a Child Protection Plan under the category of neglect. When analysing the early health visitor input for this case it could be suggested that neglect is difficult to assess because it is subjective and people have differing levels of what is acceptable. How good does parenting have to be to be good enough?

Cowley (2000) suggested in the search for health needs the key lay not in the proactive nature of the enquiry but in the health visitor's ability to convey a caring, interested attitude, rather than a judgemental and inquisitorial one. This enabled a trusting, honest relationship and allowed the disclosure of complex and sensitive information. The Framework for Assessment is universal and accessible to health, social care and education for the safety and welfare of children (Children's Act, 2004). It is in a common language used to understand the needs of the child within the family, the context of the community in which they live and in Lucy's case her foster placement.

The sharing of information is highlighted so often in the cases of Looked after Children due to their high level of need and the number of referrals made for assessment and treatment, most commonly speech and language assessment, hearing and vision checks, dental care and Children and Adolescent Mental Health Services input. Policies and reports published in recent years recommend more effective collaborative working. The Bristol children's inquiry (2001), Lord Laming's Inquiry (2003) and his report (2009), Every Child Matters (2004) and most recently the Munro Report (2011) all recommend that there must be greater integration of primary, community, acute and specialist health care for children. It is recognised by that the provision of children's services is complex due to the wide range of professionals in different locations. There is often a confusion of roles and responsibilities and a duplication of work which is further confused by information being held in different forms, different databases and by different services. Therefore closer collaboration is so very important.

As HV's we have an ethical and moral duty to be advocates for these children who are after all the innocent victims in these cases. In Lucy's case and that of all looked after children the importance of advocacy for the child is highlighted. Where a child is the joint responsibility of parent, carer and local authority it is perhaps inevitable that responsibilities become ambiguous. Considering the past experiences of poor parenting, neglect or abuse that these children have been through we can understand the often desperate needs that are hidden behind their behaviours. The assumption should not be made that their suffering ended when they entered the care system, it is often on-going and can be worsened by insecurities and confusion for pre-school aged children who have little understanding. It is essential that these needs are identified, assessed and managed early

to prevent further suffering and future problems. The use of professional guidance and evidence based practice is most successful within a multiagency approach to delivering services, and the health visitor plays an invaluable role in coordinating this.

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Julia completed the Specialist Community Public Health Nursing – Health Visiting Programme at UCS and enjoyed working on the above topic, which she presented to fellow students during her course of study.

Resettlement of a refugee family from the Congo

A reflective case study approach has been used to critically analyse the resettlement of a refugee family from the Congo. The United Nations Convention defines a refugee as someone “owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion is outside the country of his/her nationality or habitual residence and unable or unwilling to return to it” United Nations High Commissioner for Refugees (UNHCR) (2001).

The Democratic Republic of Congo (DRC) has a population of 56 million. Annually 15 Congolese families arrive at the Gateway Programme in my area of practice. This is due to rise to 25 families in the coming year. It is important to gain an understanding as to why they are coming to the United Kingdom and how they are being helped via a resettlement programme. A civil war began in 1998 and officially ended in 2003 as a result of warring factions accepting a power sharing agreement. In 2003 85% of DRC’s displaced persons were in the East, 12,000 fled to Uganda to escape the violence. The physical safety of refugees in Uganda, continue to cause concern. There are still reports of death resulting from rebel attacks on the settlement.

The Gateway Protection Programme, (GPP) was instigated in April 2003, creating a legal pathway for refugees to enter the UK. The aim was to resettle 500 refugees a year. In 2011 this figure increased to 750 refugees. Authorities have the costs of resettlement met for the first year of the refugee’s life in the UK. This includes expenditure on health, housing and education. The aim is for them to be integrated into local society and services within one year.

The family identified for this case study are one of the many families resettled with the help of the GPP. Molly aged 29 has been married twice, and her three children have different fathers. She has a disability; one of her legs is longer than the other making it difficult for her to walk. In the Congo she was raped repeatedly and assaulted by soldiers. She fled with her children, and brother Jack 27 (who the authorities believe to be her

husband). Molly's children are Jade 12, Ann and Jane 2. The children have all witnessed the rape and assault of their mother. The family have been housed. Jade had a placement in school and the family were integrating into their new environment. The family were transferred to the local health visiting service, a year after coming to England. No problems were highlighted by the health visitors at the GPP.

Assessing whether a child is in need and the nature of these needs requires a systematic approach. The Assessment Framework (DH, 2000) is a key tool guiding this process. It enhances collaborative working ensuring the child's welfare is at the centre of care delivery. This is the core paradigm of health visiting. Gathering information and understanding a family's situation is a pivotal component of the assessment process which is made more difficult when a family does not speak any English. There is often a need for an interpreter to be present or at the end of a telephone line. Dust and Phillips (DH, 2000), argue 'Issues of race and culture cannot be added to a list for separate consideration. Referral through to core assessment, race and culture had to be taken account of using a holistic framework of assessment'. When an analysis of a child's needs and parenting capacity within the family context is complete, there is then a base line from which further assessments and reassessment can take place.

A number of concerns were raised in regard to this family. The health visitor identified Jane 2 years to be two levels below the acceptable centile weight. Following this contact the nursery nurse and social worker carried out a joint visit to discuss diet and play with Molly. On their arrival Molly was not at home and the front door was wide open. Jade had been left at home to do the house work and look after the other children. Molly was contacted by her mobile phone and could not comprehend why this was not acceptable. The obstacles surrounding these issues were language and culture. Several C39d reports were received by the health visiting services from the police before Molly gleaned this was not an acceptable practice in the UK. During her short time at school Jade has been bullied resulting in her having police escort to school. Once at school this persecution did not stop. There are a significant number of refugee children in UK schools. They are likely to have encountered various risk factors which relate to psychological distress, including trauma, loss, change and social exclusion arising from prejudice, (Beiser et al, 1995). Due to this situation Jade had been subject to a Common Assessment Framework which the health visitor was unaware of. When working with families there is a need to take a holistic over view which should include the whole family, as the actions of one can impact on the whole.

Two months after transfer from the GPP another C39d was issued. Jade had been admitted to hospital following assault by her mother. Molly had found £2.00 missing from her purse and blamed Jade. They had an argument and Molly hit Jade over the head with the heel of a stiletto and

on the body with a nail from the banister. The head trauma wound bled profusely. As a result of this assault Jade was placed under section 47 of the children's act, (1989) and has not returned home, her own choice. A professional meeting was held. Present were the consultant paediatrician, police officer, social workers, support teacher and health visitor. It was agreed that Jade could be placed with a local Congolese family, where the head of the family was a pastor, and was known to both Jade and Molly.

By June 2011 the family had been seen by approximately 250 professionals. Jade was placed in foster care outside the county and the CAF process was on going. One of the key resources for this family has been the local sure start centre. The centres deliver a fully inclusive responsive multi-agency service with in the local community driven by the ethos of Every Child Matters (2004) and the Healthy Child Programme (2009). Their aim is to improve life chances of every child so that they can enjoy and achieve, making a positive contribution to the 'big society'. This goal is met by working in partnership with all families, empowering them to make a difference for their children, by helping them to be healthy, stay safe and aspire to achieve economic wellbeing. Following referral by the health visitor an outreach worker was assigned to the family. Offers were made to introduce Molly to parents in the friendship group. It ran once a week for parents of different nationalities many of whom had limited English. English classes were free and offered to those in need. Molly has integrated into this group well, and has started to learn English. While Molly is in class her children stay and play at the Sure Start Centre. Ann and Jane are establishing a routine and gaining stability. They remain under the protection of Section 17 of the Children's Act 1989. Under section 17.1 (a) of the Children's Act 1989 local authorities have a duty to 'safeguard and promote the welfare of children within their area who are in need'. Molly is due to appear in court as a result of the assault on her daughter Jade. The work with this family will be an on-going process of constant re-assessment, good communication and collaborative working.

Partnership working is required with families like Molly's. Race and culture need to be taken into account and a holistic assessment made. Transition services and cross boundary are essential for the seamless care. Timberlake and Cook (1984) argued that refugee's problems suppress their pain and loss for six to twelve months after their arrival. This was not demonstrated in this case study, as the difficulties emerged a year after they had been in the UK. It is hoped that lessons have been learnt, and that the awareness of good transition services and cross boundary working are essential for seamless care of refugee families in the community.

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Prior to commencing my Specialist Community Public Health Nursing in 2010, I had trained as both an adult and mental health nurse. My interest in mental health has continued to develop during my training and since qualification as a health visitor. I hope to expand upon this by specialising in this area in the future, commencing with collaborating with other professionals to develop a training programme aimed at enhancing the knowledge and skill base of health visitors and support staff who work with clients with mental health needs.

Collaborative working in health visiting

Over the last decade there have been several incidences and high profile cases reported in the media involving Health Visiting and affiliated professions (www.nspcc.org.uk). Enquiries into these cases have highlighted a number of difficulties. However, a dominant theme throughout these and other investigative reports into the care of children was a lack of professional collaboration. "The future lies with managers who can demonstrate the capacity to work effectively across organisational boundaries. Those able to operate flexibly need encouragement, in contrast to those who persist in working in isolation and making decisions alone. Such people must either change or be replaced." (Lord Laming 2003)

Collaborative working within child and family services has been focussed upon by the government across a wide spectrum of voluntary and statutory agencies as a recognised way to achieve best practice and safe and effective care for families. Within Health Visiting, the concept is regarded as so fundamental to practice that 'Collaborative working for health and wellbeing' forms principle 2 of the standards of proficiency for Specialist Community Public Health Nurses (www.nmc.org.uk). However, as illustrated by reports in the media, ranging from child protection issues, behavioural issues and examples of compromised physical health such as childhood obesity, there remain challenges to achieving the optimum level of partnership working.

It has been highlighted that health visitors have a particular importance in taking a leading role within delivery of universal services but there have been reports of insufficient health visitors nationally. This not only has an impact on their ability to lead and collaborate effectively, but also to deliver core services. They take a significant role within progressive

services such as safeguarding, care of children in need or with special needs and training other practitioners and students. As part of the recently published 'Health Visitor Implementation plan' (2011) a workforce sub group has been tasked to assess the number of whole time health visitors working in the UK, information suggests the number of health visitors has reduced over a period of time.

Potential barriers to effective collaborative working may be a lack of understanding of other health professionals' roles and an associated lack of training in order to rectify this. The Healthy Child Programme (2009) states the importance of shared knowledge of other professionals' responsibilities as paramount in effective partnership working but given the pressures of workload and staffing levels, does this occur in practice? It has been suggested that collaborative working is not something which comes naturally to all health professionals. Despite Lord Laming's statement that there was no longer a place for those who were unwilling or ill equipped to work across professional boundaries, it would be unwise to assume that all professionals do work in partnership. Casey (2007) highlights the significance of a 'mutual respect and willingness to negotiate and cooperate' amongst other attributes when achieving good inter-organisational relationships, however, Kaur (2009) argues that it is not a lack of enthusiasm which is responsible for gaps in partnership working but the emphasis on theoretical ideal at managerial level.

Perhaps the most important collaborative relationship in health visiting is that between the health visitor and family. In order for this relationship to fulfil its potential it is of vital importance that the nurturing of the therapeutic relationship is given due consideration. "Therapeutic relationships can lead to job satisfaction for the nurse and a relationship that empowers the child and the family" (Benner 1984). Many families, particularly those who have had negative experiences of statutory services may be reluctant even to let a health professional through the front door of their family home, let alone trust them enough to reveal what may be on occasion distressing and life changing information.

The innovation for practice conceived to maximise the positive impact of partnership working is a 'multidisciplinary antenatal drop in clinic'. This idea arose following a routine antenatal appointment. The client was well and did not have any obvious problems. She had worked full time until her maternity leave commenced, felt generally prepared for her baby's arrival and had a supportive family. However, there were certain areas which were of concern to her. On leaving work she felt socially isolated. Her friends were based at work and therefore out all day along with her husband. She attended antenatal classes, whilst finding them useful, she felt that they were structured and she had not developed relationships with others in the group. Her husband was keen to be involved and prepared for the baby and wished to form relationships with other new fathers but this

had not occurred. Her final concern was that all through the pregnancy and as the birth approached she had more questions and queries which she felt were 'too silly' to phone the midwife with, so she used the internet which often gave conflicting information. These queries ranged from foods she was able to consume during pregnancy, to breastfeeding versus formula, and parenting skills. Further antenatal visits to other clients demonstrated similar concerns.

The greatest insight into the creation of a successful antenatal group was an article written on a 'multidisciplinary antenatal clinic' (Stringer 2007) which had been set up in Bradford, when concerns were raised about the lack of people accessing antenatal services by a local midwife. This midwife had a 'chance' meeting with the manager of a local service known as 'Health on the Streets' and together they formulated the idea for an informal, friendly drop in service which would be accessible to all. According to the author, 4 years following the development of this clinic this has resulted in "almost all local clients attending the advised number of consultations". From a collaborative perspective, the clinic was originally staffed by a midwife and a health visitor, but now employs 8 members of staff plus community volunteers. The clinic, though originally planned for 2 hours per week now runs for a whole day, and attendance has increased significantly since the clinics inception.

This innovation for practice was discussed with the health visiting team on an informal basis. Although the concept was acknowledged, the idea of actually instigating the antenatal drop in clinic was not well received. As previously mentioned when discussing barriers to collaborative working, the team felt that they did not have the time available with which to organise and carry out the clinics. They did not feel that the suggestion of the clinic being held in the evening, despite being once per month, would be acceptable to those who would be staffing the clinic. The high caseloads carried by the team appeared to be a preventative factor. They were also unsure of the collaborative role within the clinic and felt wary of whether this should in fact be an idea which was raised by the health visiting team during a time which is traditionally seen as midwife led. They felt that funding may be a point of contention, though one member of the team did suggest that this may be an area that the Sure Start manager would consider supporting.

The barriers I encountered during the first stages of introducing my innovation whilst ultimately resulting in my inability to set up the service also enabled me to take a closer look at what may block the path of innovative and collaborative practice both from a general perspective throughout the profession of health visiting and from my own personal viewpoint. This then resulted in a review of the literature and evidence base surrounding change management, leadership and innovation, underlining the importance of certain skills, attributes and practices which

then appear to conclude in the instigation of new ways of working. This certainly outlined the fact that creating an innovation for practice is only the beginning, and that there are many challenges to be met along the way prior to successful implementation of new practice.

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Marie completed the Post Graduate Diploma in Specialist Community Public Health Nursing – School Nursing and has had additional experience working as an educator in a Further Education College with young people. Marie is now working as a School Nurse in the North and Broadland area of Norfolk. She has a range of nursing experience within a broad spectrum of healthcare settings including the acute, community and independent sectors. She has also worked within education both as a teacher and within a pastoral role. This has led her to consolidate her experiences and make the transition into School Nursing where she is currently undertaking her preceptorship period.

The potential benefits of introducing brief Cognitive Behavioural Therapy based interventions with children and young people into School Nurse Practice

Cognitive Behavioural Therapy (CBT) is a well-established and evidence based therapy used effectively in many settings to promote emotional well-being and treat common mental health conditions such as depression, anxiety, panic disorder (Gross & McIlveen 1998), obsessive compulsive disorder (Day 2009a) and self-harm. It is recommended as part of the treatment for children and young people with depression (NICE 2005). In recent years there has been promotion of the use of its underlying principles to deliver brief but effective interventions within a broad range of predominately Tier One and Two community settings with adults, championed under the concept of 10 Minute CBT by Dr Lee David (2006). These interventions can be offered by varied members of the primary health care team including practice nurses and occupational therapists after relatively brief training and specifically these practitioners are unlikely to have formal mental health qualifications. In order to explore the potential scope for such interventions this case study looks at the precursors, incidence and characteristics of mental health issues faced by children and young people. It investigates the underlying principles of CBT and how brief interventions based on this concept could be instrumentally used to support children and young people in a school based setting.

Continued on next page...

It is essential that School Nurses recognise the significant need for emotional support both overtly and covertly displayed in school age children. They have highlighted that even by supporting a relatively few children with such needs on a weekly basis, these cases can take up a disproportionate part of their workload (Wilson et al, 2007). The CAMHS Review of 2008 recognised that School Nursing input varied by locality and that the service should be 'engaged fully in the local drive to improve mental health and psychological well-being.' It was estimated one in ten school age children suffered from a diagnosable disorder (ONS, 2005) based on the ICD-10 Classification of Mental/Behavioural Disorders. Gender differences were apparent with boys 11% compared to girls 8%. The ONS also identified the duration of mental health illness as long-term for some, with 30% of children having a disorder, experiencing consistent problems over the three years of the study from 2004 -2007. Boys were 33% more likely to suffer (ONS, 2007). UNICEF (2007) highlighted British children as being some of the unhappiest in the world.

Traditionally therapies based on a cognitive model and pioneered by the likes of Bandura and Ellis perceive 'mental disorders as resulting from distortions in people's cognitions,' (Gross and McIlveen, 1998). CBT itself was initially introduced by Aaron Beck in 1964. Typically a client would be involved in up to twenty one hour sessions. Subsequently the intention of CBT is to show a person that irrational thoughts are the key factor in contributing to their difficulties. 'Cognitive theory is based on the hypothesis that the way events are interpreted influences feelings and behaviour,' (Day, 2009b). Quite often a person has developed an irrational thought based on questionable evidence and subsequently exhibits avoidance behaviours that prevent them from disconfirming these negative beliefs and in turn impacts on their physical health and exacerbates the irrational thoughts even further.

CBT has the potential to improve confidence and competence of School Nurses when supporting young people, it could potentially reduce the stress and worry that one might carry when working with challenging and disturbing cases. Training that equips us with the tools to work constructively and efficiently is potentially invaluable and could prevent School Nurses feeling limited and frustrated in their abilities to provide effective care, in addition to recognising emerging and established mental health issues and making referrals. Undergoing 10-minute CBT training can go some way to facilitate this capacity for a School Nurse to adequately provide early intervention.

CBT has key characteristics of CAMHS innovations that clearly work for young people as identified by Kutz, et al (2002). If used in schools it is readily accessible and can be arranged for times that are most suitable to the young person; it seeks to engage the child, offers advice and has the

potential to keep in touch with the child over the long term. However it does not rely solely on lone working and can be an effective part of a multi-disciplinary approach such as a Common Assessment Framework plan for an individual. The emphasis is also one of self-help, promoting coping strategies and in turn potential social capital. Easily accessible and flexible services are essential and the school base is ideal (DOH, 2004). 'Evidence exists for service protocols that promote equity, accessibility and choice and that CBT services should be organized around multiple levels of entry and service delivery rather than the more usual secondary care referral systems' (Lovell and Richards 2001). This approach is also potentially accessible to foster carers and adoptive parents to help work and care effectively for looked after children, who are estimated to have a significantly increased prevalence of mental health issues.

Cost — benefit analysis and prevention of life long difficulty should also be considered. As identified by the Mental Health Foundation (2005). Mental health problems in children increase demands on social services, education, health and youth justice services, and families. These costs are astronomical when problems are allowed to persist into adulthood. Mental illness is costing the UK £93billion a year and this is set to rise if we do not intervene.' Wanless (2002) has calculated that the cost benefits of better mental health care would be a net saving across government as a whole of some £3.1 billion a year. This does not take into account the savings from promoting mental health and preventing problems in the first place. It is also a quick and easily documented which aids time management productively and could potentially allow staff more time to work with other public health issues.

In summary, as identified by Wells et al (2003), it is possible to have a positive impact on children's mental health through school-based programmes. The most positive evidence of effectiveness was for programmes that adopted a whole school approach. These were implemented continuously for more than a year and were aimed at the promotion of mental health rather than the prevention of mental illness. Essentially such programmes can improve effective communication by conceptualising a young person's difficulties to help them understand them and become empowered to identify their own solutions. Training is also relatively quick and cost-effective with a one day course imparting the skills required. This could help remedy the findings of a study by Wilson et al (2007) who found that few respondents working with children with psychological and behavioural problems 'had received specific training in child and adolescent mental health but most expressed a wish to receive such training.' However it is important to recognise that this concept should not be seen as a 'quick fix.' 'The delivery of early intervention work in universal services should be supported through additional training, formal supervision and access to consultation from specialist services, (CAMHS Review 2008).

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RN level 2, RN Adult, Specialist Community Public Health Nursing – School Nurse.

I have a wide experience of working with children who have a variety of needs, physical, social, emotional and special needs. I began as a teenage volunteer, then went on to complete my nurse education within a children's hospital. I have work experiences within health and education in the practice of special needs. I returned to nursing in 2004 and completed the Diploma of Higher Education to convert to level 1 registered nurse in 2009. I am currently working in school nursing, specialising in children with disabilities in special schools. I believe communication and understanding children's emotions and their perspectives to be vital to successfully supporting children and their families. This is particularly challenging with younger and disabled children. Sensitive, flexible, creative and innovative approaches are required to enable developing the children's capacities. However small the information gained is, its significance should be recognised within the context of the child's life.

Assessing emotional health and wellbeing in children aged 12 years and under

This is a case study approach to understanding the role of Specialist Community Public Health Nurse (SCPHN) School Nursing (SN), in the process of assessing emotional health and wellbeing needs in school children aged 12 years and under. Generally, school nurses support the emotional health and wellbeing of children and young people through drop-in and one to one sessions in schools. In order to do this successfully consideration needs to be given to assessment processes. This will be completed through assessment of Sam, a 6 year old boy referred to the school nurse by his teacher with his mother's consent. In keeping with the NMC Code (2008) all references to individuals have been anonymized.

Sam is 6 years old, his teacher referred to the school nurse following discussions with his mother over anxiety within school. The family situation involved separation from Sam's father a year ago, with his mother refusing access. Sam lives with his mother and younger sister aged 5 years. Sam had presented as an overly anxious child who had difficulty in sitting still and was often quite tearful. Telephone discussion with mum revealed her to be quite anxious too; she voiced concerns that

Sam was on the autistic spectrum. Fathers married to the mother at time of conception have parental responsibilities and can apply for a contact order where access is denied (The Children's Act 1989, 2004). This is the process that Sam's parents are currently engaged in, although there is no direct contact between them. In children 12 years and under parental consent is a prerequisite for the school nurse to work with a child. Practitioners ideally need to work jointly with both parents as well as the child to resolve issues the child experiences (Schmidt-Neven, 2010). Consideration was given in the work undertaken with Sam to the danger that joint contact could have in regard to the practitioner becoming embroiled in the parental disagreement. This could jeopardise maternal consent for working with Sam. As no contact details for his father were available, the decision was made that work would focus primarily on Sam's emotional needs and feelings in school as referral originated here.

It was during Sam's assessment and subsequent reflections, that the level of subjectivity within this activity was identified, prompting deeper analysis of the assessment process with emotions and feelings. Differentiating between emotions and feelings is required for professional analysis. Emotions are physiological and psychological reactions within the brain, body and mind, resulting from meaningful events. The internal and external environments are intuitively evaluated through the senses to identify whether the event is beneficial or detrimental to the individual. These are responded to unconsciously, providing a basis for social interactions. They can countermand thought and cognition and feelings result from this (Howe 2005). The resulting feelings are a subjective encounter psychologically, physiologically or neurologically. The amalgamation of emotions and feelings are called affects. Affect theory considers emotions and how these are appraised to give meaning to experiences. Emotional intelligence is recognition, understanding and the ability to reflect on experience in relationship to others and the environment to provide feedback (Douglas 2010). This supports self-regulation within the affect system and displayed in empathetic approaches and social confidence within relationships.

In children, the relationship with the carer progresses slowly to incorporate a perception of how their emotional state affects each other and the responses each make (Howe 2005). This subjective situation required an ability to hear Sam's story and make sense of this. Understanding life events, emotional responses and associated feelings that precipitated the behaviour displayed at school was crucial. This may become part of the therapeutic process as the events are acknowledged and taken seriously (Blackwell 2005, Schmidt-Neven 2010).

Due to the complex nature of problems in school age children there is less research evidence for intervention (Howe 2005). The skill and experience of the practitioner in identifying and acknowledging issues

and when these require referring on is crucial to positive outcomes (DoH 2009, McCloud 2008). It was not fully possible to gain a comprehensive picture of Sam's life experiences; he appeared to be living in a warm, loving environment but it was unclear what previous experiences had occurred. As it was not possible work with both parents, promotion of self-esteem was initiated in one to one sessions at school. Exploration of his feelings in context of his family history could be contemplated later when better understood.

Through the sessions card games were initially used to engage Sam. He played happily and engaged well. Through this medium there was exploration of his attitudes and emotional life experiences. One day he talked about the point of separation "it was Boxing Day and he kicked us out; I was happy at Christmas 'cause I got my first DS but the day after wasn't good". Another time he talked about life at home while drawing the people who live in his house. Through this Sam was able to explain his current negative feelings towards his sister. After giving snippets of information like this attempts were made to explore these further but this resulted in him ending the session with "it's complicated".

Clark et al (2005) explore listening within an education framework. Listening is not simply auditory, it is complex and multi-faceted. It requires sensitivity and cognition to enable children to expose their inner feelings (Davie et al 1996, Lefevre 2010). Listening could be reciprocal to balance the power scenario for the child. Utilising the different aspects of listening so Sam could express himself in ways that suited his needs and ability was determined (NICE 2008). It was necessary to stop thinking or planning what to say or action to take and give Sam undivided attention and time to explore his feelings. The idea of using drawing as a method for Sam to communicate and gain control was procured from Clark et al (2005). Using a life story book Sam began to explore happier times in his life. He was able to draw pictures to tell parts of his life story. This use of visual listening facilitated a dialogue where he could explore his feelings without having to find the right words.

The work with Sam continues with the aim of improving his self-esteem. Over time, work on his relationship with mum, to support his wishes being listened to, will also be considered. School appears to mostly be a safe and happy place for him. His teacher reported that he looked forward to, was more settled and less tearful following, his one to one sessions. This case study approach looked at the assessment of emotional health and wellbeing by investigating Sam who was referred to the SN. Legal aspects of the Children's Act (1989 & 2004) were considered in relation to Sam's situation and the role of the SN to work with both parents where practicable. Safeguarding concerns require multi-agency input and sharing of information; as these were not highlighted confidentiality was maintained to support consolidation of the practitioner/child relationship.

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I completed my BA Honours in Early Childhood Studies at UCS in 2012. I am currently studying for a Masters of Arts Degree in Social Work at Brunel University in London. During my time at UCS I worked as a Support Worker for children, young persons and adults with mild to severe learning disabilities. I also undertook a placement in a primary school working closely with children with behavioural difficulties and soon realised working with people with disabilities was my passion. Once my MA is completed I hope to continue this research by undertaking a PhD.

Attention Deficit Hyperactivity Disorder in Childhood: a social construct?

Abstract

Both the UK and USA have seen rising numbers of children being diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) during the last decade (Underdown, 2007). It has been estimated that five to ten per cent of children and adolescents in the UK are affected by ADHD, with up to one in every hundred severely affected (Timimi, 2005, 2009, NHS 2010). Strong assertions have been made that ADHD has reached 'epidemic proportions' (Timini, 2005: 109). This has made ADHD one of the most studied, observed, debated and treated childhood disorders (Kendall, 2007). This paper reviews and evaluates debates of the causes and definitions of ADHD. It also examines validity of labels, effects and management of ADHD.

Introduction

There is no exact known cause of ADHD (NHS, 2010), rather there are suggestions and assumptions of many factors of causation which range from brain damage, gender and environmental causes such as diet and exposure to toxins during pregnancy. There are also critics who deny the very existence of ADHD. Alongside there being no specific cause, there is no concrete definition of what ADHD is and how it specifically affects a person that is diagnosed as having it. Among the most popular labels are; learning disability, mental health issue and emotional behavioural difficulty.

The following discussions will present an overview of ADHD by outlining the diagnostic criteria for ADHD in terms of its classification as a disability. In order to contextualise the concept of disability, an overview of

the different models of disability is offered. The paper will also examine the heavily argued causations of ADHD and the stigma associated with it before finally providing a critique of the medical intervention that many children with ADHD are subjected to.

Diagnostic Criteria of ADHD

The American Psychiatric Association (APA) has produced the Diagnostic and Statistical Manual of Mental Health (DSM) which contains the official diagnosis coding system used in the USA for mental disorders. The DSM (APA 2000: 85) states that the essential feature of Attention Deficit Hyperactivity Disorder is; 'a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequently displayed and more severe than is typically observed in individuals at a comparable level of development.'

The International Statistical Classification of Diseases and Health Related Problems (ICD) which is mandated by the World Health Organization (WHO), contains an appropriate selection of internationally endorsed classifications that provides a framework for governments and providers to use as a common language of disability. The ICD (ICD-10) refers to ADHD as a 'Hyperkinetic Disorder with disturbance of activity and attention whereby there is a lack of persistency in activities which require cognitive involvement'. It is interesting to note that both classifications highlight increased levels of activity and lack of attention.

Boseley (2012) claims the DSM's influence in the USA is uniquely strong and has been termed the disability 'diagnosis bible'. Despite ADHD diagnosis being coded within a 'mental disorder' handbook, the DSM and the ICD-10 tend to focus on ADHD as being an emotional behavioural difficulty (EBD). Additionally, the foci of both definitions is the behavioural aspect of ADHD which puts aetiological factors aside, such as disabilities a child may be known to already have. The National Institute for Health and Clinical Excellence (NICE) guidelines (2009) assert that diagnosis of ADHD must adhere to DSM criteria and ICD-10 research.

For a diagnosis of ADHD in childhood, the child must be observed in two key settings, these are usually the home and school. A child should display at least six symptoms from each of the DSM criterion for inattention and hyperactivity-impulsivity persistently to a degree which is maladaptive and inconsistent with development level. The DSM also insist that these symptoms must not occur exclusively with either a Persuasive Development disorder or a mental disorder, such as mood or anxiety disorder (APA: DSM-IV-TR, 2000 92-93).

If a child displays at least six symptoms from the inattention criteria but not the hyperactivity-impulsivity criteria, then the subtype Attention Deficit Hyperactivity Disorder, Predominantly Inattentive (ADHD-PI) subtype will be diagnosed. Alternatively, if at least six symptoms from the

'hyperactivity-impulsivity' criteria are met, but not from the 'inattention' criteria, then 'Attention Deficit Hyperactivity Disorder, Predominantly Hyperactive-Impulsive' (ADHD-PHI) subtype will be diagnosed. The discussions within this paper focus on the combined type of ADHD whereby the child must display at least six symptoms of inattention and at least six symptoms of hyperactivity-impulsivity.

Models of Disability

In order to review the key debates surrounding the definitions and causation of ADHD and the ways in which it is likely to impact on a child, it is important to understand it within the realms of the medical and social model of disability.

The medical model of disability is based on the assumption that the biological structure of the body is faulty. This is known as the 'deficit' model. Nettleton (2006) stipulates that within this model, medicine is thought to be able to repair the 'fault'. This model tends to neglect discard social aspects of impairment and disablement, concentrating on the impairment as being the problem of the individual.

The social model of disability however, considers disability to be more than a biological explanation. Whilst acknowledging impairment, the social model advocates that it is structural, social and environmental factors which play a key role in disabling individuals. It is within this model, according to Barry and Yuill (2008), that the full intricacies of conditions such as ADHD can be understood. This is due to relationships that people with ADHD have with society in terms of how they are viewed and portrayed and the further impact this can have.

NICE (2009) contends that it must not be implied that ADHD is caused medically or socially but rather through the interplay of multiple genetic and environmental factors. Underdown (2007) expresses the same view, recognising that particular emotional and behavioural problems in children can be influenced by interrelationships between factors in all systems and not subjected to just one. Children who do experience emotional disequilibrium or hyperactivity, for example those with ADHD or other conditions on the autistic spectrum, are in fact affected by the interaction of many dynamic factors.

Labels and Causations

A key factor of the controversy of ADHD, besides the dramatic increase in diagnosis, relates to the beliefs and arguments of the causation itself. The following discussion outlines the most common debates;

Genetics, brain function and anatomy

Research has not been able to prove consistent neurobiological differences in children who present with ADHD and those who do not (McNair and

Hicks, 2010; NHS, 2010). However, the DSM (APA 2000) highlights that ADHD has been found to be more common in the first-degree biological relatives of children with ADHD. In the USA, the medical discourse of ADHD believes symptoms are due to that of a congenital anomaly (Hart and Benassaya, 2005 in Timimi, 2005) which implies that the symptoms of ADHD are inherent at birth and are the product of genetic inheritance. If the causation is biological, it could be argued that the speculation of the DSM is correct. Thus ADHD relates more specifically to the medical model of disability and 'cures' could be found. However, it must be questioned as to how the number of congenital anomalies reached epidemic levels in a decade. Such proportions without definite causation are implausible. This then implies that social factors come into play and that ADHD is interrelated to both medical and social factors.

Gender differences

ADHD is prevalent in boys and girls, men and women. However, research suggests that it occurs more frequently in boys than girls (Brandau and Pretis, 2004; Kendall, 2007; APA, 2000; Barkley, 2006). The idea that ADHD relates to gender suggests biological causation. However, those who assert this do not clearly state that gender is a direct cause of ADHD but that boys are simply more 'prone' than girls. Andreou et al. (2005) dispute this, believing that there are no gender differences among children with ADHD. If this is true, the interplay of both the social and medical models would be evident here.

It is also important to question why the ratio of boys diagnosed with ADHD is higher than that of girls. Indeed, if the focus of ADHD is the behavioural aspect, it could be argued that play characteristics and behaviour patterns of most boys warrant the label of a condition which may require treatment.

Association between exposure to toxins during pregnancy and symptoms of ADHD

Research has been carried out as to the adverse effects of toxin exposure during pregnancy and the associated increase in the risk of ADHD. In a review of the literature of maternal smoking whilst pregnant, Langley et al. (2005 in Ball et al., 2010) concluded there is a risk factor for ADHD. More recently however, it has been suggested by Ball et al. (2010) that there are no findings to casually link the two and further research is required. Similar studies of the effects of alcohol consumption during pregnancy have also been carried out. NICE guidelines (2009) ascertain that factors such as these are associated as having an adverse effect on brain development during pre-natal life and childhood. The guidelines also acknowledge that these are associated with an increase in the risk of ADHD. However, Ball et al. (2010) suggest that the research is inconclusive and urge that further research

is undertaken to confirm if the ingestion of toxins in utero are acting as a direct risk for ADHD.

Association between food intolerance and symptoms of ADHD

There is a wealth of evidence about the effects of food and food additives on the brain. The first link between the two was published in 1975 (Puri, 2005). Foods that contain colouring and flavouring, chocolate, sugar, orange and cheese have been listed as the most common trigger foods for hyperactive behaviour. However, recognising food intolerance as a causation of ADHD can be problematic. Whilst it is alleged that certain foods and additives cause hyperactivity and, as explained earlier, hyperactivity is a part of ADHD, it is suggested that food intolerance increases ADHD related behaviour rather than being a cause of ADHD itself. Consideration would also need to be given as to whether hyperactivity declines when such food types are removed from the child's diet or whether additives have similar effects on children without ADHD.

No existence

One more debate which is important to highlight within this paper is to question the very existence of ADHD. Mellor (2009) proposed that due to the widespread attention around ADHD, it may be possible that the behaviour is in fact being confused with attention seeking. He argues that further distinction between the two is necessary.

Whilst it is acknowledged that the discussions above are broad and encompass both medical and social aspects of suspected causes of ADHD, they serve to suggest that there is no conclusive evidence of the actual causation of ADHD. This is problematic in that ADHD presents itself in a myriad of ways and therefore, interventions strategies need to be suitably tailored towards each individual child. The concluding discussions outline the medical intervention that is currently available for children with ADHD.

Interventions strategies available for children with ADHD

The 'deficit' model of ADHD advocates seeking a medical solution to the 'problem' and treatment. As such, the medication Ritalin is often prescribed to eradicate or alleviate the 'problem' within the child. Whilst it does not cure ADHD, it reduces symptoms and makes general day-to day living less of a problem (NHS, 2010).

The first stimulant drug available to reduce hyperactivity was introduced almost seventy years ago in 1955 (NICE, 2009). It has been since the mid-nineties that a dramatic increase in the use of these stimulants has become apparent (NICE, 2009). This coincides with statistics mentioned previously that highlighted concerns regarding the epidemic rise of ADHD diagnosis. NICE (2009) guidelines on ADHD diagnosis state that in the UK Methylphenidate (which became known as Ritalin in 1995) and Atomoxetine

are licensed for children aged six years and older for the treatment of ADHD. Dexamfetamine is licensed for children from the age of three years old.

Based on these figures, questions concerning the ambition of the drug companies supplying these stimulant medications must be raised. For instance, who are the drugs in the best interest of? Is it the child who these are being prescribed to? Or are they in the commercial interests of the drug companies?

There are many who argue against the use of Ritalin as it acts on the central nervous system very much in the same way cocaine does. It also has the potential for very severe side effects. Children are being prescribed Ritalin from a very young age and take it for extended periods of time, however the long term effects are not completely known. It is unsurprising that the increased controversy of the use of Ritalin continues to rage. Rogers and Pilgrim (2010) argues that drugs such as Ritalin are used in the field of mental health are mainly benefitting drug companies as they can market benefits to a very wide range of conditions due to the weak validity of diagnosis in the first instance.

Furthermore, Timimi (2005) observes that within a system of capitalist global markets, drug companies have little choice but to do whatever works to increase the sale of their drugs, regardless of the impact on health care. Boseley (2012) points out that the current system is ripe with financial conflicts of interest. This implies that doctors who prescribe children with medication such as Ritalin are being paid to promote them without fully considering the long term effects. Advocates of Ritalin present a very valid argument in terms of managing ADHD and the National Autistic Society (2011) concede that Ritalin can be of limited benefit to some children. However, they also argue that Ritalin is used as a quick solution which prevents families and schools being able to understand real issues of the condition. These issues include acquiring the appropriate education and support for children with ADHD.

Akram et al. (2009) acknowledge this it is the medical model of disability that has been instrumental in ADHD being regarded as a legitimate psychiatric disorder. However, current criticism indicates that the DSM needs question the high volume of diagnosing what many deem to be 'ordinary behaviour'. The question is who is trying to eradicate this so called 'deviant' behaviour, and whose best interests might this serve?

Conclusion

The discussions within this paper have outlined some key issues and debates surrounding ADHD. The paper has highlighted that there are many unanswered questions and debates, and suggested that the controversy surrounding ADHD is ongoing. Clearly, the causation of ADHD remains inconclusive and requires further research.

The inattentiveness and hyperactive behaviours of some children are considered to be problematic to the extent of being considered deviant. It is argued, however, that childhood is becoming constructed in a way that requires children to conform to authoritarian forms of behaviour. If they do not, they are medicated to become more compliant. However, alongside medication comes a label of impairment. This can be disabling and stigmatising.

The author invites the reader to ponder on these complexities for a while. Whilst recognising that excessive hyperactivity may be detrimental to the overall development of the child, the behaviours exhibited by children with ADHD are considered problematic by a society that values children who are passive and compliant. Children who do not 'fit' with such expectations are labelled and their difference stigmatised as problematic.

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Gina's interests lie in increasing opportunities and improving learning outcomes for learners from socio-economic disadvantaged backgrounds in order to improve their life chances. The learner voice is also an area of interest, in particular listening to the voices of those who do not always know they have a right to be heard.

Establishing the learner voice for learners with autistic spectrum disorder in further education

Abstract

The paper uses a case study perspective to examine how a learner, with a special educational need (SEN), autistic spectrum disorder, can contribute to the learner voice within a further education college (FE). In order to raise the social power of those with SEN, the case is made for their experience of college processes to be heard alongside those of their nondisabled peers. Indeed legislation and the government expectorate Office for Standards in Education, Children's Services and Skills (Ofsted) demands it of education providers. However, in this quest for a more inclusive world, there lays a tendency for normalisation; the social model of disability focuses on breaking down societies barriers, often ignoring everyday practical problems experienced by those with disabilities. The paper supports the view that the social model does not focus on individual need and therefore, is as oppressive as the medical model of disability. As a result of this paper and on my request, a group of learners studying at foundation level in an FE College, along with their tutors and support workers, produced a presentation using their own methods of communication, which included photographs and video clips of their college experience. This was presented to the Principal of the college and contributed to immediate and long term planning for improving college provision.

Introduction

In this paper I will conduct an analysis of how a young person with a specific learning difference; autistic spectrum disorder (ASD) can be successfully included within a further education setting. A case study will be used to identify the characteristics, and learning profile of the young person. I will critically analyse the paradoxes that exist between special educational needs (SEN) and inclusion, by making use of the social and medical models of disability. The paper will evaluate current policy and practice, and make recommendations for specific intervention to effectively support the individual needs of the learner to ensure their voice is heard.

Inclusion and Special Educational Needs

Inclusive education is conceptualised herein terms of a 'rights based process of increasing participation,' (Booth: 2000, cited in Hicks, 2009, p.38), in the community and culture of a mainstream further education college 'decreasing exclusion' (ibid) must become the priority. Inclusion describes the extent to which an educational establishment welcomes pupils identified with (SEN) as 'full members of the group and values them for the contribution they make,' (Hicks et al, 2009, p.2). To be effective, inclusion not only ensures all learners have active participation in the school life, it also should welcome their 'diversity of interests, abilities and attainment,' (ibid) and recognise how this enriches the life of the school. Wherever possible, impairment and disability should be made irrelevant and classed as a 'separatist notion of disability,' (Shakespeare, 2006, p.82). Where inclusion is managed effectively there are benefits for all young people, those with disabilities and those without (Babad, 2009). It can create a social framework that helps to break down social inequalities and discrimination for those with learning differences (ibid). More active participation in the school could lead to greater access to social power in the wider society. This emancipation could be a 'strong determinant of the life-experience of disabled people in general,' (Shakespeare 2006, p.75).

Subsequent to the publication of the Warnock Report (1978) 'Special Educational Needs', children with disabilities and special educational needs where possible have been integrated into society, including mainstream education. In the UK there has been a strong emphasis on the social model of disability, which focuses on the 'removal of oppressive barriers in society,' (Kelly, 2005, cited in Shakespeare, 2006, p. 73). The medical model of disability has become viewed as negative for implying an in-person deficit. Shakespeare argues that the former can be as negative as the latter. While the medical model sees disabled people as being victims of a defective body or brain, the social model of disability 'sees disabled people as victims of an oppressive and excluding society,' (Shakespeare, 2006, p. 79). Gillman et al (2000) and Chappell et al (2001) claim that this view has led to 'normalisation' and influenced opposition to forms

of 'medical or psychological diagnosis or labelling,' (Gillian et al., 2000, Chappell et al., 2001, cited in Shakespeare, 2006, p. 71). This influence could mask individual and thus more salient problems and issues of disability. The advantage of diagnosis and professional labelling are the access to services and support. Critics of the medical model however, argue that a person's identity, including personality, gender and sexuality, can be overlooked because the impairment label becomes their most prominent and relevant feature dominating social interactions. For many people with impairments, a label or badge is rejected because they prefer to be 'seen as ordinary members of society... free of limitation or classification,' (Shakespeare, 2006, p.72). Young people in FE College may wish to be seen as ordinary, not different and part of the youth culture. However, social model theory has not 'effectively incorporated intellectual impairments,' (Chappell, 1998; Chappell et al., 2001, cited in Shakespeare, 2006, p. 75), and challenges remain. More radically, the refusal to define oneself by impairment or disability could be considered 'internalised oppression' or 'false consciousness,' (Shakespeare, 2006).

The Learner Voice in Further Education

Further Education (FE) College provide education, skills and training for a diverse group within the lifelong learning sector including learners with a wide range of special educational needs (SEN). Over recent years political influences and policies for inclusion have created a person centred curriculum that includes learners with SEN in mainstream provision. The government (2011) Green paper for SEN, includes recommendations from the Wolf Report (2011), to extend the age up to twenty five years, at which learners with SEN can access further education and training. The rationale for this is additional time for the development of vital skills for work and independent living (DFE, 2012). Depending on the government response to the Green Paper, learners with SEN may in the future spend a considerable part of their life as a young person attending FE College. To ensure a good social and educational experience, it is vital that they and their parents have a say in how this service is managed. A new focus for Ofsted Common Inspection Framework for Further Education and Skills (2012) is for educators to demonstrate how effectively they are listening to their learners' views and how this impacts on the organisation. FE colleges have a significant number of obstacles to overcome to enable the views of their learners to be heard, including those without disabilities for example socio-economic disadvantage. Significantly, many FE learners' beliefs and low expectations about the right to be heard, which may be due to economic and cultural deprivation, can be an extremely difficult barrier to overcome, (Wolf, 2011). Learners with SEN can face dual or multiple discrimination, in that they may be affected by economic and cultural deprivation factors along with their disability.

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Autistic Spectrum Disorder

Autistic spectrum disorder (ASD) refers to a group of 'identified disorders of development with lifelong effects that have in common a triad of impairments in: social interaction, communication, imagination' (Wing, 1997, p. 253). Those with ASD often have a narrow or rigid perspective and a non-holistic approach to the world around them. They may demonstrate stereotypic, repetitive patterns of behaviour which can leave them isolated and thought odd by their peers. There have been many theories developed to explain the behaviour, of which one 'theory of mind' highlights the child's 'difficulty in understanding or interpreting the mental state of others' (Long, 2011, p. 284). Babad (2009) refers to this as the inability to decode (read social cues) or encode (communicate their own emotions to others). Published accounts by young people with autism show commonality with 'pervasive anxiety and fear...of being in a social world' (Grayson, 2005, cited in Long et al., 2011, p. 286). For many these have a profound effect on their social interactions and can create language barriers between young people with autism and those without; impeding the quality of their learning experience in mainstream education, (Clough and Corbett, 2000).

Learners with ASD who attend FE College should in the interest of moral equity and to prevent marginalisation be included in all aspects of college life, including the learner voice. Identified as one of the most dangerous of the five faces of oppression; 'marginalisation,' can exclude a whole category of people from usefully participating in society (Young, 1990). This exclusion subjects them to material deprivation in a society where others have plenty, (Young, 1990, cited in Henderson and Waterstone, 2009). Wilkinson and Pickett (2010) argue that inequality, including inequality in social standing can impact profoundly on all aspects of a person's life. Their research into unequal rich countries of which the UK is one, acknowledges this as a human rights abuse, in that lowered life expectancy in the modern day is a social gradient. FE must therefore, ensure that its SEN policies and practice prepare all of its learners, including those with learning disabilities, for an adult life of participation, choice and opportunity that does not assume progression onto the welfare state.

A learner with ASD may be a vulnerable young person and therefore, developing their ability to internalise the world around them is vital for their current and future safety in an unpredictable world. Many stories from those with ASD who attended mainstream education provision, suggest that much of their interaction with those deemed to be 'normal' are negative. Others, who see themselves as having benefitted from being included in mainstream education, acknowledge that their ability to take an active part in society beyond education would not have been so had they attended a 'special school' or separate provision. While they have gone on to attend university and are in employment, they have noticed that their peers, who attended special schools have not fared so well, and are marginalised by society in their young adult lives, (The National Autistic Society, 2012).

Case Study

Appendix 1 refers to a case study in which a learner who presents with autistic spectrum disorder is asked to become a course representative and contribute to the Learner Voice within a FE College. The college has good intentions and has tried to take an inclusive approach by not making determinist assumptions that this learner is unable to make a worthwhile contribution. However, it has used unsuccessful strategies to include the learner, because it has failed to take account of her special needs. The characteristics of this learner 'Jenny' are such that she finds new situations, with new people and in particular large groups of people, stressful. Along with hyper-sensitivity to sound, this causes Jenny to become anxious and therefore excludes her from taking part.

At this early stage an intervention could be put in place to include Jenny without her necessarily having to attend group meetings, unless she develops the confidence to do so. An antecedent to the stressful reaction would be for the teaching and support staff to spend time with Jenny explaining what will happen and when. The room may be visited a few times before the day and each time relevant members of staff or other learners could be there to welcome her. This is assuming that Jenny is ever able to overcome her anxiety of being with large groups. An alternative approach is for staff to open up dialogue with one or two learners, with or without disabilities and with Jenny's permission, to become acquainted with her. This could involve one or two appointed learners from the Learner Voice, to informally meet Jenny in her familiar classroom surroundings. Research with 'conventionally' inarticulate children carried out by Boggis (2011), explored bespoke, creative and reflexive, approaches for gleaning insights into their experiences. The focus was on the:

'participant's individual communication methods rather than how their impairment affects their ability to use conventional methods of communication' (Boggis, 2011, p.4).

The National College for School Leadership (NCSL, 2007) conducted research into what children with special needs, have to say about their variously inclusive schools. The researchers wanted to find out what the children and young people with communication limitations had to say directly and move away from reliance on parents or supporting adults to interpret facial expressions or gestures. To do this the researchers used various communication tools. For example, the learners were given a camera and went around their school taking photographs of places and things they did and didn't like. A similar method could be used for Jenny, who could be encouraged to work with her tutors and support worker to put together a story board to reflect and communicate her thoughts about the college. Alternatively Jenny, with or without assistance, could create

a pod cast. Later this could be brought to the Learner Voice meetings and discussed on her behalf without Jenny having to experience the anxiety of attending in person. Jenny is able to talk however, as pointed out by Simons et al (1989, cited in Boggis, 2011), for many disabled young people their lives are controlled by others and this can result in a tendency towards acquiescence. Therefore, another method that would establish a valid opinion would be to use a 'diamond ranking game' where post it notes are arranged in order of preference. These findings could be included with other contributions from other groups across college. Another method of participation for Jenny would be to establish an online forum where she could share her thoughts with or without help from a support worker. Jenny may be very good at keeping the online forum up to date and this could be given to her as a specific role for the learner voice.

Effective leadership is critical for driving improvement; if senior management value inclusion this will be cascaded to teaching and support staff 'It is school and college leaders who drive the ethos and direction of their institutions' (DFE, 2011p62). Therefore, the college management team could reconsider its operational approach to the Learner Voice. For example; within all curriculum areas of the college separate cultures exist. Bronfenbrenner (1993) acknowledges this in the ecological model, as microsystems that exist within a macrosystem (whole organisation). These separate areas have very different physical environments eg. a construction workshop compared to a hairdressing salon; the expected normative behaviour within these areas, will be relevant to the specific curriculum environment and expectation. While there may be advantages in bringing learners together from across college for some aspect of the learner voice; it may also be effective for them to have their own views exchanged more frequently, within their own curriculum area. For Jenny this approach would be less stressful because she would be in familiar surroundings, among people she feels safe with. It would be an excellent opportunity for Jenny to develop her self-confidence and self-efficacy, offering her a social advantage she would not otherwise have had. These ideas could ensure that all learners' with disabilities can contribute to the Learner Voice if they so wish. Where this could be exclusive and not inclusive is; if a particular learner was singled out for being what Shakespeare (2006, p. 80), describes as a 'tall poppy' this is a person that succeeds despite their disabilities but who does not necessarily represent the norm.

Conclusion

In this paper I have analysed the characteristics and learning profile of a learner with a specific SEN; ASD and made recommendations as to how her participation needs can be met in terms of having their voice heard in an FE college. The recommendations I have made may help to address some shortcomings of the social and medical model dichotomy. They offer

a new approach for including learners in a way that recognises their needs and puts them at the forefront of the organisation. These recommendations offer a spectrum of possibilities for embedding equality and diversity in the experience of learners without disabilities. The learners, who become involved with the learner voice and interact with Jenny, could be encouraged to go back to their curriculum areas and share their experiences with their peers as part of the tutorial process. This could be instrumental in developing a deeper understanding of the nature of autism and other disabilities, leading to greater 'authenticity in social behaviour,' (Babad, 2009, p. 9), towards those with learning differences. Participating learners may take this with them out into the social world, offering hope for positive change, for as Oliver (2009) would declare a more inclusive world.

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Appendix 1

CASE STUDIES

Jenny is 17 and was diagnosed as being on the Autistic Spectrum when she was She doesn't communicate very well and appears quite happy to sit for long periods of time doing very little. If asked to do some written work she will inevitably bring out a dictionary which she will look at for extensive periods until asked to put it away. She might then write two words before repeating the same procedure again. She will often spend a long time

Continued on next page...

searching through her bag for a pencil or other objects which she may not even need.

Jenny does not relate well to other young people but she often appears to hang about on the periphery of their activities. In group activities her contributions are often not appropriate and she is hypersensitive to sound which causes her to cover her ears if there is too much noise. Jenny is often seen with her clothes in disarray and looking generally dishevelled. She needs to have one to one support at all times including break times.

Jenny settled in well and made some good progress during her first year at Further Education College. She has just returned for her second year and her college tutors have asked Jenny if she would like to become involved with the learner voice in order for her to open up about her college experience. Jenny is very keen and talks about it all of the time with her tutor and support worker.

Critical Incident

Jenny arrives with her support worker for the first meeting with other learners from across college, including disabled and nondisabled learners. She becomes very agitated and is unable to enter the unfamiliar room with all of the new people, whom she has not met before. The support worker has to take Jenny back to her familiar classroom to calm her down. Later Jenny's parents contact the college to say that Jenny has become very anxious about attending college.

Adapted from a case study: SCoTENS. [Available Online] http://scotens.org/sen/case_studies/andrew.html. Accessed 27.7.12.

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I was born in the UK but am half Italian, half English. I first came to work in Suffolk in 2000 when I joined Suffolk Community PCT as a Health Visitor in Whitton Clinic, Ipswich. Prior to this, I followed an extremely varied career path in both academic research & specialist community nursing. Following graduation from London University in 1979, I first worked as a Research Psychologist at Leicester University (in conjunction with the Clinical Psychology team based at Carlton Hayes Hospital) and then shortly afterwards as a Psychology Researcher based at the RAF Institute for Aviation Medicine in Farnborough, Hants.

In 1984 I decided I would like to train as a Health Visitor which in those days required around five years general nurse training, three as an RGN at Addenbrookes' Hospital in Cambridge followed by several years as a theatre and Casualty Sister in Cambridge. In 1989, I moved back to Leicester again to train as an RHV. After qualifying in 1990, I moved to Hertfordshire where I remained for the next ten years, working first as a Health Visitor, progressing to Team Leader (Child Protection) in 1990, before finally moving to Ipswich to work ten years later in 2000.

Upon moving to Ipswich, following one year at Whitton Clinic I applied for my current post as a Lecturer in Early Childhood Studies at the (then) Suffolk College, where I continue to teach on the B.A. (Hons) ECS course at UCS, also acting as an External Validator for many ARU franchised ECS courses. I am currently working towards my Professional Doctorate in Health, Social Care and Education at the University of Essex.

Finally, I am very pleased to be able to make a contribution to this exciting new UCS journal by critically examining research in an area of ever-increasing global public health and academic concern; the current childhood obesity epidemic which plagues three quarters of the Western world and which is set to increase to pandemic proportions by 2015. That is, unless we academics and health professionals choose to take action!

Article follows on next page

Secondary data analysis of an ESRC – funded research article: “Parents’ and teenagers’ conceptions of diet, weight and health: Does class matter?”

Article authors (2008) Wills, (Principal researcher) W.J., Backett-Milburn, K., Lawton, J. MacKinnon, D., and Roberts, E.M. University of Hertfordshire.

Background and rationale for the study

As a panel review member of the research review body ESTRO (Essex Student Research Online, University of Essex) in Oct 2012 I was asked to review an ESRC – funded study by Dr. Wendy Wills (2008). The topic of healthy nutrition is of particular interest to Essex University researchers as well as UK Specialist Community Nurse Practitioners, in the light of recent government research into the growing global child obesity ‘epidemic’ (WHO 2010 and “The Healthy Child Programme “ DoH 2012).

The aim of my critical review was to reflect upon the key research design features of the study, taking into account the existing suitability of the sampling methodology, data coding frames used, methods of data collection and analysis and comment on the overall significance of the research findings.

Definitions

The definition of “secondary data analysis” is a process whereby original data is reviewed and re-analysed in peer reviews, in cases where researchers have wanted to explore a topic in more depth, or for alternative applications to a similar research topic. (Heaton 2004, p.2) This particular project was chosen as it conforms to the qualitative research standards as set out by the ESRC (2011). The “robustness” of the study was also evaluated using Heaton’s “sound research” criteria (2004). Interestingly this particular study was classified by the ESRC as being “good” (Wills et al, 2008b, p.14) and this was another one of the reasons it was selected for critical analysis.

Introduction to the study

This study was originally commissioned because U.K. Health Agencies

have finally acknowledged the huge growth in global obesity rates over the last decade, particularly amongst children and young adolescents. For example, in 2010/11 around one fifth of all pupils in Year 6 (aged 10-11 years) were classified as obese (DoH, 2005). Furthermore, over the last few decades, government-commissioned reports into health inequalities such as "The Black Report" (1989) and "Our Healthier Nation" (1998) (cited in Baggott 2000 p.225) have demonstrated a clear, causal relationship between epidemiological outcomes and "social class" socio-economic differentials, particularly in relation to long-term mortality and morbidity rates.

Furthermore, according to Wills et al (2008a) and Baggot (2000), there is much evidence to demonstrate that teenagers from lower social class groups consume diets that are less "healthy" in that they contain fewer fruits and vegetables than children from middle-income families. There is also evidence from the literature that children from "lower classes" have a higher risk of becoming either overweight or even obese (Jotangia et al 2005, cited in Wills et al 2008c p.1). The original rationale for conducting this study was therefore to see whether there were any obvious, identifiable social class differences in parental and teenage attitudes towards the importance of both aspiring towards and maintaining, a healthy diet and lifestyle.

Key research aims and objectives;

Wills et al (2008b p.2) had the following five key research objectives;

1. To gain a better understanding of "middle" and "lower-class" parents' and teenagers' "conceptualisations of the teenagers' dietary practices and health concerns."
2. To explore similarities and differences in "dietary practices and health/weight conceptualisations" between the two classes of participants, (classified as "lower" and "middle-class" by the researchers) which were selected via a purposive sampling method from four local Scottish schools.
3. "Exploring the salience of class-based distinctions (e.g. habitus) for understanding the health-relevant behaviours and conceptualisations of obese/overweight and non-obese/overweight young teenagers and their parents "(Wills et al 2008b p. 2).
4. & 5. The final two objectives relate to the need to carry out consultations with relevant health agencies with a view to creating new social policy outcomes, aimed at reducing health inequalities for young people and their families' U.K.-wide (Wills et al 2008b p. 2).

Whilst these five research aims are relatively complex, they do fit Bulmer's (2003, pp. 45-47) recommendations in that they can be seen to contain both deductive and inductive elements. However he does acknowledge that the relationship between research and policy is not straight-forward, because when considering how social issues come to be defined as "social problems" it requires interest groups to engage in

“claim-making activities” in order to make “fact-based claims” that support their cause. In the reviewers opinion the Wills et al (2008b) study fits into this category.

Critique of the Methodology

Sampling

Drawing on data from an earlier qualitative study of “lower-class” Caucasian Scottish teenagers and their parents (Wills et al. 2008a), the researchers set about selecting “middle-class” children and families in this study so that attitudinal and dietary social comparisons could be made (n = 36, 18 girls and 18 boys each with one parent, giving 72 rich data transcripts). Interestingly, despite the fact that these one hour-long, highly detailed interviews covered nearly every aspect of the families’ daily eating and exercise habits, none of the exercise-related interview ‘rich text’ data was considered for detailed analysis save for a brief, generalised allusion to attitudes of families in the ‘middle-class’ sample, e.g. “Being physically active was put forward as an essential aspect of being a healthy, moral citizen” (Wills et al 2008b p.11).

This was despite the fact that at least three of the transcripts relating to both teenagers and parents in the ‘working-class’ sample analysed by the reviewer from data retrieved from Wills et al. (2008a) discussed at length their enjoyment of physical outdoor activities such as “I can’t wait to get out when I’m at home because everybody’s out” (Boy ‘Tod’) ” and (Girl, ‘Amanda’: “(We) like not to make plans for certain days because we are going out.” (Wills et al 2008d).

Since differentials relating to levels of and attitudes to exercise are key factors in determining whether or not a teenager is likely to be overweight (Sarafino and Smith 2011, pp.177-181), the reviewer did wonder why the researchers went to the trouble of asking detailed lifestyle questions of all their participants, but then decided to lump all their findings into one “broad code” of their final data coding frame, effectively ignoring the impact of exercise as an important attitudinal lifestyle variable (Wills et al 2008b p.6).

If the data were to be re-analysed, taking account of exercise variables, then arguably a much more comprehensive understanding of both the parents and teenagers’ overall attitudes to their weight might very well emerge. For example, in at least four interview transcripts considered by the reviewer, (102A & 361A, Wills et al 2008d) and Todd and Amanda (Wills et al 2008a), active teenagers from both social groups indicated that their parents were more willing to allow them a snack in-between meals, as they were “always out and about” and “on the go a lot, walking the dog and such-like” (Wills et al 2008d).

Methodological flaws

To summarise then, one of the key criticisms this reviewer has in relation to this particular study, is that whilst the research team did acknowledge some methodological weaknesses in their participant-selection/classification questionnaire, which was based on a quota-sampling method (Arber 2003, p. 64) they pressed ahead with using it anyway. One questions the validity of their 'screening questionnaire' in that it was essentially post-code based as well as including "brief observations" of each family home.

In Wills et al (2008c) the researchers clearly stated that occupational status was taken into account, but in the reviewers' opinion some of the occupations listed in the Wills et al "middle-class" study (2008b) would not necessarily fall into standardised, OPCS categories. (1980 cited in Rose, 1995 p.1). For example, the parental occupation of parent 369P is described as: "working with husband's own business." This could range from being a person booking appointments for a gardening business, (categorised as Social Class IV-V) to being the personal secretary of a medical consultant (Class I-II); yet she was placed in the "middle-class" participant group by the researchers (OPCS (1980) cited in Rose 1995).

Further critical considerations

Whilst it is to the researchers' credit that they did acknowledge the difficulties of classifying the research population in this way, namely: "this prompted much discussion ... about whether objective indicators truly capture what it is to be middle-class" (Wills et al 2008b p.4), they still decide to use the original tool they had developed, despite the fact that most government-based social research is based on OPCS categories (cited in Rose 1995). Another difficulty here, as noted by Wills et al (2008b) themselves, was that socio-demographic location does not always take account of professional families who may have moved house to a more affordable, but more socially-deprived, area and vice versa. In Rose's view, 'social class' as defined by OPCS classifications (which derive principally from professional occupational status) probably provide the most reliable indication of parental educational levels and therefore are a more accurate measure than socio-demographic location (Cited in Rose, 1995, p.2).

Ethical considerations

Teenage participants were classified into "normal weight" and "overweight" categories according to their BMI, which was calculated after a confidential weighing and measuring session, consented to by both teenagers and parents (Wills et al 2008b). A BMI of 19-24 was considered "normal" and 25-30 was categorised as being "overweight". This type of physical classification of children does raise ethical questions however, as the research selection process itself may have highlighted to teenagers who did not previously regard themselves as overweight, that they were now

being medically classified as such (Tschudin, 1992, Ewles and Simnett, 1989).

This may well have triggered feelings of anxiety for all concerned, as well as having the potential to impact upon subsequent interview responses from the perspective of potentially heightening the need for social desirability in respondents (BPS 2009). Once again, Wills et al (2008b p.12) did indicate that they were aware their strategy was potentially risky and that whilst they accepted that some of the girl subjects refused to be weighed at all, they nevertheless continued to use this method of participant categorisation and labelling. The reviewer would argue here that the team were prioritising the objectives of the research above the well-being of their teenage participants (Wills et al 2008c).

Furthermore, in relation to the “overweight” versus “normal weight” participants, Wills et al (2008b p.12) concede: “There were few differences in relation to families with and without an overweight or obese teenager.” Therefore, the reviewer wonders whether this aspect of sample categorisation was even necessary, although from a secondary data analysis perspective it would be interesting to compare teenage eating habits with exercise levels to attempt to get a better understanding of precisely which factors were more likely to account for these teens being overweight in the first place (DoH 2005, 2008).

Lack of consideration of pre-existing biomedical and psychological factors.

Linked to this is another medical aspect worthy of secondary analysis. This was the failure by the research team to record prior to interview, any individual medical histories from participants of any familial, dietary-related diseases, such as high blood cholesterol levels, or history of dietary-related diabetes. This is important because as health psychologist Ogden (2010, pp. 60-67) are keen to explain, there is a vast difference between people’s “health beliefs” and “health behaviours”. The fear of knowingly not preventing the ill-health of a loved one is a factor that would inevitably trigger parental concern, affecting both their attitudes and behaviours in relation to minimising health risks for their families’ future health (Ewles and Simnet 1989).

Interestingly, concerns related to the potential risks posed by a history of high LDL levels did arise in at least two of the transcripts the reviewer analysed, in both the “lower” and “middle-class” groups (Wills et al 2008d). A “middle-class” parent in cited a ‘family history of coronary artery disease’ as a factor which affected her purchasing choices when meal-planning; interview 102P (Wills et al 2008d). Therefore, in terms of secondary analysis of the data, any health concerns raised by parents in particular, need to be included as an important influencing factor in their overall dietary, decision-making process (Odgen 2010).

Critique of the data coding frames used and data analysis.

As in Wills et al. (2008a), in a later paper Wills et al. (2008c) state that they used a semi-structured interview approach in order to facilitate “flexibility and depth” in relation to their data and to try to ensure that the interpretation of the data was an accurate reflection of the experiences of their participants. May considers this to be good research practice (May 2003, pp. 200-219). All the rich text transcripts were examined and later cross-examined by the five researchers in order to establish a consensus in terms of “emergent and recurrent themes in the data” (Wills et al 2008b p 5). In order to be able to carry out clear comparisons with data from their previous study, the researchers re-used the broad coding scheme they had developed in Wills et al (2008a) study. Codes in the (2008b) study were similarly listed as; “Eating with family”; “Eating with others”; “Tastes and preferences”; “Weight/body image” and finally two rather broad categories of “Health” and “Physical Activity”.

It is important to note here that a useful and comprehensive “Users’ Guide” to the research is provided, containing copies of the screening tools used and “Topic Guide” proformas for the structure of both interviews, which had been redeveloped following the use of a teenage focus group and a pilot study Wills et al (2008c). Again, this is an indicator of academic rigor, according to Arthur and Nazroo (2009, p.115).

However, whilst in the data archive (Wills et al 2008d) individual transcripts have been numerically codified, in the “End of Award Report” (Wills et al, 2008b) participants have been given pseudonyms instead, making it extremely difficult for reviewers to identify exactly which participants the researchers are referring to. It also makes it almost impossible to draw clear comparisons between the two data sets.

Furthermore, an actual comparison of the data relating to the original study (Wills et al, 2008a) is not included as an appendix to the later study (Wills et al, 2008b) and therefore the reviewer had to look extremely hard to find data from the data archive (Wills et al 2008d), in order to be able to locate the original interview transcripts for the “lower income families” study discussed in Wills et al (2008a) and (2008b). According to Peräkylä (2004, pp. 283-300), this apparent lack of transparency means that this report does not bear the hallmarks needed for a “good” research study, which is how the Wills et al (2008b) “End of Award Report” was originally described by the ESRC funding body (ESRC 2011).

Critical evaluation of the reliability and validity of the findings.

In terms of internal validity, clearly efforts had been made to cross-validate interview coding themes and draw comparisons between current and previous data sets by external members from the ESRC grant-holding bodies, which Wills et al (2008b p.4) claim helped them differentiate more clearly between “classed” differences in dietary-related “perceptions and

conceptualisations" which they otherwise might have missed.

As previously discussed the entire basis for the researchers' somewhat crude, two-tier classification of participants into "lower" and "middle-class" groups needs to be questioned and may account for some of the similarities in dietary attitudes and behaviours of the two participant groups, as reported by Wills et al (2008b). For example, when performing a secondary analysis of several interview transcripts, randomly selected from both parents and teenagers from the two social groups (including both 'normal' and 'overweight' teenagers), it quickly became apparent that the majority of parents and children demonstrated good, clear knowledge and understanding of those food groups classified as being "healthy" by the Department of Health (DoH, 2008). They also demonstrated, in the case of the all parental interviews especially, a very clear understanding of the short and long-term importance of providing teenagers with a variety of different healthy options -see 102P , 332A, 361P, 369P (Wills et al 2008d).

Rationale for the use of secondary data analysis.

Interestingly, although the researchers' claim (Wills et al 2008b) was that there was a marked social difference in the actual enforcement of healthy dietary values upon the 'lower-class' versus the 'middle-class' teenagers in the study by their parents, when re-examining the transcripts no such clear differences could be identified by this reviewer. In fact, in one of the 'middle-class' families interviewed, the mother demonstrated an extraordinary flexibility and lack of vigilance with regards to both the types of foods she allowed her daughter to eat and the timings of her daughters' evening meal, which on some school nights was kept warm for her up until 9.30 pm if she was "playing out". See 361A and 361P, (Wills et al 2008d). The reviewer therefore challenges the assertion by Wills et al (2008b) that it is possible to make broad, class-based generalisations regarding dietary behaviours and attitudes on the basis of interview transcripts alone. Hammersley (2008, p.30) provides a compelling argument for the importance of not relying exclusively on interview transcripts, stating that "they do not provide a reliable basis--on their own--for inferring what people say and do in other contexts."

A further, in-depth secondary analysis of the data would therefore seem to partially refute the findings of Wills et al (2008b p.12) who confidently conclude: "This study has shown that experiences and conceptions relating to diet, weight and health are driven by class-based distinctions and tastes". Interestingly they do not trouble themselves to clarify in their report exactly what they mean by this. When comparing the interview data on dietary preferences for both "lower" and "middle-class" groups, the reviewer notes that the range of "favourite" foodstuffs catalogued in both data sets is remarkably similar, in that it included a mixture of both relatively "unhealthy" meals, such as pizzas, chips etc. and

“healthier” meals such as fish, chicken and a range of fruit and vegetables (Wills et al 2008d).

Final critique of the research findings

The proposal that variations in health status and morbidity rates can be linked to differences in food choices and health behaviours made by families from different social classes has, to a certain extent, been corroborated by some of the research findings in the Wills et al (2008a) and (2008b) studies. However, the reviewer would argue that individual differences in parental attitudes towards diet are not exclusively driven by social class, but can be attributed more to personal attitudes towards dietary habits and lifestyle, which in part derive from a uniquely individual, general knowledge-base (Sarafino and Smith, 2011). In their final paragraph which points to “future research priorities”, Wills et al (2008b p.14) do identify the need to explore further how health practices and attitudes might shift over time. The (2008b) research findings to date have been disseminated to health professionals, academics and policy audiences at six different conferences and social policy recommendations have also recently been put before the Scottish Parliament (Wills et al 2008b, Appendix B).

In conclusion it might be argued that on a far simpler level, the practicalities and risks associated with everyday life experienced by those in relative poverty may go a lot further towards explaining why both parents and teenagers living in these families, have more of a functional, “good-enough” attitude towards healthy foods and a relatively casual attitude towards being overweight, than their middle-class counterparts.

However, the actual complexity of the data reviewed in the secondary analysis does not justify some of the over-generalisations reported by Wills et al (2008b p.12) such as: “Working-class practices are based on a need to ‘get by’ which impedes a future-oriented outlook.” Based on a relatively small sample of the 144 interview transcripts examined by the reviewer, huge generalisations such as this, which attribute a fixed set of attitudes to all “lower-income families” in this study is, in the reviewers’ opinion, not only potentially biased but is also a poor reflection of the rich content of the interviews as they were originally transcribed.

Conclusions of this secondary critical review

Interestingly Hammersley and other sceptics (2008 and 2011) have considered whether any claims made by social researchers are able to properly reflect or represent the actual social and personal characteristics of the participants; or whether the process of analysis by individual researchers merely constructs the phenomena they claim to document. It is the reviewers’ critical opinion that Hammersley’s perspective can certainly be applied to the Wills et al (2008b) study, by virtue of the fact that it was commissioned with the clear purpose of adding to an existing body of class-

specific, social policy- based topical health research.

Quite simply, this study satisfies nearly all the requirements of its' ESRC sponsors. However, the reviewer does wonder whether in the course of the research analysis, essential truths lay buried and undiscovered in the murky depths of the ESDS data archive (Wills et al 2008d), which may still only come to light if the data transcripts were to be thoroughly re-examined through perhaps a clearer, more objective, interpretative lens. This begs the final question; "Can ESRC – funded research (or indeed any form of funded research) ever be wholly objective?"

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Specialist editors

Childhood Remixed editorial team would like to thank all the specialist editors for peer reviewing the submissions in this edition.

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Nigel Ball has been lecturing at UCS on the BA (Hons) Graphic Design course since 2007, for which he became course leader in 2011. Prior to working at UCS, he taught on FE art and design courses at Suffolk New College.

Nigel has been undertaking graphic design commissions and producing self directed projects under the moniker *Dubdog* since 2002. In 2006 he established a blog dedicated to art and design criticism and published his first book, *McJunk*, in 2011. He has recently contributed to the blog of international graphic design magazine *Eye*, and visual research projects by the likes of Daniel Eatock and GraphicDesign&.

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Allison Boggis is a Senior Lecturer at the University Campus Suffolk and a Course Leader for the Foundation Degree in Children's Care, Learning and Development. As a mother of a disabled son and having worked with disabled young children and their families in her role as project manager for Scope, Allison has a personal and professional interest in researching with disabled children and young people. She admits to enjoying the 'messiness' and unpredictability of researching with disabled children and is particularly intrigued about the ways in which they are (under) represented in academic literature.

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Specialist editors

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RN, BSC, (Hons) Nursing Studies, PG CERT, RNT, PGDIP SN, MSC, Doctoral Candidate. I am a lecturer in the School of Science Technology & Health and have a range of professional experiences in nursing and healthcare provision, ranging from acute, community, charity, management and education. My current responsibility includes leading the pathway for school nursing in the Specialist Community Public Health Nursing programme and working within the CPD programme. My Masters is in Public Health and I have a Post Graduate Diploma in School Nursing. I am currently completing Doctoral studies.

I also teach across the schools in a range of areas. I have particular interests in care, ethics, public health/nursing (Global), children's health, philosophy, spirituality, leadership and governance. I lead the ethics module here at UCS.

I am active in various professional organisations in order to keep abreast of issues and support student development. I have been a Board Director for the International Association for Human Caring and have presented at their International Conferences. I am an Executive Board Member of the International Philosophy of Nursing Society and have presented at several IPONS Conferences. I am a member of Sigma Theta Tau International Nursing Research Organisation. I have completed a Caritas Coaching course with Watson Caring Science Institute and believe that care underpins many areas of practice and life that impacts on wellbeing.

Nursing and Healthcare in the 21st century has many challenges but equally there are opportunities and learning presents a space for students to grow and open up to their creativity and develop their thinking. I was a mature graduate and found the experience rewarding in opening up more perspectives. As the Philosopher Wilbur acknowledges all knowledge is partial.

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Catherine worked with adult survivors of child abuse in Ireland for three years. She heard survivors' personal accounts of difficult childhoods and it led her to value the importance of providing quality training in safeguarding children's rights and equality and diversity for students who intend to work with/on behalf of children when they graduate.

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Gill Lowe is Senior Lecturer in English. Her specialist interests are life-writing and early twentieth century literature. She teaches courses at UCS on Textual Studies, The Short Story, Modernism, Autobiography and reading and writing The Short Story.

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Darryn has a first class BA (Hons) in Early Childhood Studies and a PGCE in Post-Compulsory Education. He joined the Suffolk College/UCS Foundation Degree in Early Years Team (Now the Children's Care, Learning and Development-CCLD) in 2004. Darryn has lectured across all levels of the CCLD programme with a particular interest in Personal Development, Research, and ICT modules. He has also developed and delivers a software based Data Analysis module to psychology, sociology and criminology students.

Darryn has over fifteen year's previous experience as an ICT solutions manager and the development and design of business orientated data-bases. He has for many years been involved with local schools and has undertaken various roles including supporting ICT and as a school governor.