Who is speaking for children and adolescents and for their health at the policy level?

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The Bristol inquiry has put children at the heart of the public's agenda on health. This contrasts with the seemingly low position of children on the Westminster government's own health agenda. This status is exemplified by the current consultation exercise to draw up a national plan for health. Although this, together with the increase in funding for the NHS, is welcome, paediatricians are dismayed at the inadequate voice for children and adolescents in the modernisation action teams that are taking forward the definition of the plan.[1] Only one registered children's nurse and a health visitor have been appointed to be custodians of the interests of all children and young people. This reinforces a widely held perception by children's doctors and nurses that the government is not committed to ensure that the interests of children and adolescents—whose needs are different from those of adults—are spoken for as a client group in the health service. We argue that there is an urgent need for children and adolescents to be explicitly represented at all levels of health policy. Furthermore, measures need to be implemented to deliver not only a coherent strategy for children's health in England, but also more effective responsibility for integrating service delivery at the local level.

These criticisms may seem unfair in view of the government's clearly stated intention to transform society through economic and social policies designed to reduce inequality and poverty. It has responded to the Acheson report on inequality and provided much needed direction on improving education and children's welfare, particularly in vulnerable families. It has also emphasised the need for "joined up" working, particularly through the Quality Protects initiative, and has created new structures in the NHS, including health action zones, health improvement programmes, the Commission for Health Improvement, and the National Institute for Clinical Excellence. Although it is too soon to assess the impact of these far reaching changes, they are likely to benefit the lives and health of children and adolescents, and this is welcome.

However, until now these initiatives, with some exceptions such as Sure Start, have been introduced without children and adolescents being recognised as a defined client group with specific needs. In England, despite the government's support for the United Nations' Convention on the Rights of the Child, there has been no national or governmental body or person specifically charged with protecting the rights of children nor with assessing the impact on children of the policies emerging from individual ministries. For the NHS, improving the health of children and adolescents in itself is not a key target. Although identified for development in due course, the process for creating a national health service framework for children and adolescents has yet to be implemented. In those that have been implemented, children are excluded, with the exception of those with diabetes. Children are mentioned only in passing in the recently announced reforms of funding for research and development, and, with some exceptions, improving child health is not a high priority for local service delivery. Few English health authorities have health purchasing commissioners dedicated exclusively to children, children's needs are found in only 16% of health improvement plans, and only 1 in 10 health authorities has any policies on adolescent physical health.[2,3] Furthermore, there is currently a dismantling in some districts of services that have been well integrated and commended in the House of Commons select committee's report on the state of children's health.[4] Finally, specific services for

Summary points

Children and young people are a nation's most precious resource, and their health is vital for the future success of our society

Despite this, improving the health of English children is not a key government target

Children are not young adults: their special health needs should be acknowledged

A strategy needs to be defined for children and young people, with responsibility allocated for integrating care within the health service and between sectors

It needs to be recognised that children have fundamental human rights for which protection is needed

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children are still not available in 40% of the country. This is despite reduced inpatient stay and an increasing number of children and adolescents with complex needs for continuing care. The recent creation of eight Diana Children's Community Nursing Teams is welcome, but they are not financed by monies from the Department of Health.

This unsatisfactory position contrasts starkly with child focused initiatives appearing from the new national governments, particularly in Scotland. There, an accessible minister for children has been appointed, the health of children is one of four health priorities for 2000-2003, paediatricians serve on key policy groups, and the needs of children are the responsibility of local health boards on which paediatricians sit. The National Assembly for Wales has also identified the needs of children to have high priority and will soon be appointing a commissioner for children. There is also a minister for children and a health secretary who has a special interest in children's affairs. Children's health issues are at the top of the agenda for the Specialised Health Services Commission for Wales.

If the benefits to children and adolescents in England from the current financial and policy reforms are to be realised, then several fundamental cultural and organisational changes are needed (box). Implementing these changes depends on effective advocacy for the interests of children and young people at all levels from central government to local communities. If these proposals require justification it can be found by answers to several questions.

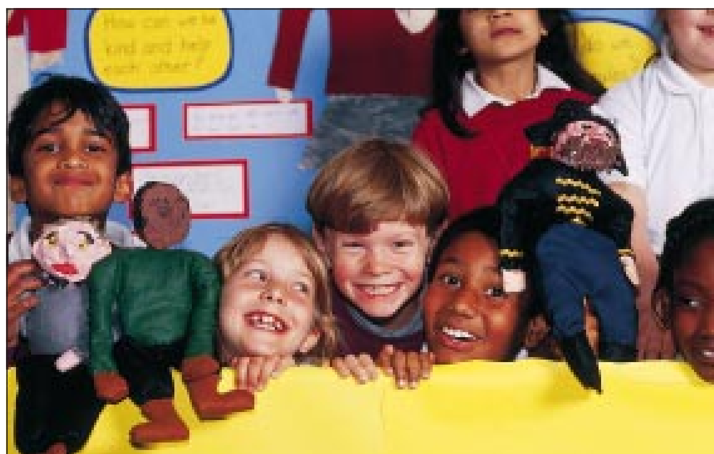
Cultural and organisational changes that would benefit children and adolescents in England

- As articulated in the UN Convention on the Rights of the Child, there should be explicit recognition that children have fundamental human rights for which protection is needed
- Children should be acknowledged to have special requirements for health and should not be regarded as small adults
- Specific authority should be delegated to individuals and bodies to be responsible for defining strategy for children and adolescents and for integrating care within the health service and between sectors

Key questions

Why are children important?

Although it might seem superfluous to ask this question when children and adolescents represent about 25% of the population, the answer is fundamentally important. Children are vital for the future strength and success of our society. They are our guarantee for the future, yet currently one in three children lives in poverty, with major effects on their health. Although healthy children become healthy adults, much adult disease has its origins in early life, and events in childhood and adolescence have long term sequelae that determine adult wellbeing. There would seem to be an irrefutable case for giving child health high priority in the government's philosophy, policy, and strategy, and in allocating resources. It seems perverse that so much resource is currently being targeted to the palliation of adult disease, with so little focus on addressing the antecedents of adult health in childhood and adolescence. Although social policy interventions to reduce poverty are important in areas such as obesity, diabetes, cardiovascular risk, injury prevention, and mental health, other interventions in early life are likely to be more cost effective than at any other age. The need for urgency in addressing these issues is supported by the fact that in many areas, key indicators for youth health are going the wrong way—these include obesity, smoking, suicide, and exercise. The successful prosecution of the case for children and adolescents demands effective advocacy.



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Some of the basic principles in the health care of children are ignored

Are children just small adults?

Childhood encompasses specific groups: newly born babies, infants, children, and adolescents. Each is at a different stage of emotional, neurological, and physical development, and each demands policies, services, and support tailored to reflect these differences. Since most cannot speak for themselves or are not given the opportunity to express their views, others must advocate for them. Children are not small adults, yet health professionals caring for children and adolescents fight a continuous battle for this concept to be understood. With an increasingly older population and the demands of services for the elderly, the needs of children, unless made specific, are increasingly likely to be overlooked.

Are the fundamental human rights of children being compromised by the present lack of responsibility for them?

One example illustrates a health consequence of the present lack of responsibility for children and adolescents. Children are denied effective treatment by the failure of government and professional bodies and the market imperatives of the pharmaceutical industry to ensure that the use of medicines is informed by hard scientific evidence of efficacy and safety. Thus, 50% of drugs given to children in general hospitals, 60% given to them in specialist centres, and 90% given to seriously ill neonates are not licensed for use in childhood. Because of the failure to recognise their needs and to perform appropriate research, children are denied access to information that adults would

demand as a fundamental right—is this because they cannot vote?

A voice for children and adolescents

So, who does speak for the health of children and adolescents? In 1996, under an exercise initiated by the Conservative government, the special advisory group on NHS research and development priorities to improve the health of mothers and children sought comment from the 260 bodies it identified to have interests in children and their health.[5] In 1997, the parliamentary health committee in seeking evidence on the specific health needs of children and young people sought advice from over 50 bodies and many individuals.[4] Royal colleges and other institutions speak for children by being the custodians of standards for training and professional competence. The British Medical Association has produced an authoritative report focused on the impact of social and economic inequality on child health.[6] The public supports the health of children through highly successful charitable fundraising. There is no lack of public interest or commitment to children's health.

What then is the problem? There is widespread frustration among health professionals responsible for the care of children and adolescents in England. They note that the government has failed to monitor the implementation of existing guidance despite reports showing that some of the basic principles in the health care of children are ignored.[7] In many instances, in contrast to the focus given by local authorities and social services, they see fragmentation of young people's health services, with inadequate representation in the planning and strategic process. This is linked to the failure to charge anyone at any level with the responsibility for ending the current fragmentation of children's health services and the lack of cohesion in policy. They believe that there is unwillingness or an inability at the policy, strategic, and operational levels to accept that the needs of children and adolescents are different from those of adults. Children and adolescents require resources and budgets specifically targeted to their requirements.

Events in childhood help determine adult wellbeing

Proposed strategies for improving the status of children and adolescents

- Children and adolescents should be seen as a defined and specific client group in all hierarchies of responsibility
- An independent children's commissioner or ombudsman for England working with others in Scotland, Wales, and Northern Ireland should be responsible for integrating and evaluating the impact of all threads of government policy that relate to children and adolescents and for protecting their rights
- A national strategy for children's and young people's health should be informed by multiprofessional strategic forums that have direct access to the management executive, chief medical officer, and chief nurse and implemented by designated officials with identified responsibilities for children
- Individuals should be appointed at regional, district, and trust level to be responsible for defining local health policy, priorities, and practices relating to children and adolescents. This is particularly important to ensure that the opportunities provided by the development of primary care groups and trusts are not compromised by the creation of new functional barriers between service providers
- Authority should be given to implement change and to deliver effective services in the light of specific budgets for children and adolescents and their health needs within the framework of local health improvement programmes for young people
- Children's health improvement programmes should be truly intersectorial embracing other joint children's planning devices, particularly children's and young people's services plans
- Local multiprofessional forums between education, social services, and health should be created to inform strategy, monitor performance, and develop joint commissioning
- Effective leadership is needed at all levels to facilitate joined up working, with effective intersectorial communication, collaboration, and working practices
- Improving the health of children should be a key priority for research and development in the NHS
- The views of parents, children, and adolescents together with those of clinicians dealing with young people urgently need to be incorporated into the formulation of strategy and delivery of services

Improving the status of children and adolescents

There should be better prospects now than for many years to speak effectively for children, to improve the responsibility for young people's rights, and to address in particular the fragmentation and lack of coordination of health policy and service provision. To achieve these we propose several strategies (box).

Children are our most precious resource. We urge that proper recognition of this be shown by improving the explicit profile given to them in government health policy and practice. We hope that these proposals will be considered carefully in the current debate on the national plan for the NHS. Effective advocacy for children is the key to changing attitudes. Staff engaged in caring for children have much to learn from our American colleagues in training to become effective advocates.[8]

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Conflict and health

War and mental health: a brief overview

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This is the third of four articles

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About 40 violent conflicts are currently active and nearly 1% of the people in the world are refugees or displaced persons. Over 80% of all refugees are in developing countries, although 4 million have claimed asylum in western Europe in the past decade. Many wars are being played out on the terrain of subsistence economies; most conflict involves regimes at war with sectors of their own society—generally the poor and particular ethnic groups, such as the ethnic Albanians in Kosovo. Atrocity—extrajudicial execution, torture, disappearances, and sexual violation—generates terror, which maximises control over whole populations, as does the intentional destruction of the fabric of social, economic, and cultural life. Community leaders, health workers and facilities, schools, academics, places of worship, and anyone who speaks out for human rights and justice are often targets. In many regions such war is a factor in the daily lives and decision making of a whole society.

Summary points

The reframing of normal distress as psychological disturbance is a serious distortion

Personal recovery is grounded in social recovery

Rights and social justice shape collective healing

Researchers must attend to resilience factors and beware of extrapolating from clinic based samples

Individual effects

There is no such thing as a universal response to highly stressful events. However, somatic presentations such as headaches, non-specific pains or discomfort in torso and limbs, dizziness, weakness, and fatigue are central to the subjective experience and communication of distress wrought by war and its upheavals worldwide. This does not mean that these people do not have psychological insights but that somatic complaints reflect traditional modes of help seeking and also their view of what is relevant to bring to a medical setting.[1] Some researchers see somatic symptoms as physiological responses driven by stress; others emphasise their communicational element—these may be the only available expressions of the collective distress of powerless and persecuted people denied societal acknowledgment and reparation.[2]

Though the impact of combat on soldiers has been studied since the American civil war, the medical literature on civilians has burgeoned only in the past two decades. It is still based mainly on clinic populations of war refugees who have reached the West. One exception is Northern Ireland, one of the few conflicts from which comprehensive medical records are available. Over the past 30 years there has been no evidence of a significant impact on referral rates to mental health services.[3] The current literature is dominated by post-traumatic stress disorder, the successor to formulations such as "concentration camp syndrome," "survivor syndrome," and "war neurosis." Although post-traumatic stress disorder is reported to be prevalent worldwide in populations affected by war, the assumption that a Western diagnostic entity captures the essence of human response to such events anywhere, regardless of personal, social, and cultural variables, is problematic.[4] Features of post-traumatic stress disorder are often epiphenomenal and not what survivors are attending to or consider important: most of them remain active and effective in the face of continuing hardship and threat.[5] Thus uncritical application of diagnostic checklists for post-traumatic stress disorder may generate large overestimates of the numbers needing treatment.

Although some victims do develop significant psychiatric and social dysfunction, the relation between traumatic experiences and outcomes is not clearcut. A prewar history of psychological vulnerability is a risk factor.[6] Recent research shows that secondary consequences of war—on family, social, and economic life—are important predictors of psychological outcomes.[7] In Iraqi asylum seekers in London, poor social