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Childhood Remixed, University Campus Suffolk

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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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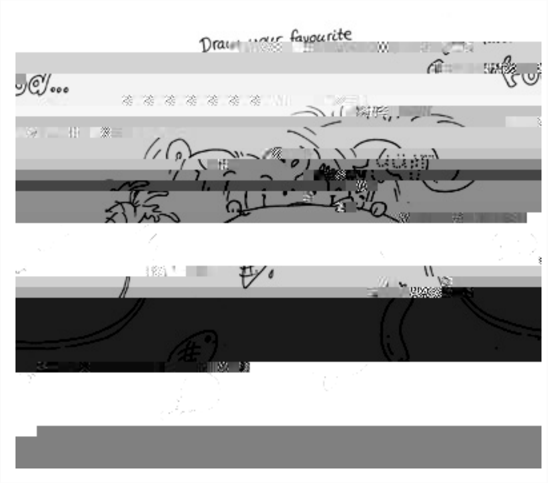
Jade Redford is a third-year student of BA (Hons) Graphic Design (Graphic



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.

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

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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.

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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

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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

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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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‘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.

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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 Frobel 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

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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

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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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routine. Light switched on. Bags placed next to the chest freezers. Door

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‘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

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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.

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Christine completed the Specialist Community Public Health Nursing – Health Visitor programme at UCS and is now working as a Health Visitor and Mentor in the Ipswich locality.

Addressing health inequalities of non-English speaking families

- • 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).
- 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.

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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.

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

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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

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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.

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

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on the body with a rail 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

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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

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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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- School of Science Technology & Health

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.sectereecterien3ent61sectereect485en3ent61

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.

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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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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

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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 1.36s notwasnegaj 0 -64 TDcontto64 dsonal sua0erhe a. Af<</Ag

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Both the UK and USA have seen rising numbers of children being

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‘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

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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 a 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 characteri-2.stf 576n3 804eTroural

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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.

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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

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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?

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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.

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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

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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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"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.

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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 wh77 dI222soutd224 (WBoy‘wTod222Grls,
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“healthier” meals such as fish, chicken and a range of fruit and vegetables (Wills et al 2008d).

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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.

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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-

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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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