State of Children's Rights in England 2017

Children's Rights Alliance for England

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Article 6.1 States Parties shall ensure to the maximum extent possible the survival and development of the child.

Article 23 A disabled child should enjoy a full and decent life in conditions which ensure dignity, promote self reliance and facilitate the child's active participation in the community. States Parties recognise the right of the disabled child to special care and ensure they have effective access to education, training, health care, rehabilitation, preparation for employment and recreation opportunities.

Article 24 All children have a right to the highest attainable standard of health and to health care services that help them to attain this. State Parties shall in particular, take measures to:

- Reduce infant and child mortality
- Ensure the provision of necessary medical assistance and health care to all children
- Combat disease and malnutrition
- Ensure appropriate prenatal and postnatal care for mothers
- Ensure everyone has health education and information, and understands the advantages of breastfeeding, basic hygiene and sanitation, and the prevention of accidents
- Develop preventative health care guidance for parents, and family planning education and services

Article 27.1 States Parties recognise the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

Article 39 (recovery from trauma and reintegration) Children who have experienced neglect, abuse or exploitation must receive special support to help them recover their health, dignity, self-respect and social life.

Definitions and glossary

Children: All children and young people under-18 as set out by article 1 of the UN Convention on the Rights of the Child (CRC).

Mental health issues: Used to describe a variety of conditions children may experience, including mild, moderate to severe, and ensuing conditions ranging from anxiety or depression through to bipolar disorder, schizophrenia and eating disorders.

Clinical Commissioning Groups (CCGs): NHS organisations that commission health services for their local population.

Local Transformation Plans (LTPs): Developed by local partnerships of health and care leaders across the country, setting out each area's strategy for improving services in line with the vision of Future in Mind (the Government's strategy for improving children's mental health, published in 2015). They are a condition of receiving the first year's tranche of the investment announced as part of the Future in Mind programme.

About this briefing

The UK ratified the UN Convention on the Rights of the Child (CRC) in 1991. This means that all areas of government and the state including local government, schools, health services, and criminal justice bodies, must do all they can to fulfil children's rights.

This briefing is part of CRAE's *State of children's rights in England 2017* and assesses the progress made in England towards implementing the UN Committee's recommendations relating to health and mental health. It highlights areas of progress and concern since last year's *State of children's rights in England 2016* was published in December 2016. It is based on written and oral evidence from CRAE's members and additional analysis of recent laws and policies, newly published research, official statistics, and responses to Freedom of Information (FOI) requests.

What is the CRC?

The CRC applies to all children aged 17 years and under and sets out the basic things that children need to thrive: the right to an adequate standard of living, to be protected from all forms of violence, an education, to play, be healthy, and be cared for. Children's rights should act as a safety net, meaning children always receive at least the minimum standard of treatment whatever the changing economic climate.

The CRC has four guiding principles (General Principles) which are rights in themselves but also the framework through which all the rights in the CRC should be interpreted. They are: non-discrimination (article 2), the best interests of the child (article 3), survival and development (article 6), and respect for the views of the child (article 12). England's compliance with these General Principles is covered in Briefing 2.

Concerns of the United Nations

In June 2016 the UK Government was examined by the **UN Committee on the Rights of the Child** (the UN Committee) on its compliance with the CRC for the first time since 2008. The UN Committee made a number of recommendations (Concluding Observations) for change.[1] In May 2017 the UK was examined on all its human rights treaties, including the CRC, by the 193 member states of the Human Rights Council as part of the **Universal Periodic Review (UPR)**.[2] This is a process where states can reiterate previous recommendations made by UN Committees and can be used by civil society and parliamentarians as an additional advocacy tool. The Government can choose whether to "support" (accept) recommendations or "note" them (reject or not agree). We are very disappointed that the Government has only supported 28% of the recommendations relating to children's rights compared to 42% of all the recommendations it received. Below are the relevant UN Committee and UPR recommendations for this briefing:

- Regularly collect comprehensive data on child mental health CRC
- Rigorously invest in CAHMS and develop strategies to ensure the availability, accessibility, acceptability, quality and stability of such services, with particular attention to children at greater risk CRC
- Support and develop therapeutic community-based services for children with mental health conditions CRC
- Expedite the prohibition of placing children with mental health needs in adult psychiatric wards or police stations, while ensuring provision of age-appropriate mental health services and facilities CRC
- Abolish all methods of restraint against children for disciplinary purposes in all institutional settings CRC
- Develop strategies on child health to eliminate inequalities and address underlying social determinants, using maximum resources and monitoring mechanisms CRC

- Collect data on nutrition, breast-feeding and obesity to identify root causes of child food insecurity and malnutrition CRC
- Monitor and assess effectiveness of policies and programmes on food security and nutrition of children CRC
- Promote, protect and support breastfeeding CRC
- Set out a clear legal commitment to reduce air pollution levels, especially in areas near schools and residential areas CRC

Introduction

The Government has continued to make considerable effort to tackle children's mental health in 2017, with the Prime Minister describing the lack of support for those affected by mental ill-health as a *'burning injustice* [...] *that demands a new approach'*.[3] However the significant ongoing investment in CAHMS is still not reaching the frontline, with access and waiting times continuing to be a postcode lottery. While strides have been taken to improve the impact of key factors affecting children's health, such as childhood obesity and poor dental health, poverty is still the key factor undermining a child's right to have the best possible health and access to services.

What progress have we made?

There has been a series of positive announcements in relation to mental health and schools including a second pilot of the CAMHS schools link Single Point of Contact,[4] Mental Health "First Aid" training for one representative from each secondary and primary school by 2020/21,[5] and 100,000 children (aged 15-17 years) to be trained in mental health awareness through the National Citizens Service programme.[6] A drive to recruit a further 2,000 CAHMS staff is also welcome.[7] Further positive measures are awaited: a forthcoming Green Paper on Children and Young People's Mental Health (due to be published in early 2018), and a new Mental Health Act during this parliament, which will be informed by the findings of an independent review of mental health law and practice focused on mental health detention and mental health capacity.

Promisingly, the Government has committed to update the Early Years Foundation Stage Framework for Schools and Childcare, including specific reference to the UK Chief Medical Officer's *Guidelines for Early Years*[8] and Ofsted are undertaking a thematic review of obesity, healthy eating and physical activity in schools in 2017.[9] New online and social media restrictions on junk food advertising for children are welcome.[10]

Encouragingly, after a review, the Government has pledged to keep the five mandated health checks, from pregnancy to age two and a half.[11] The Government's new strategy to increase children's engagement in sport (particularly among girls and disabled children) is to be commended, backed by a new £120 million fund to tackle inactivity in these groups.[12]

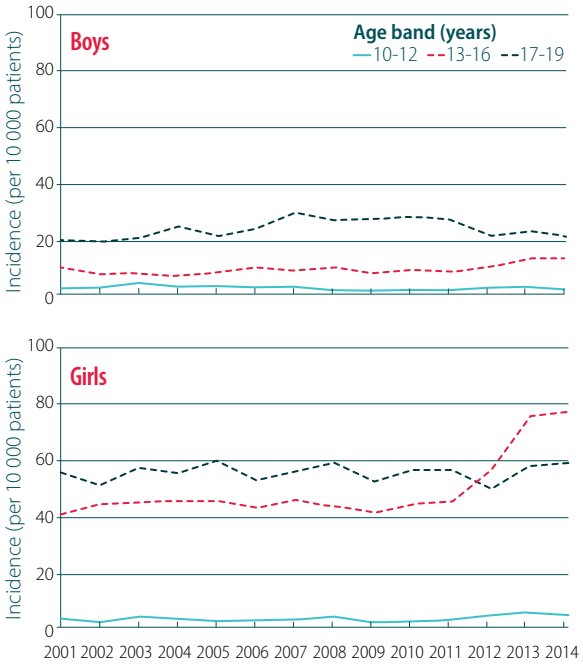
Where do we need to improve?

Demand for child and adolescent mental health services is increasing

200,000 children received specialist CAMHS treatment in 2016, nearly 3% of 5-17 year olds.[13] The true figure of children with mental health issues is likely to be much higher, as this includes only children who have accessed CAHMS services. Referrals to specialist child and adolescent mental health services have increased by 44% over the last three years, however this could relate to increasing prevalence, reduced stigma and willingness to access services.[14] The last prevalence study took place in 2004 and the next one is not due until 2018. There is still no commitment to ensure that these take place every seven years in line with the UN Committee's recommendations. The recent Millennium Cohort Study found at age seven, approximately 7% of both boys and girls have a diagnosable mental health condition, but by adolescence the gap has widened significantly to 18% of girls and 12% of boys.[15] The findings are starker when looking only at depression, with 24% of girls being found to be depressed, but only 9% of boys.[16] **Rates of self-**

harm are still rising at an alarming rate. An in-depth study revealed a staggering 68% rise in rates of self-harm among girls aged 13 to 16 since 2011, with annual rates of self-harm at 4% for girls and 1% for boys.[17]

Graph 1: Self-harm rates for boys and girls since 2001



Source: The British Medical Journal (October 2017) *Incidence, clinical management, and mortality risk following self harm among children and adolescents: Cohort study in primary care*

Suicide rates have increased since last year for boys aged 15-19, with one study showing only a quarter of all cases had previous contact with mental health services. Conversely, rates for under-10s have decreased.[18] See Briefing 2 for more information. With mental health issues beginning at such a young age, prevention and early support is crucial. The rise in children's mental health issues has been potentially attributed to the growing pressures of reaching adolescence: from anxiety about passing exams and getting a job, to worries about body image fueled by a hyper-sexualized media environment, to threats from social media.[19] Poorer children are more likely to be depressed, which suggests that their mental health may be linked to factors like family income and housing.[20] Other research reveals that children's happiness is at its lowest since 2010 but that girls are less happy than boys with their friendships, appearance and life as a whole.[21]

Increased investment in CAHMS not reaching the frontline

Despite the additional £1.4 billion over five years pledged by the Government in 2015 to transform CAMHS, a refusal to ring fence this means there is wide variation in how it is being invested. **FOI requests to Clinical Commissioning Groups (CCG), local authorities and mental health trusts in England found that in 2016/17 (the second year of extra funding) only half of the CCGs who responded had increased their CAMHS spend to reflect their additional government funds.** The other half are using some or all of the extra money for other priorities. Worryingly, fewer than half of the CCGs who responded were able to provide full information about their CAMHS budgets.[22]

Unsatisfactory access to mental health services for children

The Government has committed funding to introduce a national waiting time and access standards for eating disorders, plus early intervention psychosis and Improving Access to Psychological Therapies. However, other standards haven't been published to date and will not come fully into effect until 2020. In the meantime, access to CAHMS continues to be a postcode lottery due to under investment and capacity. **The Care Quality Commission (CQC) found CAHMS waiting times of between 35 days to 18 months in different areas.**[23] However, recent FOI requests found that there has been some progress over the last five years in reducing lengthy waiting times,[24] which can lead to children not engaging with the service and/or their condition worsening. Nevertheless, the CQC also found that crisis care for suicidal children or those with severe mental health issues was sometimes available only between 9am and 5pm, with night-time care provided by adult psychiatrists who lacked expertise in children's mental health.[25]

Over a quarter of children referred to specialist mental health services are not accepted for treatment, most often because they did not meet the eligibility criteria for specialist CAMHS. Eligibility thresholds are often very high due to a lack of capacity or appropriate early intervention services in place.[26] Further research has found that more than half of all areas will miss the

Case study

Just for Kids Law

High threshold for CAHMS

Matthew* is 17 and has been accommodated under Section of 17 Children Act 1989, however his solicitor believes this is wrong and is not being provided with the level of care and support he feels he requires. He should be looked after under Section 20 and has a solicitor who is challenging this.

Matthew tells his support worker he has mental health issues: severe difficulties dealing with his anger, feels very anxious all the time and has a very distorted sleeping pattern. He is often so depressed and in such low mood that he does not find the drive to do anything else. He feels very isolated because he gets angry very easily and can find it difficult to communicate with people.

Matthew has approached his GP, who agrees that he might be suffering from a mental health condition and made a referral to CAMHS. However, this was rejected on the basis that he did not meet the eligibility criteria required to access support from CAMHS.

This means Matthew does not have a formal diagnosis and can not access or receive the support he needs to live his life, he is hoping to start a construction course soon.

'I know I need some help because of my mental state…I know things are not right and need to get some help and sort myself out…Everything is taking so long and I don't understand why, it all makes me very frustrated.'

*Not his real name

Government's stated target of 35% of children with diagnosable conditions being treated by specialist services by 2020/21.[27]

Even when children's referrals are accepted, it does not always mean that they access and benefit from treatment. New research has found that in 2016, children missed approximately 157,000 appointments with specialist CAMHS, often repeatedly.[28] This was due to a range of reasons: long waiting times, the stigma surrounding mental illness, or the unsuitability of appointment times and locations. This was found to be more prevalent in lower socio-economic groups and families with more diffuse social issues. It was revealed that a significant proportion of missed appointments are not followed up upon, and thousands of children are discharged from services as a result of repeatedly missing appointments, with no risk assessment. This can result in children's mental health needs deteriorating and reaching crisis point.

Source: Education Policy Institute (2017) *Access and Waiting Times in Children and Young People's Mental Health Services*

Stretched mental health capacity in schools

School leaders report a dramatic increase in the number of students suffering from mental health and wellbeing issues, with 90% of teachers noting a large increase in anxiety and stress among students over the past five years.[29] A joint inquiry by the Health and Education Select Committees found schools and colleges struggle to provide adequate time and resource for children's wellbeing, with increasing numbers forced to cut back on mental health services (such as in-school counsellors) despite the growing prevalence of mental ill-health starting at a young age.[30] Early mental health intervention in schools is crucial, and is also much cheaper to deliver. The Department of Health estimate that a targeted three months of therapeutic intervention delivered in a school costs approximately £229, yet derives an average lifetime benefit of £7,252.[31] The Schools Link Pilot to improve joint working with CAHMS and Mental Health "First Aid" Training for teachers are positive steps, but more must be done to

improve Ofsted inspections on mental health and wellbeing, and to increase funding for schools.

Inadequate mental health services for children in and leaving care

A quarter of children in care have a mental health disorder,[32] and new research has revealed that by the time children leave care, this has increased to half.[33] **A shocking two-thirds of care leavers who identified as having mental health needs were not receiving any help from a statutory service.**[34] Sadly, the Government rejected amendments to the Children and Social Work Act 2017 to introduce a mental health assessment for children in care and leaving care. It has committed to a pilot to improve the mental health assessment of children entering care, however this has been delayed until 2018.[35] An Expert Working Group on mental health commissioned by the Government has called for more training for those working with looked after children, and for all councils to appoint Virtual Mental Health Leads.[36] For more information on children in care see Briefing 4.

Children with learning disabilities at higher risk of developing poor mental health

New research has found that children with learning disabilities (LDs) are at a much higher risk of developing psychiatric problems. **Over a third of children and young people with an LD aged 11-25 have a psychiatric problem, and they are four to five times more likely to have a diagnosable psychiatric problem than those without an LD**.[37] One in seven of all children with mental health issues in the UK will also have an LD. The highest risk factors for developing mental health issues stem from social and emotional factors, rather than their LD. Research found this is apparent by three years old, meaning a child's mental health issues could be preventable. However, children reported that professionals often only see their LD rather than their mental health needs, which overshadowed their diagnosis.

Just over a quarter of the children with an LD and a psychiatric disorder have had any contact with mental health services, with nearly a quarter having to wait more than six months. Children with both LDs and mental health issues are largely being overlooked. There is very little about LDs in *Future in Mind*, which covers them as part of a wider group of vulnerable children, and the *Five Year Forward View for Mental Health* does not cover LDs at all.

Source: FOIs to British Medical Journal (2017)

Continuing lack of specialist inpatient mental health provision

A shocking seven out of 10 children with severe mental health issues were admitted to hospitals outside of their local areas in 2016/2017.[38] This is an increase from 57% the previous year and in contravention of the Government's Crisis Care Concordat.[39] At a time when they are the most vulnerable, placing children far away from their family, friends and local support services once they have been discharged, can cause them to experience further trauma, worsen their problems, and delay their recovery.[40]

In a positive move, the NHS has recently begun to collect experimental data on the number of children being admitted to inpatient care located 50 or more kilometres from their home—in March 2017, this came to 331 hospital stays for children.[41] **However there are questions about data quality, with different CCGs recording data in different ways.**

Worryingly, 9,000 days were spent in mental health wards between October 2015 and February 2017 by children who should have been able to go home, but did not have an effective community social care support team available.[42]

Despite a decrease in inpatient admissions, there is still a shortage of beds for children needing inpatient mental health treatment, resulting in children being placed in adult wards against both the law and the UN Committee's recommendations.[43] In the last quarter, 42 children were held on adult wards, totalling 321 days. Although this is a decrease of 50% from the last quarter, this practice should not be taking place.[44] More positively, the number of children being held in police cells as a place of safety has substantially decreased in 2015/2016 to 43 (a 73% decrease).[45] This trend should continue as the Policing and Crime Act 2017 made this illegal. See Briefing 8 for more information.

Five years after the Winterbourne View Concordat pledged to reduce the practice, 185 children with learning disabilities are still currently living in Assessment and Treatment Units. The numbers have been rising since 2015,[46] and a quarter are placed 100km away from their home.[47] The Government discontinued the Learning Disability Census in 2015 (an important source of data on restrictive practices, physical assault and self-harm and medication) promising to collect data on these through NHS Digital. However, data on the first three have only just started being collected and none has been published. Worryingly, data on medication is not being collected at all. The UN Committee called on the UK to *'systematically and regularly collect and publish disaggregated data on the use of restraint and other restrictive interventions on children.'*

Concerning use of restraint

Face-down restraint, the most dangerous form of restraint, was used more than 2,500 times on children in inpatient care in 2014/15, despite calls from the UN Committee to abolish the practice in institutional settings.[48] **FOIs reveal that girls are being restrained more frequently than boys, with 17% of girls physically restrained and 8% of girls restrained face-down in inpatient units, compared to 13% of boys and 6% respectively.**[49] Such practices are frightening, humiliating and sometimes fatal.

Health

Although the recent funding allocation for the NHS in the 2017 Budget is welcome, this should be ring fenced for children's services to ensure improved outcomes for children.[50] It is concerning that the Government is still planning on abolishing the Public Health grant for local authorities altogether.[51]

Rising levels of obesity

Despite the UN Committee's concerns about the: *'high prevalence of* [...] *obesity among children',* levels have increased in reception aged children from 9.3% in 2015/16 to 9.6% in 2016/17, and in year 6 from 19.1% in 2015/16 to 20% in 2016/17.[52] A worrying gender divide has emerged, with obesity rates higher for boys than girls in both age groups.[53] **Rates are also higher amongst lower income households: children belonging to poorer groups are twice as likely to be obese at age five, and three times as likely by age 11.**[54] For more information on the links between access to food and poverty, see Briefing 3.

Graph 2: Obesity levels for reception and year 6 children

Source: National Child Measurement Programme England Programme 2016/17

Worryingly, England's teenagers are the biggest consumers of sugar-sweetened drinks in Europe.[55] Government plans to use revenue from the "sugar tax" on soft drinks manufacturers to double the Primary PE[56] and Sport Premium is a positive measure.[57] However campaigners have been disappointed that the scheme's plans are not stronger and targeted at confectionary.[58] New restrictions on advertising food and drinks that are high in fat, salt or sugar (for non broadcast media where under-16s make up a quarter of the audience) are positive, however critics have said this will not cover media specifically targeted at children.[59]

The Government's continuation of the Healthy Start Scheme, which provides vouchers for fruit, vegetables and milk to low income families across England, is welcome. During 2015/16 an estimated £60 million worth of vouchers were distributed to low income families in England.[60] Encouragingly, levels of children involved in sport remain high with 88% aged 5–15 taking part in the four weeks prior to the research, compared to 87% last year.[61]

Concerning levels of tooth decay

Figures from 2016/17 reveal that 31-41% of five year old children across the UK have some evidence of tooth decay.[62] Although this is down from 69% in 2013, this is still worryingly high.[63] **Tooth decay remains the most common single reason why children aged five to nine require admission to hospital.**[64] Social deprivation increases the likelihood of childhood tooth decay, with children in poorer households more likely to develop tooth decay. In the highest income areas of the country, 83% of five year olds had healthy teeth compared with 70% in the UK's poorest areas.[65] A socio-economic divide in access exists, as the percentage of parents reporting a difficulty finding an NHS dentist was substantially higher among those with children eligible for free school meals at 18%, compared to only 11% of those ineligible. The pilot of the Government's Dental Contract scheme, which aims at developing a national dental health strategy focused on long term preventative health care,[66] is welcome. However, while the NHS's *Five Year Forward View for Mental Health* trial will increasingly integrate health services, the lack of childhood dental health in this scheme is concerning.[67]

Illegal levels of air pollution harming children's health

The UK's pollution levels regularly breach EU law and in 2014 areas of London had the highest concentrations of the pollutant nitrogen dioxide (NO2) on earth, despite calls from the UN Committee for *'a clear legal commitment to scale up and expedite the implementation of plans to reduce air pollution levels, especially in areas near schools and residential areas.'*[68] The UK was recently criticised by a UN Special Rapporteur for flouting its duties to protect citizens from illegal and dangerous levels of air pollution.[69] London exceeded its annual air pollutant limits just five days into 2017.[70] In 2017 more than 2,000 UK schools and nurseries tested within 150m of roads showed illegal NO2 levels, some as much as 2.5 times more than the limit.[71] In 2016, 83% of schools with illegal levels of NO2 were considered deprived.[72]

Children's close proximity to pollution while in school is alarming, with long term exposure linked to impaired growth of lung function in children.[73] A recent study has revealed that unborn children are particularly susceptible to air pollution, noting evidence of *'effects on growth, intelligence, asthma, and development of the brain and co-ordination.'*[74] Two High Court rulings now require the Government to take action to comply with legal limits "as soon as possible".[75] In October 2017 the Government announced proposals for clean air zones for Birmingham, Leeds, Nottingham, Derby and Southampton by 2020, driven by the promotion of electric cars and fining of diesel cars.[76] Although this is a positive step, campaigners have criticised the measures as not being broad enough.[77]

Low rates of breastfeeding

The UN Committee has voiced concerns about *'extremely low rates of breastfeeding'* and called on the UK to *'promote, protect and support breastfeeding.'* Despite this, the Government has not reinstated the National Infant Feeding Survey (IFS), which it cancelled in 2015. This means that there is no data collection beyond infants aged 6-8 weeks, as recommended in the Global Strategy for Infant and Young Child Feeding. Experimental statistics show that the aggregate breastfeeding rate after 6-8 weeks is only 44%, with variation across the country ranging from 23% in Knowsley to 77% in London.[78] The last IFS in 2010 shows that just 1% of women maintain exclusive breastfeeding to six months and only a third (34%) of babies continue to receive some breastmilk by six months.

Worryingly, more than half of Infant Feeding Leads across England have seen cuts to support services for mothers and babies, with concerning implications for the level of care families receive.[79] Another study found that many women do not receive the peer support they need to enable them to continue to breastfeed,[80] whilst negative public attitudes towards breastfeeding have also been linked to low rates.[81]

Recommendations

1. The Government should invest in additional and sustained funding for CAMHS to meet the true cost of unmet need, and ring fence the £1.4 billion investment to CAHMS.
2. The Government should publish maximum access and waiting time standards for emergency, urgent and routine CAMHS, as recommended by the Five Year Forward View for Mental Health. Performance against these standards should be measured at CCG level.
3. The forthcoming Mental Health Bill should seek to introduce a statutory requirement on providers of children's mental health services to adequately follow up on missed appointments.
4. The Government should establish emotional wellbeing and mental health as a fundamental priority of schools in legislation and the Ofsted inspection framework.
5. The Government should commence the pilots to improve mental health assessments for looked after children without further delay.
6. The Government should ensure that children who have both learning disabilities and mental health needs have easy access to appropriate, evidence based, mental health interventions.
7. The Government should encourage local areas to invest in new models of places of safety for children, so they are never placed in a police cell, adult ward or far from their support networks.
8. The Government should establish a commitment in the forthcoming Mental Health Treatment Bill to end the inappropriate use of force and harmful practices.
9. As a matter of urgency, the Government's commitment to ensure that no child with learning disabilities and behaviours that challenge be placed inappropriately in an inpatient ATU should be fulfilled. Future admissions should be prevented by securing both evidence based support, close to home, and early intervention services. NHS Digital should urgently publish data on restrictive practices, physical assault and self-harm, and collect data medication.
10. The Government should develop a child health and wellbeing strategy which is coordinated, implemented and evaluated across the four nations.
11. The Government should ensure universal early years public health services, including health visiting and school nursing, are prioritised and supported financially, with targeted help for children and families experiencing poverty.
12. The Government should introduce a ban on advertising before 9pm of products that are high in saturated fat, salt and sugar.
13. The Government must ensure that a national dental health strategy focused on prevention in childhood is produced and integrated into national schemes (such as the F*ive Year Forward View for Mental Health*) alongside the creation of a more holistic approach to childhood dental education, combining factors such as diet, dental health education and practices. Funding should be increased to improve access to NHS dental care for families living in deprived areas.
14. The Government should pass a new Clean Air Act to bring together existing (but fragmented) national, EU and international air quality legislation, particularly in light of Brexit. Legislation to prevent new schools from being built in areas testing above the legal air pollution limit should be introduced.
15. The quinquennial UK National Infant Feeding Survey should be reintroduced alongside the appointment of National Infant Feeding Coordinators, and the requirement for all hospitals, maternity, health visiting and neonatal services to work towards baby-friendly accreditation.

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About CRAE

The Children's Rights Alliance for England (CRAE) works with 150 organisations and individual members to promote children's rights, making us one of the biggest children's rights coalitions in the world.

We believe that human rights are a powerful tool in making life better for children. We fight for children's rights by listening to what they say, carrying out research to understand what children are going through and using the law to challenge those who violate children's rights. We campaign for the people in power to change things for children. And we empower children and those who care about children to push for the changes that they want to see.

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