BRITISH MEDICAL JOURNAL

LONDON SATURDAY OCTOBER 7 1950

CHILD HEALTH AND THE FUTURE*

BY

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I am deeply conscious of the honour conferred on me by the Trustees of the Dawson Williams Memorial Fund last year in recommending me as worthy of a prize for work for child health. I am particularly happy to be able to try in this lecture to discharge a debt to the forerunner whose name we honour. He was a noted paediatrician at the turn of the century, a member of the medical staff of the East London Hospital for Children at Shadwell who gave up his hospital work and practice to join the staff of the *British Medical Journal*, one of the few successful consultants ever to have devoted himself entirely to journalism. Dawson Williams gave me my first assignment (I believe that is the word) in medical journalism—an annotation on a book about medical missions, somewhere about 1923. I have been privileged to follow humbly in his career both as a paediatrician and in a part-time capacity in medical journalism.

When history is being made it is not always obvious to those taking part. At the present time and for some years past the improvement in infant and child health has been very remarkable, and yet the implications of this in the child-health services are not yet fully appreciated. Since much of what follows is in a critical mood it is necessary to state at the outset that those of us in academic posts in child health have a very definite responsibility in this matter, and in criticizing local authorities or central authorities in the health field we are including ourselves in our capacity as advisers or even participators in various aspects of the subject. Secondly, criticism will so far as possible have here its constructive side. It is proposed first to look at the infant-welfare scheme and next at the school health services. In each case the present arrangements will be scrutinized with special reference to what should be the objects of preventive paediatrics to-day—in other words, what are the diseases and disorders of children which call for preventive measures.

Infant-welfare Centres

To what extent does the average infant-welfare centre to-day differ from the milk depots of Budin in Paris of the last century or the earliest centres for distribution of milk and advice that were started in the north-western corner of England at the turn of the century? Milk is still distributed, with dried milk taking the place of milk in bottles. Vitamin preparations and certain infant foods are also distributed. Health visitors attend for weighing the babies and generally interpreting the advice of the

medical officers who examine the infants periodically, advise on child care generally with special reference to diet, and deal to a varying degree with minor ailments. This service is correlated to an extent which varies in quality and quantity in different areas with home visiting by the health visitors. Immunization against diphtheria or vaccination against smallpox may be carried out in some centres either at the routine visits or at special sessions. Some medical officers do not approve of these services being mixed up with routine centre work, and yet they seem to me to be an essential part of preventive medicine. The compromise solution is, of course, to have special immunizing sessions.

To sum up, the infant-welfare centre began and has largely continued as part of a campaign to reduce deaths in infancy from digestive disorders. Indirectly the scheme has served to play a part in reducing the deficiency disorders. General advice on child care appears to vary very much in quality and in the energy with which it is given. It is unfortunately easy to get stale in this type of work, and it is perhaps a fair comment that in recent years the most valuable contributions to the management of breast-feeding, for example, have come, not as might have been expected from members of the infant-welfare service, but from "outsiders" such as Dr. Harold Waller and Dr. Charlotte Naish. This is a criticism not of individuals so much as of the way the service has somehow failed to produce opportunities for advances in knowledge. Indeed, with the well-known decline in breast-feeding it is pertinent to ask whether or not the infant-welfare service is everywhere pressing for natural feeding with full enthusiasm. I have heard a prominent medical officer of health state in public that he thought the merits of breast-feeding were greatly exaggerated. In quite recent times a medical practitioner, having carried out certain published investigations in breast-feeding, failed to secure appointment by a local authority for child-welfare work and was told that the lay members of the appropriate committee thought that she must be very narrow-minded and would expect all mothers to feed their babies. They considered that breast-feeding was an imposition on any woman now that the Government provided national dried milk. An infant-welfare service that is not whole-heartedly in favour of breast-feeding cannot surely be regarded as fulfilling its proper task in the community.

Yet by a paradox which is well recognized and not easy to explain a decline in breast-feeding has been accompanied by a sensational drop in the infant-mortality figures. For 1949 we are told that the provisional infant-mortality

*Dawson Williams Prize Lecture, delivered at the Annual Meeting of the British Medical Association, 1950.

rate is only 32 per 1,000 live births. Deaths certified as from gastro-enteritis in 1948 for the eleven months of the first year of life excluding the neonatal period were only a little over 2,000 for England and Wales, about half of the corresponding figure for 1947 and less than half of the total deaths in the same period in the same age group certified as due to bronchitis and pneumonia. Indeed, to-day after the newborn period it is acute respiratory disorders rather than digestive disorders which present the major difficulties. The preventive service has to a large extent won its fight against the scourge of infective diarrhoea as a national problem, although this is no excuse for allowing breast-feeding to decline still further or for slackening every effort to prevent outbreaks on a smaller scale in institutions. The newer antibiotics and a better understanding of the clinical management of the infant with the "diarrhoea and vomiting" syndrome may lower the death rate even further.

Need for Co-operation

Despite this remarkable improvement there are still gaps in the service, and this is particularly seen in the early weeks. There is not enough co-operation between the hospital, the general practitioner, and the child-welfare service in relation to the discharge of the newborn baby from hospital, and this is especially serious in reference to premature babies. The Biological and Medical Committee appointed by the Royal Commission on Population (1950) had something to say about this:

"A serious defect in the maternity services is that women are often discharged from hospital on the ninth or tenth day before they have been taught how to handle their babies. Sometimes hospital almoners try to arrange for health visitors to supply the needed instruction, but this cannot always be managed, and the health visitor may not call for several weeks. Among women confined at home there is also frequently a gap between the time when the midwife ceases to come and the health visitor makes her first call, though during this period many women start taking their babies to infant-welfare centres and in this way receive continuing care and advice."

But it is the minority who receive this "continuing care and advice," and it ought to be the rule rather than the exception. A good slogan should be, "The health visitor on the doorstep to greet the mother on her arrival home." With a little organization between the ward sisters, the almoner, and the appropriate superintendent health visitor this can be achieved, and is achieved by some maternity hospitals and units. It might even go further and give the health visitor the chance to visit the hospital and see the mother before discharge. Continuity of feeding is important, especially if the baby is artificially fed, and maternity hospitals and units should see that their choice of dried milks, for example, and methods of feeding correlate closely with those available in the infant-welfare centres of the area to which mothers will subsequently go.

In quite recent times, in a London borough which I would regard as well above the average for its standard of child-welfare work, a mother left hospital with her baby on a bottle with feeding instructions that could not be carried out at home, and she struggled in her amateurish way for nearly four weeks before bringing the baby to hospital. During the whole of that time no health visitor had called and the mother said she was too exhausted to get to a centre. A previous baby had died of gastro-enteritis in similar circumstances in another part of London.

If it is argued that the shortage of health visitors will not permit of these idealistic arrangements I would reply

that in many areas health visitors are cluttered up with duties which intelligent lay people could perfectly well do. There is an urgent need for a sort of "job analysis" of a health visitor's work to see that she is not spending time as a clerk, a secretary, a food-store manager, and so forth.

Another method of co-operation in these early weeks which merits attention concerns the possible staffing of the paediatric side of maternity hospitals and units by medical officers of the local authority services. Both at Middlesex Hospital and at Queen Charlotte's Hospital I was privileged for some six years to look after the newborn babies in the wards and to follow them in orthodox infant-welfare centres attached to these hospitals. I am certain that it made for a high degree of continuity of care. Under the scheme proposed by the Ministry of Health circular 118/47, whereby joint appointments were advocated, with infant-welfare medical officers being eligible for part-time hospital work, I should have thought that hospital appointments for supervision of the newborn and of the premature infant would bring a measure of variety and responsibility to the work of infant-welfare-centre medical officers which is often lacking.

(At a different level, and for different reasons, the spirit of the circular is being carried out successfully at the Hospital for Sick Children, Great Ormond Street, whereby six medical officers of the London County Council attend for work in the out-patient department, one each day, and six registrars from the hospital supply one session each in the service of the London County Council. Similar schemes are no doubt in operation elsewhere.)

Prevention of Infections

This gap in the services in the early weeks is something which needs careful attention. The suggestions made require changes, and it is just the relatively unchanged nature of infant-welfare work over the past fifty years that causes some degree of anxiety. The infections of childhood that can be prevented by recognized methods of immunization are diphtheria, smallpox, and probably whooping-cough. Surely the welfare centre is the place where such methods should be preached and practised with the greatest hope of success.

The infectious disease, however, which has the highest numerical significance in childhood is tuberculosis. Dr. J. E. Geddes (1950), at the Eastbourne Congress of the Royal Sanitary Institute this year, gave the total deaths from infectious diseases for children under the age of 15 in Birmingham during the years 1946-9. In numerical order these ran as follows: scarlet fever, 2; diphtheria, 15; measles, 48; whooping-cough, 114; tuberculosis, 203. It is fair to ask, therefore, what the preventive child-health services are doing about tuberculosis. In the infant-welfare service the use of the tuberculin-patch test at intervals—for example every six months—followed by an x-ray examination if the test is found to have become positive, might prove very revealing, and I know that at some centres this is in fact the programme, or something like it. Yet when a young colleague of mine asked to be allowed to perform patch tests at a welfare centre at which he worked he was told by the medical officer of health that this could not be allowed, because it was not the "job" of the centre. This seems a strange decision. Surely the early detection of tuberculous infection, the tracking of contacts, and the use of B.C.G. vaccine for negative reactors amongst them could be made a fine co-operative effort between the infant welfare and the tuberculosis branches of the health service.

There is more to be said about this disease in relation to school-children. For the present it must be recorded with regret that a step in the prevention of tuberculosis is in some areas, for administrative reasons, not permitted amongst the most susceptible age group.

It has already been pointed out that respiratory disorders nowadays account for far more deaths than enteritis in the young infant. What can the infant-welfare service do about this problem? First, more must be known about the epidemiology and pathogenesis of respiratory tract infections in young infants. The work of Dr. F. J. W. Miller (1950) in Newcastle in this field will, it is hoped, be especially helpful. This is part of a morbidity survey carried out jointly by the University of Durham Department of Child Health and the Newcastle City Health Department. With the help of health visitors specially chosen for the work, a study of acute infections in the first five years of life is already revealing that acute infective disease at this age period is essentially a family infection. The "cold" of the baby or sore throat of the toddler is not an isolated phenomenon, but must be regarded, with special reference to prevention, from the basis of the household and the contacts all around in the family circle. This is an excellent example of field research by the preventive services at the infant-welfare-centre age. It may well indicate the lines upon which sound preventive measures to deal with acute respiratory disorders in infants can be evolved.

The Newcastle work lays stress upon the family as a unit in relation to infection of the "droplet" type. Has the infant-welfare movement as a whole given enough thought to the family as a unit in relation to its general work in child care? The father should certainly be known personally to the health visitor, and preferably also to the medical officer. It often occurred, when I was doing infant-welfare-centre work, that some aspect of the child's behaviour or even of physical appearance was clarified only after I had asked that the father attend. Actually, because of the peculiar circumstances of one of my centres with mothers who spoke little English and fathers who worked evening shifts in restaurants, I often had the pleasure of seeing the fathers attending with their babies, and I am sure that better work can be done with families in this way. This is particularly important with regard to psychological problems.

Mental Health

As modern methods of treatment and prevention have so radically improved the outlook for the child as regards physical disorders, it is possible to turn more definitely to study the psychological side, not on the relatively small scale available in the most valuable work of the child-guidance clinics dealing with more or less gross disorders, but in the much larger field afforded in the infant-welfare centres. More and more experts are tracing severe breakdowns of adolescence, leading to delinquency and mental misery, to events in the critical early years of life when disturbance of the profound yet delicate parent-child, and especially mother-child, relationship may wreak such havoc with a child's mind. The quality of advice on child care in the psychological field must vary very much, as in general terms the training of medical officers and of health visitors for this side of their work is minimal and is likely to remain so until radical reforms in the curriculum become effective. Unfortunately, too, the very mothers (and fathers) who are most in need of help are those who do not come to an infant-welfare centre. Yet the services of the centre—the advice—can be taken to them, and this is, in fact, being done in some areas as a method of tackling the

"problem family." My point here is the simple one that the opportunity for establishing sound mental hygiene in the pre-school age is enormous, and yet, judging by the number of psychological troubles in later life, preventive measures are not proving very effective. In the figures for the "defects" found on routine medical inspection in schools of the London County Council (1948) the percentage of "psychological defects" is about the same as that for otitis media and for heart disease. The prevention of chronic ear trouble and of rheumatic heart disease is certainly approached with more enthusiasm than preventive mental hygiene.

A particular field in which the welfare centre could help is in regard to sex education. The recent developments in the schools whereby more sex instruction is being given has revealed that to begin sex education in the senior schools is much too late and may in fact lead, as it has done in the area of one school of my acquaintance, to almost an epidemic of sex offences between schoolboys and school-girls. What is happening is that the parents have no idea of how to deal with questions on sex matters or on the elementary facts of pregnancy and child-bearing. They fob the children off with unsatisfactory answers in early life, the child begins to learn from companions in the early years of school often in a soiled and dirty fashion, and then the "facts" are imparted in early adolescence, at an inflammable age, to children quite improperly prepared to receive them in this way. At the pre-school stage parents should be helped by series of talks on the whole subject of how to answer the inevitable questions of the young child. Discussion groups, especially if fathers can be persuaded to come, held in the evening would go a long way to help in this difficult and important field.

Yet another field in which somehow or other the infant-welfare centre ought to be doing more preventive work concerns the question of accidents. If the mortality figures for the 2- to 5-year-old group are examined it will be found that "violence" is responsible for the largest death rate. For 1948 the rate per million from this cause was 372 for males and 244 for females, compared with 222 and 208, respectively, for tuberculosis, 27 and 19 for diphtheria, 39 and 34 for measles, and 50 and 24 for appendicitis. The "violence" group can be subdivided into road-traffic accidents, which account for just under half of the total, and "other violent causes," which largely means burns and scalds. Is the infant-welfare service doing enough by means of educative measures—talks, posters, pamphlets—to play a part in preventing accidental deaths? It has been pointed out how very rare it is for a second case of severe burns to come to hospital from the same home (Colebrook, 1949), but what a tragically expensive way of teaching the parents. Instruction on non-inflammable clothes, especially night attire, on guards for open fires and stoves and all electric and gas fires, on street drill, and so forth seems to-day to be as important in preventing death and injury in childhood as instruction in infant feeding.

So far I have been dealing with the future of infant-welfare work as if the general pattern of the centre—the medical officer and the health visitor—was to remain essentially unchanged, and that such changes as were necessary were concerned with a different emphasis because of a changed disease pattern. It is important, however, to take this a stage further to see whether or not something more radical may not become desirable. This question largely arises because of the interesting studies in Luton of illness in infancy. The latest report from this town (Dykes, 1950) indicates that, whereas infant-mortality rates show a definite social gradient, infant morbidity does not. In less

favoured towns this may not yet be the case, but the Luton experience suggests that there comes a time when "no substantial reduction of infant sickness can be expected from general measures which fall within the scope of public health and social medicine." Since, however, a social gradient in regard to infant mortality still exists, it follows that practical measures may be expected to bring about a substantial reduction of the infant death rate.

I do not propose to discuss here the alarming conclusion that what determines—in a relatively favourable environment—whether an infant becomes ill or not in the first year of life is a constitutional factor to be controlled, if at all, by eugenics or by aspects of antenatal care which are not yet by any means apparent. What does seem important is that when an infant becomes ill the ultimate result of such illness would seem to depend upon the standards of care that are then applied. In the lower-income groups, failure to secure early medical attention may have, in the past, partly been governed by financial considerations, but education and lack of it as shown by fear and prejudice may have also played a part. It may be that with the passage of the National Health Service Act the financial barrier to early treatment will disappear.

The Luton report suggests that to lower the infant death rate still further will not necessarily be achieved, in a relatively favourable environment, by raising the income and economic status of the lowest social groups. "It seems rather," runs the report, "that this result will be achieved by ensuring that sick infants in the lower social groups are afforded a higher standard of medical and nursing care than some of them have hitherto enjoyed."

The Need for Change

Let us see where this is leading us. I have long held that preventive medicine should include not only measures to preserve health and prevent disease but also the adequate treatment of minor maladies and of serious illness in its early stages to prevent major catastrophes. The Luton experiences support this view. After a certain stage has been reached in the improvement of environment and the general standard of child care, further advances necessitate early medical help when infants are ill. Obviously at the early stage of illness treatment is best carried out in the home, with the use of hospital only when home circumstances are unfavourable.

The crucial question for the infant-welfare service is, "Who is to carry out this treatment?" I think the answer must be, "The family doctor," provided that he is given a better training in the care of sick children than has been possible in the curriculum of past times, and provided that he is given the services of home nurses well trained in the care of sick babies—a highly specialized type of work in grave danger of being submerged and lost in certain proposals for nursing reform. But if the next steps in reducing the infant mortality—the next steps in preventive work in the infant-welfare sphere—are to be along these lines, then surely the infant-welfare service must reorganize its whole staffing programme. Its medical officers should logically be the family doctors who will be carrying out the work in the homes as well as at the infant-welfare centres, and its health visitors must have a specialized training in the nursing of sick babies as well as in the education of mothers in the care of their children.

The infant-welfare centre would then become a consultative clinic where minor ailments could be treated, as well as continuing its educative functions and the preventive measures already discussed. The services of a consultant paediatrician will be required. This scheme would

mean that, far from health visitors being given less training as nurses and more in social work, they would in fact require even greater training in the care of children in sickness and in health than they receive to-day.

It may be argued that Luton is not representative, that such revolutionary changes are unnecessary, and that the present pattern of infant-welfare work should continue. But the present-day facts of infant mortality and infant morbidity and their social significance are inescapable. A system largely planned and run on vital statistics which were valid 30 or 40 years ago may conceivably be ripe for revision. There is surely a case here for experiment on a bold scale, and a magnificent opportunity for infant welfare to step forward. Medical officers of health have expressed their feeling of frustration in the atmosphere of the Health Service. Surely a change in the whole mode of work of the infant-welfare service would give them an interest again in this field of preventive medicine.

School Medical Inspections

The school health service also presents aspects which have changed little in the last 30 or 40 years. The form of the medical service for school-children was largely determined in the period 1907-8 and was based on three routine medical inspections, the detection of defects, and arrangements for their treatment. In this basic service there has been little change. Workers in the service complain of the monotony of the school medical inspection, and whereas hitherto it has often been possible to dilute such work, so to speak, with maternity and child-welfare sessions, there is a clear lead in official circulars to let antenatal work go to obstetric teams and the child-welfare work, in part at any rate, to child-health officers.

Suppose that such officers, for the most part specialist paediatricians, also take over school medical sessions as they are already doing in some areas: it will surely be a waste of expensive medical man-power to employ such sessions in routine medical inspections. Across the Atlantic they have been asking for some years—what can the school physician detect that the school nurse cannot detect? I specially commend the New York study by Dr. Dorothy Nyswander (1942) and her colleagues for a more detailed answer than it is possible to give here. Workers in Canada have also criticized medical inspections by a school medical officer as being wasteful of time, money, and effort. It is argued that there are few defects which are not obvious on inspection or in which a careful history will not suggest the need for a medical examination. A competent nurse can "screen" the children and select those requiring a more detailed overhaul by a physician. Such a scheme is, I believe, already in operation in parts of Canada. In New York, as a result largely of the studies already mentioned, only entrants now have a complete medical examination and after that the school physician sees only children referred to him as a result of consultation between nurse and teacher.

Defenders of the present system will no doubt maintain that only by a medical examination can heart disease, for example, be detected. But without a history of rheumatism, without some cyanosis or shortness of breath, the apical systolic murmur in childhood is possibly best left undetected. If there is no history and the child is free from symptoms there is little danger of harm coming from the non-detection of a heart lesion. In any case it is illogical to insist that the heart must be examined by a doctor and not include full examination of the urine. The nurse could easily do the latter. She can also apply a tuberculin-patch test and refer those changing from negative to positive for further

examination, repeating the patch test at suitable intervals in the negative reactors. In view of the relatively high importance of tuberculosis in the mortality of childhood already mentioned it is surely illogical to defend current methods of inspection which do not include any special means to detect this important disease. Mass radiography is being used experimentally, I believe, for certain school-children, and the findings will be of great interest. There is almost certainly a field among school-children who react negatively to tuberculin for B.C.G. inoculation in certain circumstances.

If the school medical officer can somehow be released from the burden of routine inspections there is great scope for more interesting and more important work of a preventive type among children of school age. In passing, it is fair to record that the work of the school health service in regard to the handicapped child in this country is of a very high standard and the provisions made are viewed with admiration by visitors from many parts of the world. Moreover, the supervision of children in residential schools for the physically handicapped brings a special interest of a clinical type into the work of school doctors. This side of the work, however, is rescue work of a special and somewhat limited type dealing with a minority of lame ducks in the community. Even in this field I doubt if we are doing enough for the parents of educationally sub-normal children or more especially the uneducable group. There is much unrelieved misery here.

Health Education by the School Doctor

On a much wider scale the health service can reach in the schools such an important population that the school doctor should be encouraged and able to play a part in the whole field of health education. He may or may not be a good teacher, but if he is, then surely he should be encouraged to take some part in teaching. Whether or not he does this, he should certainly be concerned with the syllabus, help to plan practical studies and visits of observation, and, above all, to see that the child learns the elements of hygiene by being able to practise them at school. This means that the school doctor should be directly interested in ventilation, lavatory and washing accommodation, drying facilities, and changing facilities. He should be concerned with school meals and milk in schools, using the opportunity to get the whole subject of food and nutrition, including food hygiene, put before the children.

In the field of physical education the school doctor should also be encouraged to show interest. There is a growing feeling that this subject, together with the whole study of remedial exercises, needs a more critical supervision than has hitherto been the custom. School medical records might well show that certain postural defects right themselves just as quickly without special exercises. I know that this is true in one area for scoliosis. School doctors could soon settle whether or not exercises are necessary for many conditions for which they are now ordered, and with this study the validity of the theories of certain schools and sects in physical education, and indeed in physiotherapy, could be tested.

There is also the question of the teaching of biology in schools and the associated problem of sex education. It is generally agreed that it is not wise for sex education to be dealt with in a highly specialized way by a visiting and strange teacher. But a school doctor who knows his school and is known by the children—by his contact in special medical examinations, through his interest in the food, lighting, and hygiene—would be no stranger, and he or she

might well take some part in this important aspect of the curriculum. Such suggestions would bring the school doctor into much closer contact with the school staff than is generally the case to-day. They may learn to consult him on special problems concerning the children or concerning themselves. The head master or head mistress could come to find the doctor a real help in many aspects of the school life. In this way a contribution to health and happiness among school-children would be made which would be of far greater ultimate value than much of the inspection work done to-day.

In connexion with the school health work also I would commend the work of the school care committees in the London area. They are invaluable for much of the social and preventive work of the school services. They represent an aspect of social paediatrics for the child of school age which is an important part of the school health programme.

I have roamed far and wide in this subject. I repeat again that if there are faults in the child-health services to-day those of us in responsible positions must accept part of the blame. I have tried to indicate why I think the amazing change in the pattern of disease in infancy and childhood must mean a change in the methods and objects of preventive measures. I would especially stress the growing importance of such measures in the field of mental health.

I am aware that some, and possibly most, of the suggestions for changed procedure have already been adopted in certain areas by forward-looking authorities and their progressive medical officers. What can be done in one area can surely be done in most other areas. The child-health services of this country in their beginnings showed the whole world what could be accomplished in the fields of child welfare and school health. The changes, which seem to me urgently necessary, could well once again put these services right in the front of the campaign against death and disease and unhappiness in early life.

It will be clear that I am indebted to many sources for my ideas, some of which are recorded in the list of references. Apart from this there are many colleagues in the academic field and medical officers of health who have wittingly or unwittingly allowed me to gain access to their thoughts. I am also deeply grateful to St. Marylebone Borough Council, who employed me to conduct infant-welfare centres, and to the London County Council, who employed me as part-time medical officer in the school medical service for several years before the last war. Neither body is, of course, responsible for anything I have said in this lecture.

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According to a Home Office paper issued recently there was less juvenile delinquency in England and Wales in 1949 than in 1948. Those under the age of 14 found guilty of indictable offences and dealt with by magistrates' courts numbered 21,152 in 1947; 26,715 in 1948; and 24,872 in 1949. Those under 17 but 14 or more were 13,861 (1947); 16,991 (1948); and 15,064 (1949). A decline was also noted in those of all ages under 17 found guilty in higher courts: 681 (1947), 728 (1948), 494 (1949). Local authorities are urged to hold conferences with interested statutory and voluntary bodies to study ways of preventing juvenile crime, and many have already begun this work.