INEQUALITIES IN HEALTH OUTCOMES AND HOW THEY MIGHT BE ADDRESSED

The basic premise: a real determination to close gaps and iron out inequalities

Considerable variations exist in both health service outcomes for children, and it follows, their whole-of-life-course outcomes. Variations become inequitable if individuals or groups in a population of community are denied fair access to either determinants of health or lifestyles or services which could improve their life chances and outcomes.

Many children today still do not have access to 'three square meals a day' (meaning an adequate diet), a warm coat/new shoes or a quiet place to do their homework.

Society must make a commitment to improve the life chances of children by addressing these underlying problems. The approach should be not only to protect children from hazards, known to have a negative impact on health and well-being, but also promote exposure to positive experiences which enhance assets and resilience. Children in families where mental health problems, substance misuse, learning difficulties and domestic violence are particularly at risk, and specific evidence-based preventive programs should be implemented to address these issues and enable children and young people to have a secure and nurturing home.

Health services should be aware of these adverse determinants of lifestyles, and tailor the delivery of services to both mitigate against their adverse effects, for example the proven financial impact of a long-term condition or a disability, as well as building on positive aspects to improve outcomes. An example would be positive support for involving extended family and/or community members to support the family.

The important message for all in the system, is that we must promote exposure to positives, protect exposure from negatives, and prevent harm of all kinds at every stage of the pathway. It follows that if those who design, commission, deliver and evaluate services against the evidence of a continuum of need are committed to dealing with health inequalities, it takes concerted joint action, preferably before the person is sick, rather than waiting until they are so. Commissioning and delivering to narrow the gaps, whilst not allowing those already well served to see their wellbeing suffer is undoubtedly a challenge. That should not stop the endeavour.

This paper makes five overarching recommendations:

1. **Given we know what the problem is, and from all the evidence collected and discussed for many years we know what could fix it, the entire system concerned with wellbeing and health should commission, spend, and evaluate what it does as if fixing the problem of inequalities is its primary intention.**

2. **The system across all agencies has long accepted the benefits of early intervention and the need for services to work together to ensure that potential issues are dealt with at earliest opportunity to prevent them becoming entrenched and developing into adulthood. The 'new NHS' presents ideal opportunities to turn that acceptance into sustainable practice.**

3. **The child or young person must be a co-constructor of the necessary improvement in equalities, and any gap closing that could achieve this. So are her/his family, a range of health professionals, and a wider group of non-health providers: for example schools, youth services, sports coaches, YOTs, social workers, local authorities' and other bodies' neighbourhood support team members, play leaders, NGOs in the community and so on.**

4. **Given that inequalities discussed in this paper manifest themselves in ill health and poor wellbeing but often arise from other circumstances, an integrated and child centred approach must be judged primarily on the basis of the child's needs and subsequent experiences, not those of the services concerned.**

5. **Where partnership structures and practices are already in place they should remain the basis of action to ensure the first three outcomes above: local duties to cooperate, children's trust or partnership arrangements, schools forums, LSCBs must be central alongside HWBs, Healthwatch, localities' Public Health developments, the local CCG landscape and so on. New NHS arrangements must not bypass these existing ones.**

The paper was commissioned by the co-chairs of the Children's Health Outcomes Strategy Forum from Maggie Atkinson, Children's Commissioner for England.

This final text has benefited from and incorporates generous and detailed inputs, research based evidence and commentary on both policy and practice from a wide range and large number of people: from the Office of the Children's Commissioner, the DH, the Royal Colleges, Forum members from all backgrounds, staff at the MoJ and the DfE, and many practitioners in the field. I am grateful for this collaborative effort to strengthen this text and ensure it covers as many bases, from as many angles, as possible.

Maggie Atkinson
Children's Commissioner for England

26 June 2012

Health Inequalities: what we know

Statistics from Public Health, local government bodies and research have for many years shown inequality in health outcomes is closely related to socio-economic measures of a citizen's status in society. We could list all the many contributors to health inequalities, but most research indicates that they are predicated upon poor early childhood experiences, combined with the multiple impacts of deprivation. Combined, these factors have significant impacts on resilience, attachment, agency, risk taking behaviour, readiness to learn, social behaviour, attainment, physical health, mental health, social and community cohesion, substance misuse, youth offending, unhealthy eating, employment, moving on to higher education. Sadly these are neither different nor more sophisticated determinants from those described by Townsend in the 1960s, Hogarth in the 18th Century, Mayhew in Dickensian London, or Beveridge in the 1940s.

Children most affected by health inequalities are also affected by other inequalities. They include children living in areas of deprivation, with poor childhood experiences, living apart from their parents, suffering abuse, neglect or exploitation, children who are carers for others at home, those with a parent in prison, those who are physically or mentally ill, those involved in the youth justice system, asylum seekers or refugees, those who are not in school for a large number of reasons, and those who are marginalised because of learning or physical disabilities, ethnicity or cultural differences, or by dint of their sexual identity and/or orientation.

Poor health in the population overall often presents differently in children and young people. It is therefore sometimes easy to overlook until it progresses to crisis. For example, one of the most common childhood mental illnesses, early onset and persistent behavioural difficulties, can be misinterpreted just as 'bad behaviour' rather than an outward sign of deeper, more serious emotional distress. It is important to note in this context that only around a quarter of children with childhood mental health problems receive specialist help, which could ameliorate those problems and allow them to move on. The likelihood that such children become sicker, presenting longer term burdens both on themselves and health services, is obvious.

Poverty (both absolute and relative) is a major common characteristic in communities where there is a combination of factors discussed below. None of them are new. In this instance relative poverty is based on a definition of poverty as having a net disposable income (before housing costs) which is equivalent to 60 per cent, or less, of the contemporary median. *Department for Work and Pensions (2010) Statistics: Households Below Average Income (HBAI) and since updated June 2012* Many communities where inequalities are seen display some rather than all of these inequalities. It is important to recognise here that in communities and families affected by any of these factors, by no means every child leads a life which is unremittingly bleak. Rather, research indicates that overall outcomes for children depend far more on subtle interplays between individual, family and community factors. Some children from poorer communities go on to have positive outcomes, due to either individual or family resilience factors.

However, research also indicates that where circumstances discussed below are found, the effects on health for the majority living there are multiplied the more characteristics that are present. In the communities most marked by the greatest number of social and economic inequalities, one

particularly stark health outcomes indicator is that the difference in life expectancy between the poorest and the best off in the district is documented as anywhere between 10 and 15 years.[1]

■ There is a pattern of life limiting physical conditions in the community, including (examples only, not an exhaustive list): type 1 diabetes at higher than the population's average rates; similarly higher rates of type 2 diabetes in adults at or beyond middle age; chronic cardio-vascular, pulmonary and related conditions, including in formerly heavy-industrial communities, industry-related conditions in older adults of both genders; poor nutrition, low levels of physical activity and high rates of obesity, including in children aged under 11; higher than average levels of depressive illness;

■ Children living in such areas (classified as either 'of moderate means' or 'hard pressed') are more than twice as likely to have conduct disorder (one of the most common childhood mental health problems) than children living in 'wealthy achiever areas' (Green, et al. 2005);

■ Take-up of – and reports of communities' trust in – proven preventative and protective health measures, are low. For example:

i. Higher than average rates of: early onset sexual activity in children and young people; common reports of risky personal and sexual behaviours, sometimes with evidence of coercion and abuse within and beyond children's peer groups; sexually transmitted infections and teenage pregnancy rates (whether teenage girls' pregnancies are terminated or go to term) are higher than the national average;

ii. Infant mortality rates are higher than the national average;

iii. Take-up is poor of good ante-natal and immediate post-natal care including both sustained breast feeding advice and support, and advice on infant nutrition;

iv. Take-up of immunisation of infants against childhood diseases lags behind the national rates;

v. Residents' use of assistance, either with avoidance, or later with cessation, of tobacco, alcohol or other substance misuse, is patchy and results are poorer than national average patterns;

vi. Lower than average advantage is taken of available NHS dental services; and

vii. Lower advantage is taken of mental and emotional health and wellbeing services, and higher incidence MH conditions such as depression are common.

Circumstances which are not directly health service or health condition related are also prevalent in these communities. Poor physical and/or mental health there stems from people's life circumstances:

■ Average incomes are below 60% of the Mean and have been so for many years. The Commission on Social Determinates of Health (CSDH) studies show that poverty and low living standards are powerful determinates of ill health and health inequality;[2]

■ Work currently available is of a low or unskilled nature, often transient and poorly paid;

■ The take-up of working age and tax system based benefits is therefore higher than the national average;

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1   Eg: JSNA analyses, Local Government and Public Health statistics over many years; Atlas of Variation in Health Outcomes March 2012; reports: Joseph Rowntree Foundation, Frank Buttle Trust, Child Poverty Action Group, ACH, Barnardo's, Unicef, Save the Children, The Children's Society over many years; research for government's 2011 claimthat 120,000 families are affected; The riots Communities and Victims Panel report, March 2012, citing '500,000 forgotten families'.

2   Commission on Social Determinates of Health (2008) CSDH final report: Closing the gap in a generation: Health equity through action on the social determinates of health. Geneva: World Health Organization.

- Higher than the national average of 16–19 year olds are not in employment, education or training (NEET). This pattern was there when the economy was vibrant, and has worsened since 2008 onwards' economic downturn;
- There is an inter-generational pattern of worklessness and low incomes, and associated, often multi-generational, low educational aspirations and outcomes;
- There is a lower than average pattern of well-qualified and/or professional status adults in the community;
- There are reports from professionals in health and other services of issues regarding citizens' assertiveness (as opposed to aggression, inarticulacy or open resistance) towards authority in whatever form it presents itself in their lives;
- Where universal services are made available to support children's outcomes in such communities, learning from SureStart has been that those with the greatest needs are least likely to access available support designed to promote outcomes. This can often be due to service design not just parent or child attributes;
- Many members of the communities concerned are characterised by what social researchers term poor 'agency' in their own lives, and those of their children, meaning that without support and intervention, those children grow to have equally poor 'agency' as adults;
- Levels of lower level, persistent, anti-social behaviours and criminal activity are above the national average;
- There is a higher than average rate and range of reported domestic violence and abuse incidents, including those witnessed by and affecting children; and
- Safeguarding concerns in local authority social work teams, the LSCB's analysis, schools' daily interaction with families and so on, concentrate in communities affected by these multiple challenges to families' stability and wellbeing.

We have known for many years that in some communities there is a persistent issue relating to children and young people showing a number and range of risk factors. It is important here to reflect on inter-relationships between complex, often multi-faceted circumstances such as those listed above. When found together, they compound each other to make some children still more likely to suffer extremes of inequality in comparison with their peers. Children who are most marginalised, suffering the greatest disadvantage, often experience many of the factors described above, in a complex and individuated pattern that affects aspects of their and their families' lives in ways that do not directly relate to health, but to their day to day lives in all settings. Because these patterns are relevant to the individual, it is also important to note, and to seek the reasons why, some children facing these issues do, whilst others do not succumb to poor health.

Because taken singly each issue in a child's life does not present at crisis level, many children remain 'sub threshold' for intervention, by either single agencies' services, or a combination of targeted or specialist services, especially as they all face budget pressures and thresholds therefore rise. Collectively rather than singly, these factors have been shown by research to add up to a child or young person being at risk of poor outcomes about which, by dint of their age and stage of maturity, they can do little or nothing. We have, also for a long time, struggled to capture or compensate for such children's many personal and familial vulnerabilities, some directly, most at least indirectly connected to their wellbeing. The factors they face make them particularly vulnerable children,

including when they experience multiple problems which restrict their life chances and mean they are in a position of inequality in comparison with more advantaged or less challenged peers. Whilst too often they do not meet the thresholds of individual services, cumulatively they do suffer inequalities in outcomes. It follows that they will need extra – potentially long term rather than episodic – attention, so as to improve their wellbeing.[3]

Inequalities in health outcomes – selected examples

- Half of those with subsequent lifelong mental health problems first experience a range of symptoms before the age of 14.[4]

- Around 60% of Looked After Children and Young People have some level of emotional and mental health problem (NICE). A high proportion experience poor health, educational and social outcomes after leaving care (DCSF 2009).

- In comparison with their peers, looked after children and care leavers are four to five times more likely to attempt suicide in adulthood. They are also at risk of a five-fold increase of developing all childhood mental, emotional and behavioural problems and at six to sevenfold increased risk of conduct disorders.

- Early behavioural difficulties are an important marker for children's health outcomes inequalities. Longitudinal studies tell us children with early onset behavioural or conduct problems face adverse life chances. They are more likely to experience almost every type of adult mental illness, to commit suicide, to experience chronic health problems, to be out of work, to be teenage parents, to end up in custody and to face other disadvantages (Fergusson, 2005). This is in spite of the fact that several evidence based parenting interventions have been noted to improve outcomes for some of these children and families, if they are well implemented (Scott). Supporting positive parenting is a significant protective factor in promoting children's positive outcomes. For those experiencing more complex and multiple needs, ongoing support with positive parenting may of course be required.

- One in three children and young people in contact with the criminal justice system were looked after in their childhood (DCSF 2009). A substantial majority of those living in care who also commit offences had already started to offend before they became looked after (Darker et al 2008). (NICE Guidance on Looked After Children).

- Some ethnic groups experience higher incidences of certain physical and mental health conditions. However, the link between ethnicity and low health outcomes is particularly complex, and must be seen in relation to an equally complex, inter-related set of factors. These include the fact that the same ethnic groups are often characterised, within the broader national population, as enduring lower than average income, education, occupational and living standards. These features of social class matter. Gender differences also apply, given abiding cultural expectations in some minority ethnic communities that girls and women must conform to norms and expectations about work, parenting, domestic arrangements, personal status and behaviours, which differ from those applied to males in the same communities.

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3   We already use such approaches when dealing with children and young people who are in (or are at risk of) contact with the youth justice system. (Healthy Children, Safer Communities 2009)

4   Kim-Cohen J, Caspi A, Moffitt T et al. (2003) Prior juvenile diagnoses in adults with mental disorder. *Archives of General Psychiatry* 60: 709–717; Kessler R, Berglund P, Demler O et al. (2005) lifetime prevalence and age-of-onset distributions of DSM-Iv disorders in the national comorbidity survey Replication. *Archives of General Psychiatry* 62: 593–602.

■ Children of teenage mothers are generally at increased risk of poverty, low educational attainment, poor housing and poor health, and have lower rates of economic activity in adult life. [5] They are also likelier than their peers from other parental circumstances to become young parents themselves.

■ Research shows young people in prison are 18 times more likely to take their own lives than others of the same age. In 2008, there were 686-recorded incidents of self-harm by girls in custody and 743 among boys, although it is likely that these figures represent under counting, given that children in secure settings report an ingrained and inculturated reluctance to disclose that they are hurting themselves, meaning counted incidents are only those which come to staff's notice and are placed on record.

■ Those in the youth justice system are statistically more likely than their age groups to have an (often un-or-under diagnosed but observable and sometimes self-reported) speech and language disorder, and any one of Attention Deficit Hyperactivity Disorder, Autism Spectrum Disorder, emergent or borderline personality disorders, diagnosed or undiagnosed mental health conditions, or neurological or neuro-developmental disorders.[6] Research demonstrates consistently high levels of complex developmental issues and unmet emotional and other mental health needs among children in the youth justice system.[7] [8] [9] [10] [11] [12] [13]

■ Children and young people in secure settings in the Youth Justice system have more unmet health needs than other children. These are compounded by loss of contact with families and other discontinuities, early onset substance misuse, and a mixture of violence and mental health problems. The Bradley Review among other reports has highlighted the health needs of these young people. Initiatives such as the relatively new liaison and diversion schemes are demonstrating success in addressing the health needs of some young people in the youth justice system. The same is true of the partial, not altogether successful, inclusion of clinicians in youth offending teams. Large numbers of children and young people in the secure estate clearly have mental health problems which are addressed patchily as the OCC report *'I Must Have Been Born Bad'* captured in 2011, though the DH is working with the YJB and individual settings to try to address this. There are also ongoing concerns about un-assessed and untreated neuro-disability in the same cohort of young people, about to be examined for research commissioned by the OCC in 2012.

■ Based on 2009 prison population data, approximately 90,000 children have a parent in prison on a given day. Over the course of a year, 200,000 children may be affected by a parent being in, or going to, prison (*Ministry of Justice Research Series 4/12, March 2012. Prisoners' childhood and*

5   Straight Talking (2010) Taking Responsibility for Young Lives: A policy Report on Teenage Pregnancy and Young Parenthood. London.

6   See OCC report, June 2011, *I Must Have Been Born Bad,* on the accessibility or otherwise of mental health services for young people who are incarcerated in the youth justice system.

7   Bryan, K. Freer, J. and Furlong, C. (2007). *Language and communication difficulties in juvenile offenders.* International Journal of Language & Communication Disorders, 42, 505 –520.

8   Bryan, K. Freer, J. and Furlong, J. (2004). *Speech and language therapy provision for young people in prison.* Third project report.

9   Clegg, J. Hollis, C. and Rutter, M. (1999). *Life sentence RCSLT Bulletin*; 571, 16–18

10 Lens, R. (2009). *Speech and language therapy within the Milton Keynes Youth Offending Team.* A four-month pilot project.

11 Department of Health. (2009). *Healthy children, safer communities.* London: Department of Health.

12 Sainsbury Centre for Mental Health. (2009). *Chance of a lifetime: preventing early conduct disorders and reducing crime.* London: Sainsbury Centre for Mental Health.

13 Green, H. M. (2005). *Mental health needs and effectiveness of provision for young offenders in custody and the community.* London: Youth Justice Board.

family backgrounds. Results from the Surveying Prisoner Crime Reduction (SPCR) Longitudinal Cohort Study of Prisoners). The age of the child during their parent's imprisonment may be linked to the likelihood of the child's future involvement in criminal behaviour (*Besemer, S et al (2011). The relationship between parental imprisonment and the offspring offending in England and the Netherlands. The British Journal of Criminology Vol 51(3), pp 1–10*).

■ Children of prisoners have three times the risk of anti-social/delinquent behaviour compared to their peers. They a vulnerable group which is in need of targeted support (*Murray J and Farrington, D P (2008) Effects of Parental Imprisonment on Children. In Tonry, M. (ed), Crime and Justice: A*).

■ Research indicates that 65% of boys with a convicted parent go on to offend, compared to 22% of boys whose parents are not offenders (*Farrington D and Coid J (2003) Early Prevention of Adult Anti-Social Behaviour. Cambridge: Cambridge University Press*).

■ Children who have a parent in prison have twice the risk of developing behavioural problems and poor psychological health than children who have not had a parent in prison (*Murray J, Farrington D, Sekol I, Olsen R (2009) Effects of Parental Imprisonment on Child Antisocial Behaviour and Mental Health: A Systematic Review. Campbell Collaboration*).

■ The children of the poor and those with the complex experiences described earlier, are likelier than their peers to be excluded from school; to self-exclude through persistent poor school attendance; to do less well in tests and examinations; and to be in contact with the youth justice system, including being likelier to be incarcerated for their offences, with all that follows of likelier mental and emotional health issues.

■ Literature also suggests that disabled children are afforded few opportunities to voice their views, and that health professionals often struggle to communicate effectively with them, making their situation worse rather than better and their poor outcomes by dint of their conditions potentially still poorer by dint of professionals' less than effective bespoke practice.

■ Data collected as part of point of arrest liaison and diversion pathfinder screening suggests some children have significantly higher than average, multiple health inequalities, compared to others entering the Youth Justice System. Young women associated with gangs, or with other groupings of peers where violence is a characteristic, tend to present to Youth Justice services with an average of 11 health and social risk factors or vulnerabilities, compared with the average entrant to the Youth Justice System where the average recorded is 2 such vulnerabilities. They are also shown to be 5 times more likely than their peers to report having witnessed and/or directly experienced physical abuse in the home, 5 times more likely to have sexual health needs and between 3 and 6 times more likely to have a range of other risk factors or needs such as a parent with mental health needs, to have been excluded from school, or to have developmental needs, dentistry needs and other issues. *(Centre for Mental Health, Pending 2012)*.

The UN Convention on the Rights of the Child (UNCRC): what we need to consider in engaging children and young people as solution-finders

In 1991 the then Prime Minister John Major signed, and the UK became become a Ratifying State Party to, this international Human Rights treaty. As it is governed by the Vienna Rules the Convention

is binding on public bodies' actions, whether or not it is formally incorporated into UK law.[14] Parts of UK law either already reflect or are more binding[15] than the Convention. Commentators on rights, diversity and equalities, including in the Supreme Court,[16] contend that the Convention is already binding. Its basic premise is that children are citizens and rights holders, holding their status without a need either for adults' mediation, or to earn the rights or seek permission to hold them. Readers unfamiliar with the principles underlying the Convention should note that the UN's expectation is that these rights are only relevant and can only fully be realised when they are applied, and when children are made aware of them in a society characterised by the equal importance of rights, mutual respect, and personal and societal responsibility.

The new edition of DfE's statutory guidance for Local Authorities' Directors of Children's Services and Lead Members for Children and Young People (2012) makes it clear that these two key figures are responsible for the fulfilment of the UNCRC in English localities. It follows that their statutory partners, charged with a statutory Duty to Cooperate, are co-owners of that responsibility. It behoves them to acquaint themselves with the UNCRC and related materials including UN General Comments on the treaty. The Children and Young People's Health Outcomes Framework, and the need to address longstanding health inequalities, both connect this treaty.

The rights contained in the Convention include (amongst others):

- **Article 2**: The Convention rests on the notion of non discrimination: it applies to all children under 18, regardless of their social standing, ethnicity, family circumstances or state of mind, and it cannot be taken away if they commit a crime or for any other reason. Every Article applies. Experts in the field speak of 'indivisible, inviolable and inalienable' rights.
- **Article 3:** The best interests of the child must be a prime consideration, including where they can express those interests for themselves.[17]
- **Article 6**: Every child has the right to survive, make the best of their potential, and grow up healthy.
- **Article 12**: Every child, in accordance with their age and stage of maturity, has the right to have their voice heard in all decisions taken about their life, and to have their views taken seriously.
- **Article 20**: If a child cannot be looked after by their family, governments must make sure that they are looked after properly. The Convention is clear that families are the prime agents in their children's lives, and that they should be supported by the state to ensure their rights are upheld.
- **Article 22**: Every child who is a refugee or seeking refuge, governments must ensure that they enjoy the same rights as any other child
- **Article 23**: Every child with a disability has the right to live a full and decent life, to be helped to achieve to their potential, and to be offered services that adjust to what the child needs, not the other way round.

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14 At the moment it is not incorporated. The Welsh and latterly the Scottish Governments, have begun to move towards incorporation where they have the power to legislate. The Welsh Government has a Childs Rights Measure and is currently consulting on means to test all new legislation against the UNCRC. The Scottish Parliament is in discussion on similar action.

15 For example the 1989 Children Act's insistence that the best interests of the child must be **THE** primary consideration in all dealings with children, exceeds the requirement under UNCRC Article 3 that they must be **A** primary consideration on those dealings.

16 See Baroness Hale's Commentary on the case of ZH (Tanzania) in the Supreme Court, 2011 (ZH (Tanzania) [2011] UKSC 4)

17 See text under footnote 15 above.

■ **Article 24**: Every child has the right to the best possible health and access to services that will ensure that the best health is attainable. The Convention is always read to assume physical and mental health have equal standing in this regard.

What do we know about children and young people's participation in health service design and delivery?

When they are well or only occasionally unwell, children and young people are often both more curious, and more expert, about their own health and wellbeing than adults give them credit for. The older they grow, the more (as Marmot's and Kennedy's reports have both noted) they wish and expect to be treated as service users in their own right rather than having their interactions with health services filtered through an adult, even one they love and trust. Those diagnosed with a recognised physical or mental health condition, or who are physically or learning-disabled, are often still more expert and knowledgeable.

There are of course materials in existence that guarantee children and young people a voice and a part in their experiences of health services. Positive developments have included the *You're Welcome* Quality Criteria[18] and the principle of *No Decision About me Without me* criteria outlined in *Equity and Excellence: Liberating the NHS*,[19] and a range of Healthy Schools Standards programmes for improvement. The latter, over many years in schools across the country, resulted in an in-school emphasis on the correlation between emotional health and wellbeing, physical wellbeing and health promotion.

Notwithstanding the positive developments outlined here, too often in practice and in children's reported experiences there is considerable distance to travel. For example, YoungMinds surveyed council Health Scrutiny Committee Chairs and found that 79 per cent had not had outlined to them how local children young people should be involved in shaping both policy, and local services.[20] The synopses of the 75 Health Watch pathfinders also found that only 5 even mentioned children and young people. None of the documents reviewed gave concrete details of how children and young people would be involved in active participation as co-constructors of services and evaluators of outcomes.[21]

Evidence from LINks evaluations has demonstrated uncertainty about whether engaging with children was part of their official remit. Even those LINks that engaged with children often set different age parameters for their involvement, many of which excluded younger children. In addition, research by the UCL Institute of Child Health has found that the views of under–16s were only sought in 1 of 38 national surveys of patient experience in the NHS between 2001 and 2011. This comprised less than 0.6% of respondents, despite the fact that children represent a substantial service user group.

Contrast the somewhat bleak national picture of the gaps between policy intention and practice on the ground described above with the following selected – anecdotal, but certainly replicable – examples from some localities' practice. There are far more examples across England than the few presented here. Collecting and publicising them could help localities and their professionals better to

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18 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073586

19 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/

20 http://www.youngminds.org.uk/news/news/528_changes_to_nhs_landscape_devalue_young_people_s_participation

21 http://healthandcare.dh.gov.uk/details-pathfinders

include the voices, views and influence of children and young people in services' design, commissioning, delivery and evaluation.

- Hammersmith and Fulham's young people have for several years worked with their local community of GPs to challenge them to live up to the *You're Welcome* standards, and also to deliver the relevant standards in the NHS's NSF for Children Young People and Maternity Services. They have been aided by commitment from the GPs concerned, and by a Council prepared to facilitate their engagement in decision making and scrutiny.

- Medway Council and its partners, including in health services, are challenged on a regular basis by a group of Young Commissioners, who understand and are supported to work within the accepted Commissioning Cycle models in use in health and other professional and service delivery settings.

- South of Tyne and Wear PCT's three areas are now served by a new and integrated CAMHS service that, in its design and delivery across agencies from schools to youth services and into all tiers of CAMHS, has taken keen notice 'from the drawing board onwards' of the wishes and experiences of children and young people with emotional and mental health issues, and their families. Very recently opened as a new service run on a contract won by the Newcastle and North of Tyne Trust, the model of practice will be strongly determined by how much can be done in the child's home, in schools and other settings and in collaboration with education, social care, youth and youth offending services, the third and voluntary sectors, with clinics reserved for the provision of more complex and specialist services and sessions.

- Following the Young Minds/Children's Commissioner for England's report '*Pushed into the Shadows'* about the inappropriate placement of 16 and 17 year olds in adult mental health ward beds, several Mental Health Trusts worked through the materials presented in the report and with groups of service users – many supported via YoungMinds' 'VIK' (Very Important Kids) initiative – not only to change their facilities, but to involve service users in steering and monitoring the changes concerned. Under he Mental Health Act 2007, guidance on age appropriate services requires hospital managers to ensure that patients aged under 18 admitted to hospital for mental disorder are accommodated in an environment that is suitable for their age (subject to their needs). This was implemented in April 2010. www.dh.gov.uk

What can we say about what works to help close the gaps?

There is considerable evidence of good practice on the ground in communities across England now, seeking to eliminate inequalities in health and other outcomes for children and young people. Some of these are outlined below. They are presented as examples of good practice which should be developed everywhere if the five recommendations at the start of this paper are to be delivered.

Health Education and Healthy Schools

Whole schools' approaches to wellbeing in recent years have included work on nutrition, bullying, awareness raising. Teachers' and adults' as well as children's and young people's awareness and comfort in dealing with emotional and mental health and wellbeing issues were further developed by the Targeted Mental Health in Schools programme. The work within this programme demonstrated good outcomes for children and young people's behaviour rather than tackling deeper issues in secondary school pupils when coupled with information about wellbeing that the young people could access and use. It had less impact on emotional symptoms concerning primary school children's

emotional health and wellbeing in the overall population.[22] TAMHS funding has now ended, but – again anecdotally – schools which benefited from it report that they continue to use the lessons they learned whilst they were involved. The Social and Emotional Aspects of Learning (*SEAL)* programme had been used in 90% of Primary and 70% of Secondary schools when last checked, and where it is well embedded results are positive. Reports and evaluations of the programme in use, indicate that when well used, the SEAL approach has proven positive effects on children's and young people's self advocacy and consequent wellbeing, both of which are proven to be important contributors to positive health outcomes.

Parenting programmes

Local Authorities and health partners are increasingly providing a range of evidence based parenting intervention programmes to support children's outcomes and seek to close the gaps between those whose outcomes are good, and those whose outcomes are wanting. These interventions, where they are available in a non-stigmatising way to children with early behavioural difficulties and their parents, delivered in a concerted and determined multi-agency environment, and in ways that remain faithful to the original model of such programmes, are shown to have the potential significantly to improve outcomes for children otherwise at risk of having poor life chances.

Safeguarding, domestic violence and prevention

The links between safeguarding children and interpersonal violence generally are profound in their implications for related health inequalities. The impact of, domestic violence on children and the intergenerational effects cannot be overestimated. Family Intervention Projects are based on multi-agency action aiming to avoid children being taken into care, families falling into substance misuse, domestic violence, crime and unemployment, or to intervene to solve their problems if any of these factors had already materialised and the family was a cause of concern in the community. These programmes when last evaluated were reported as relatively successful, with DFE evaluations showing 34% families with reduced mental health and physical illness, drug and alcohol problems.

The Troubled Families Initiative

The Government has announced its intention to work through Local Authorities and their partners to help to turn around the lives of some of the country's 120,000 most troubled families and has established the cross-Governmental Troubled Families Programme. Under this programme, Local Authorities will deliver interventions which really get to grips with the people who are the most problematic. Families included in the initiatives concerned will be those with a history of both adult and youth offending, anti-social behaviour, and in the children concerned, truancy, school exclusion and a likely result in long term worklessness once they become adults. The programme will work to address inter-generational problems and help to ultimately reduce the numbers of families and children drawn into the criminal justice system. It has only just begun. The hope across the system is

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22 http://www.chimat.org.uk/camhs/tamhs/eval http://www.education.gov.uk/rsgateway/DB/STR/d000956/index.shtml
http://www.iscfsi.bbk.ac.uk/projects/files/third_year.pdf
http://www.actionforchildren.org.uk/media/922804/childrens_centres_in_2011_final_report_june2011.pdf
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098694
http://www.childrenscommissioner.gov.uk/content/publications/content_503
http://media.education.gov.uk/assets/files/pdf/u/under–18%20and%20under–16%20conceptions%202010%20-%20key%20findings.pdf

that it will be given time to deliver results. Rigorous evaluation of its successes, and reports on the lessons to be learned, will both be crucial.

Children of adult offenders

Prison governors and probation providers, both responsible for offender management, have important duties under the Children Act 2004, many of them associated with either the child's right to contact with parents held in custody, or with the safeguarding and wellbeing of children with whom they have contact.

The National Offender Management Service (NOMS) Commissioning Intentions 2012–13 Discussion Document sets out its priorities and confirms the importance of supporting offenders' families to commissioners (who purchase services locally) and providers. It sets an expectation on Prisons and Probation to maintain investment, whilst at the same time acknowledging that further work needs to be done to develop a robust evidence base and outcomes framework.

To support NGOs working directly with partners and families of prisoners, the Ministry of Justice funds Action for Prisoners Families, a membership body that supports and represents those working in this sector. The delivery of services to the children and families of offenders is currently being considered in the context of other cross-government initiatives around supporting families with multiple needs (known as troubled families). This involves a partnership approach to whole family support.

The MoJ and NOMS are in contact with The COPING (The Children of Prisoners, Interventions and Mitigations to Strengthen Mental Health) Project Team from the University of Huddersfield, which is conducting a Europe-wide study on the mental health impacts on children of having an imprisoned parent in the UK, Germany, Sweden and Romania.

Family Nurse Partnerships

Family Nurse Partnership (FNP) programmes aim to improve parenting capacity in particular at risk groups such as teenage parents and the national evaluation found that more child behaviour problems were associated with higher levels of parental stress, less warmth and a lower level of mastery of parenting skills. However consistent support in pregnancy and over two years, associated with attendance at Children's Centres appeared to correlated to greater parental warmth, lower emotional health and behaviour problems in toddlers and increased uptake of contraception and education in mothers more importantly, a range of longer term (after a 40 year follow up) benefits such as greater educational achievement, decreased involvement in crime particularly for young women, improved work involvement and therefore a greater likelihood of long term success in life.

Children's Centres

Children's Centres evaluations show the picture in the families using these multi-agency centres is never simple. Reports include commentary such as 'needs were multiple' whenever Children's Centres are considered. These needs are described as including parenting (94.3%) and family and social care issues (81.1%). Health-based needs in the multiply-challenged communities served by Children's Centres are also reported as widespread, including issues of mental and general health, children's development, and issues connected to physical disability in either parent or child. Drug and other substance abuse featured in a significant minority of cases handled in Children's Centres'

reports, and many of the behavioural and emotional issues identified among client families appeared to be health related. Children's Centres, especially those opened in the early phases, were deliberately targeted in communities where these levels of need had already been recognised and were often deep seated. They are seen by localities' Directors and Lead Members of Children's Services and their partners as remaining vital in helping to address inequalities in health, social wellbeing, educational aspiration and issues such as women finding and returning to work. Some families who do not engage with and may not be registered with a GP practice also use ease of access through their local Children's Centres to gain access to at least a basic level of health advice and care. One of the criticisms of Surestart from the evaluations were that they struggled to engage those most at risk . This raises the ongoing dilemma of universal versus targeted services. Universal services, as the literature tells us, are least likely to engage those most at risk, whilst targeted services run the risk of stigmatising.

Commitment to Children's Centres' continuation, and the linked continuation of inter-agency working that includes health professionals such as midwives and health visitors is widespread across England, though in many localities they are now commissioned from providers other than the local authority and spending on their provision has been – often radically – scaled down or re-profiled. The 'new NHS,' including in the work of CCGs, should build on what has happened to address inequalities through children's centre activity and related work, rather than seek to re-draw provision.

Interventions with children either in care, or at risk of custody

Children and young people on the edge of care or custody are currently being offered intensive , evidence based approaches which tackle child and family difficulties across home, school and in the community through the further development of a number of evidence based programmes (www.education.gov.uk/childrenandyoungpeople/families).

These programmes all have a strong international evidence base and also a growing evidence base from UK based research and are currently being implemented or are under development across sixty local authorities in England. They are all licensed programmes and all practitioners receive standardised initial training and on-going consultation regarding their practice. They are supported by Department for Education in partnership with Department of Health and the Youth Justice Board.

The Multidimensional Treatment Foster Care programme for looked after children young people with high levels of need and also for adolescents as an alternative to custody. These programmes work with children and their carers from pre-school age to adolescence and provide intensive support to carers to maintain children in the community who might otherwise be placed in residential care or custody, based on social learning theory principles. The programme also works to improve children's health, social and educational outcomes. The KEEP programme is also being implemented in the UK and uses the same principles to work with mainstream foster carers to improve outcomes for looked after children (www.mtfce.org.uk).

For children and young people who are at risk of entering care or custody two programmes are being implemented , Multisystemic Therapy (MST) and Functional Family Therapy (FFT).

MST is an intensive community based intervention, involving one therapist working intensively over 3–5 months with families of children aged 11–17 years who have offended or are at risk of out of home placement due to anti-social or disruptive behaviour at home or school. It is an ecological

intervention and works at an individual, family and community level using evidence based interventions, such as behavioural, cognitive behavioural and family therapy. There is 20 years of international research providing evidence of improved outcomes and cost effectiveness of this intervention internationally (www.mstservices,com) and in 2011 the first Randomised Controlled Trial (RCT) of MST in the UK was published. This found that young people receiving MST from the Brandon Centre in North London, showed significant reductions in offending compared to usual services and improvements in family relationships compared to usual services (ref Butler, S et al, Journal of the American Academy of Child and Adolescent Mental Health December 2011). In addition, the qualitative study undertaken as part of this research indicated that both parents/ carers and young people found the MST intervention helpful and accessible.

An RCT of MST across 9 further sites in England, including over 650 families, is now near completion, led by Professor Peter Fonagy and colleagues and will provide further detail about outcomes for both children and families in terms of health, education, and offending outcomes and also cost effectiveness. MST is currently being implemented across 14 sites in England with 10 further areas due to open teams by April 2013.

Current adaptations of the model being used in England, include one for younger aged children who are subject to abuse or neglect and one for young people who sexually offend. In the US further adaptations are also being sued for young people with chronic health conditions, such as asthma and diabetes (see attached pdf).

Liaison and Diversion

With reference to relatively new Liaison and Diversion Pathfinders, in a recent evaluation the following statements illustrate the positive developments concerned:

> There are statistically significant reductions in overall need, levels of depression and levels of self-harm and a significant association between improvements and the amount of YJLD contact. The study found no significant changes in reoffending rates between any of the intervention and control sites. However, Youth Justice Liaison and Diversion clients desisted from offending for longer periods than the comparator group.

Functional Family Therapy also targets young people with problematic behaviour in school, home or their community and details can be found at www.fftinc.com. There is currently one site operating this programme in Brighton and Hove and two further sites are under development.

Given the amount of robust evidence of their success, both in the UK and elsewhere, the system and all agencies within it need to commit to the use of strongly evidence based interventions such as those described above.

Teenage Pregnancy and SRE issues

Teenage Pregnancy Advisors combined with PHSE/SRE programmes in schools and other educational and awareness raising campaigns, have had a positive impact on the rate of teenage pregnancy. Annual Pregnancy statistics show that conception and pregnancy rates fell at all ages under 18 and the conception rate for u18s is at its lowest rate since 1969 but with considerable variation across local authority areas. In new ways of working, it will be crucial that localities commit to continuing to address teenage pregnancy and associated risk taking behaviours among some children and young

people. This commitment will require multi-agency working across education, social care, youth services and health, just as the Teenage Pregnancy Strategy (TPS) did.

Health and Wellbeing Boards: optimism for the future

Health and Wellbeing Boards (HWBs) should be well positioned to effect positive changes in children's health outcomes through their duty to promote integrated working, to drive improvements in health and wellbeing. Because their agenda extends beyond health and adult social care and must include children's health and wellbeing, and wider areas that impact on health such as housing, education and the environment, there is great potential for HWBs to be a significant lever in improving health outcomes for children and young people because they are at the fulcrum of commissioning and integrated delivery. Listening to children and young people directly, engaging with the mechanisms already in place such as youth assemblies, forums and shadow councils, will be crucial to their success in this regard. The presence of the DCS and locality DPH as members of the HWB will also be crucial, to help HWBs to avoid reinventing partnership infrastructures and ways of working with and for children and young people when these already exist.

JSNAs done well

Joint Strategic Needs Assessments will be critical to understanding and analysing the health needs of populations to inform and guide commissioning of health, well-being and social care services within local authority areas. The JSNA will underpin the health and well-being strategies and commissioning plans. It will be critical for JSNAs to take into account the specific health needs of children and young people.

What can we say about public health inequalities given the development of Public Health England, Public Health Outcomes Framework, and the transfer of PH to LG?

The new Public Health landscape, and the placing of preventative approaches at the centre of localities' work on tackling health inequalities, presents all concerned with opportunities. The Marmot Review outlined health inequalities in 2010 using life expectancy and healthy life expectancy as health measures and early child development and NEETs as social measures. Marmot noted that poverty and poor child development and school attainment are closely linked.

Kennedy's report *Getting it Right for Children and Young People* identified cultural barriers in the NHS which get in the way of children receiving good services. Kennedy quoted the UNICEF report which ranked the UK bottom out of 25 industrialised countries for well-being enjoyed by children, based on a range of measures, including subjective well-being, with child mortality rates lagging behind the EU and problems of integrating and co-ordinating a range of health and care services which should benefit children and young people.

Graham Allen's review of early intervention *Early Intervention – the next steps* recommended to Government that early intervention should provide a social and emotional bedrock for the current and future generations of babies, children and young people by helping them and their before problems arise.

The government-commissioned review of child protection social care, undertaken by Professor Eileen Munro, published a series of reports culminating in the final one, *A Child Centred System* in 2011. The recommendations centre on the concept of early help, available not only via social care but across the multi-agency landscape in a locality. Health services must play a central role in the systems concerned as well as in children's trust arrangements and Local Safeguarding Children Boards, if inequalities are to be addressed on children and young people's behalf.

Appendix 1: OCC REPORTS – Selected evidence

Standing Together – principles to reduce CYP involvement in gun and knife crime: 2010[23]

This report found that parenting education increased young people's resistance to being involved in knife crime. Given that research indicates those children and young people who become involved in violence are often those whose life chances are already poor and who end up mentally ill and under intolerable pressure from the gang environment and the results of both carrying weapons and being prepared to use them, this report is prescient.

Children and Young People's Views on education policy: November 2010[24]

The most important priorities for children and young people to help them improve their school life and education were preventing bullying and having good teachers. Concerns around bullying decreased with age – it was a concern to a greater proportion of younger children, compared to older young people, whereas older young people (particularly in year groups 10 and 11) were more concerned to be listened to and involved in co-shaping their learning, and to have support in stressful periods such as examination season.

Children and Young People's Views on child protection: 2011[25]

Children and young people who are abused have poorer health outcomes than those who are not. CYP in this study, who had all had contact with child protection services and systems, said their parents needed help with substance misuse and other health problems. Given the dependent nature of children on their caregivers, there is an evident proxy health outcome indicator in this report, for children and young people living with parents who have problems with substance abuse or other difficulties which have a direct and negative effects, particularly on children's emotional and mental health and wellbeing.

Where is my Advocate? 2011[26]

CYP need advocacy in all sorts of situations: in hospital, in care, in secure settings, in mental health settings. This report highlights the need for and the right to independent advocacy for CYP and is the first stage in an ongoing research and advice project now in the hands of the Advocacy community who will now progress the work.

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23 www.childrenscommissioner.gov.uk
24 Ibid.
25 Ibid.
26 Ibid.

Trying to get by: children and young people on poverty: march 2011[27]

In this report CYP describe poverty as including emotional poverty, embarrassed to ask for help therefore less likely to receive timely help, the stigma of poverty, that maintaining friendships is difficult when you are poor, that eating well is difficult, and that they see poverty as both a cause and a consequence of family breakdown.

Young People's views on restraint in the secure estate: 2011[28]

Girls experienced restraint in a different way to boys, but restraint generated bad memories in boys and in girls. This work has been at the centre of OCC's work on issues of restraint, its dignity or indignity, the nature of it, and the continued permission to the regime to include, as a last resort, restraint techniques which cause pain to the inmate. Give the young age at which English children can be sent to secure settings the matter continues to cause grave concern.

Landing in Kent: 2010[29] – a report on the experience of unaccompanied children arriving in Britain, assessed as children and placed into the care of Kent County Council in the Mill Bank residential setting in Ashford. The report, based on discussions with the young people met during the visit to the centre, the inter-agency staff team at Mill Bank and the County Council, highlights the importance of accurate age assessments and medical examination.

I Must Have Been Born Bad: June 2011 – a report of an OCC-led investigation into the mental and emotional health and wellbeing of young offenders aged under 18, held in the secure estate. The report includes accounts of the lived experiences of these children and young people. It highlight good and challenges less effective practice in Secure Children's Homes, Secure Training Centres and Young Offenders' Institutions. The report contains recommendations for implementing best practice, for the Department of Health, the Ministry of Justice, the Youth Justice Board, commissioners and providers of services, and institutions themselves. Launched in June 2011 the report has gained widespread support and both Departments, at Ministerial and Officials levels, have responded with action plans. The National Offender Management Service (NOMS) has responded positively I directing all secure settings under its jurisdiction to modify and improve practice in strip searching children and young people, acknowledging the change it has now directed is a direct result of this investigation and report.

Landing in Dover: March 2012 – a report on the experiences of a very small group of children and young people arriving as unaccompanied illegal entrants to the port of Dover. They recount their experiences of the journeys they made to get here, many of them harrowing. They have then been held, questioned, medically assessed and their cases reviewed to determine their needs for social care and other services. Their experiences vary from being treated with the greatest care and concern, to being questioned whilst still tired, hungry, thirsty and frightened, and sometimes sick after the harrowing journeys they had undertaken. The worst cases were those who, without a translator, health or welfare assessments, were – in cases occurring between 19995 and 2011 – returned to their port of embarkation in France or Belgium under the 'Gentleman's Agreement' between the governments concerned. The United Kingdom Borders Agency ceased using the Agreement

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27 http://statistics.dwp.gov.uk/asd/index.php?page=hbai
28 www.childrenscommissioner.gov.uk
29 Ibid.

forthwith in November 2011, once the Children's Commissioner made it clear she knew about it and would expose it in the report.

Child Rights Impact Assessment (CRIA) on the Welfare Reform Bill: January 2012 – this critique, widely quoted in debates in Parliament and used in ongoing negotiations on the legislation and its effects, presented OCC's first forensic CRIA on draft legislation. Its content strongly supports the commentaries put forward by others about this radical overhaul of the system. We conclude that around 200,000 more children could end up in poverty under these reforms. Given the comments in this paper around the strong links between poverty and inequality in health outcomes this is a significant concern. Particular groups of children could be worst affected, for example those with disabilities, those from some ethnic and cultural groups where families tend to be larger than the average, earnings lower and benefits caps a real and imminent threat. The potential effects of these reforms will need to be at the forefront of decision making by commissioners and providers alike in the newly configured NHS, not least because those already suffering inequalities may face still more and still worse ones as a result of the changes concerned.

They Never Give Up On You: March 2012 – a report of an eight-month formal Inquiry into school exclusions, the equality, legality and balance experienced by children at risk of exclusion or already excluded, and the greater likelihood of some groups of children and young people than others to be excluded. Those with specified and recognised special needs are among the likeliest children in the school population to be excluded. There are then multiple factors, from gender to ethnicity and poverty, that contribute to an ever greater likelihood that some children will, whilst others will not, be excluded from school. Heads and parents were clear, in evidence gathering, that the availability of good health services to come into school and work with troubled, vulnerable and difficult children, is hit and miss. This particularly applies to lower level CAMHS interventions, meant for prevention rather than cure. A second year's work on the inequalities highlighted in year 1, will now follow.

The Home Front: January 2011 – research commissioned and funded by the OCC and written and published by *Demos.* Heavily based on 'lived experience' accounts from families with whom researchers went to live for a time, it reports on the factors that enable, and those that hinder a good quality of stable, balanced and healthy family life.

(Unpublished) Children and young people's views and experiences of GP Services – this survey of 780 children and young people found nearly half had been unhappy at some point with the treatment they had received, and with the attitudes of the GPs to them as patients, rather than their parents or other accompanying adults or advocates.

Current projects:
- **'Recognition and Telling' –** this research, commissioned from UEA and ongoing now, looks into how children and young people might access help and protection at an earlier stage than is currently prevalent in the course of their experience of abuse, neglect or other difficult family and life circumstances. It includes looking at what their experiences might be when living with an alcohol abusing adult or adults. The project will include taking the views of children and young people on board, where their life experience includes any or a combination of these circumstances. It will also look into the parallel issues that arise when, for reasons connected with these abuses of their situation as children, they become carers for their parents or other family members and

undertake unseen, often personal and demanding, certainly childhood-shortening, personal and other care in the home.

■ **Formal Inquiry into Child Sexual exploitation in Gangs and Groups (CSEGG)** – this Inquiry defines Gangs as groups of often similar aged people, often but not always males, who share markers and affiliations to each other concerning territory, clothing, loyalty, leadership and structures or agreed codes of behaviour. Groups in this Inquiry's context are rather looser affiliations, often featuring adults, again often but not exclusively men, as perpetrators of sexual exploitation and abuse on children and young people. The work is in its formal evidence gathering and data collection phase and will report in two stages: at the end of the first year's work (2011–12) broadly on prevalence, scope, patterns across the country from community to community; and at the end of its second year (2012–13) on advice to government, public agencies and society regarding what should be done.