

children&health

making the link



LONDON
HEALTH COMMISSION

Authors: **Katherine Curtis and Helen Roberts**

contents

	Page
Introduction	3
Building London's future	7
Exploring the city	10
Having fun and creativity	15
Creating strong neighbourhoods	17
Supporting children and their families	19
Learning and tools for life	24
Staying healthy and happy	28
Safety and justice	33
Having your say	35
The Children's Strategy	38
References	39

introduction

Aims

This report sets out

- A summary “what works” – or what appears to work, in relation to the aims/interventions proposed in the draft Children & Young People’s strategy
- other interventions with strong evidence of effectiveness in reducing inequalities in child health
- where there are gaps in the evidence and we simply don’t know what the most effective course of action might be.

Background

While the UK has a strong tradition of work on the *determinants* of inequalities in health, we are weaker on our understanding of what we can actually **do** to reduce these inequalities. Some of our actions in attempting to address inequalities are based on poor (or no) evidence, including research carried out in very different cultural contexts. Some interventions are based on no research at all, and some interventions may widen rather than narrow inequalities.

The health service on its own cannot tackle inequalities in child health. Adequate income, affordable child care, parental employment, an inclusive education system and accessible health, leisure and transport facilities are all essential for the prevention and eradication of inequalities.

How do we know “what works”?

Different kinds of research help us answer different kinds of questions. In order to understand *cause and effect* – the relationship between a particular intervention and a particular outcome – randomised controlled trials (RCTs) – have the edge over other methods, and have been carried out in relation to day care, home visits, accident prevention schemes, and a range of other childhood interventions. Of course, not all interventions can be easily trialled, and not all trials carried out in other contexts can be readily transferred to London. Some interventions which may be very beneficial to child health, such as changes in the built environment, and changes in traffic management need to be tested and evaluated in other ways.

Cohort studies, such as the National Child Development Study (NCDS) can help us identify factors which seem to have a protective effect. Who does well after a poor start in life, and what can we learn from this? (Pilling, 1990)

Qualitative studies, expert opinion and surveys are likely to have crucial lessons for those wanting to understand the process of *implementing* an intervention – what can go wrong, what the unexpected adverse effects might be when an implementation is rolled out to a larger population (Petticrew and Roberts, 2003). Moreover methods which enable us to listen to the views of children and teenagers are crucial if we are to design more effective and acceptable services.

Really good evaluations, drawing on both qualitative and quantitative work, and looking at processes (‘How can I make my service attractive and accessible?’) and outcomes (‘How can I make sure my service actually makes a difference in the desired direction to a

child’s life ?’) may not be as sound as trials in telling us what works, but they are important, and important to do well. All too often, evaluations are a quick satisfaction survey, with poor quality data, and no data at all from people who drop out of a service, or who never access it in the first place. With funding for services to reduce inequalities in health at a premium, there are disincentives to reporting frankly on what *doesn’t* work well.

The state of the evidence base and what we still need to know

We have not been able to identify an effective intervention for every problem area. Having no good evidence does not necessarily mean that an intervention is worthless, but it should give us pause for thought. Is this ‘innovation’ we are planning in effect an uncontrolled experiment? There are many examples from the past of well meaning attempts to intervene in children’s lives which have had adverse

effects. For this reason 'strong' evaluation (rather than evaluation as justification) needs to be a routine part of working ethically with children. Building on the best available evidence, and robustly testing the next steps is likely to be the way forward.

The research evidence base for reducing inequalities in child health is growing, but there are considerable methodological problems to be addressed. Firstly, the more robust the research design, the more we are likely to find that things we 'know' to work are not quite as effective as we thought, and may have the reverse of the desired effect. Secondly, unless complex interventions are set up in a way which enables good evaluation to take place, we don't know which 'bit' is being effective (or ineffective). Finally, research on the same issue may come up with different results, This makes it all the more important to produce systematic reviews which can give an overview of findings, and draw together the results of different studies.

This kind of research evidence needs to be provided at a national and international level. Meanwhile, at a local level, it is important to monitor local implementation and impact. This involves considering **structure** (are the conditions in place for research-evidence based interventions to happen, ie are the funds, people and training in place; **process** ie is the intervention happening, are children and parents coming to the project and so on; and (which is more difficult at a local level) **outcomes**: what happens to these children and young people in a week, three months, a year, or 20 years?

We also need to do more to understand the ways in which listening to children may affect outcomes and the extent to which it is a benefit in itself. It may, after all, represent a cost to children, by drawing on one of the few resources over which they have some control, that is their time.

And when there is no evidence?

The impulse to want to 'do something' is strong, whether or not we have evidence. And while the default position should be to build services on good evidence of what works, there will also be situations where new challenges are faced, and rapid action needed. When unaccompanied refugee children arrive for instance, there may be little we can draw on in terms of direct research evidence, but we cannot wait to generate good research. There may be 'near' evidence – for instance evaluations of child refugees from other cultures, and studies on refugees and resilience. We do not, in the UK, have a good record of learning the lessons from work on the strengths of refugees, or the problems created by the thin dispersal of refugee groups

(Edholm et al, 1983). The ethical position in the meantime, where services are urgent, is to deliver services on the basis of the best of current knowledge; to acknowledge that innovation can be another word for experimentation, and to put pressure on national agencies to ensure robust evaluation of both outcomes and process.

How did we go about our work?

We identified the public health related aims and interventions in the draft Children and Young People's Strategy, and then searched for evidence of effectiveness in these and other child public health related areas – for example, interventions around housing, obesity/exercise, transport and safety, poverty, play, educational interventions for vulnerable groups, drugs and

alcohol prevention, and bullying and racism. We must emphasise that while we have been careful to check the accuracy of this review, we do not rule out errors of fact or interpretation. More importantly, we are aware that it is not fully comprehensive. Our understanding of inequalities in child health is growing, and there are likely to be important studies which we have missed.

We searched key literature on intervention effectiveness including:

- the Health Impact Assessments already completed for other aspects of the Mayor's strategy.
- the Cochrane Public Health/Health promotion field
- the University of London Institute of Education EPPI-centre databases
- the Health Development Agency's evidence base
- the UK ESRC EvidenceNetwork
- the Acheson Report (Department of Health, 1998)
- the Barnardo's publication on What Works in Reducing Inequalities in Child Health (Roberts, 2000)

building London's future

Accidental injury is the main cause of child death in the UK (Roberts and Power, 1996). A child in the lowest social class is twice as likely to die before the age of 15 as a child in the highest social class (Botting, 1995). Those living in poor housing are particularly at risk (Roberts, Kramer et al, 1996) – for example, children growing up in the most deprived households are *sixteen* times more likely to die in a house fire than their peers in well-off homes (Roberts, 1997). A comprehensive review of risks in domestic buildings has also identified high risks from poor air quality, hygrothermal conditions, radon, falls, house-dust mites,

environmental tobacco smoke and fires (Raw, 2001). Damp and mouldy living conditions have an adverse effect on the health of children (Platt et al, 1989). We know from qualitative studies that 'better housing' is a priority for children and teenagers' (Imagine London, 2002; Hood, 2001).

Housing and planning

The relationships between housing, deprivation and health are complex, but enough is known about the main associations between living conditions and health to enable us to understand that we need to have standards around temperature and humidity,

indoor air quality, and environments likely to lead to injuries (Lowry, 1991).

Secondary impacts need to be taken into account in order to understand how housing improvements affect health. A recent review of housing interventions (Thomson et al, 2002; Douglas et al, in press, on which we draw heavily in this section) recommends that, any health impact assessment include the following:

- Are there going to be any changes in housing costs?
- Is there any other change that may affect living costs – transport, food, access to amenities?
- What levels of displacement can be predicted over the period of improvement?

Broadly speaking, housing improvements have been seen to improve residents' mental health, and make modest improvements to general health (Thomson et al, 2002). Use of domestic safety devices such as smoke alarms and child resistant packaging on poisonous products can reduce unintentional injuries – though mechanisms to ensure proper installation and maintenance of alarms

are needed if they are to remain working after initial installation (Rowland et al, 2002).

Evidence also highlights where the positive impact of interventions may be offset by other changes in housing, or residents' circumstances. Housing or rent subsidy programmes using housing vouchers in the USA offer tenants more control and choice about where they live and improve integration of public housing tenancy (Olsen and Barton, 1983; Reeder, 1985). Yet, these programmes act on, and are acted on, by other inter-related factors such as housing supply and demand. Changes in these areas have the potential to negate the positive impact of the intervention (Douglas et al, in press).

Housing improvements, unsurprisingly, are linked to rent increases – which in an early study were associated with increased deaths (McGonigle and Kirby, 1936). Recent research in

Stepney reports that rents in the new houses increased by 14% on average and some residents report this as a barrier to employment opportunities, and leading to their economising on food (Ambrose, 2000).

Relocation from areas of deprivation has been associated with a range of benefits (Rosenbaum 1991) including reduction of children's likelihood of having an asthma attack (Katz et al, 2000). However, a number of unwanted outcomes have also been identified, from loss of community and uprooting of social networks (Freid, 1966; Yuchtman-Ya'ar and Spiro, 1979) to displacement of original residents (Walker and Bradshaw, 1999). Lack of control and opportunities to negotiate with the housing authority over the move, have also caused problems (Allen, 2000; Elliott et al, 2001).

Involving stakeholders is key. Parents and children living in particular

environments are expert in identifying local risks. At present, much of the data used by those trying to prevent child accidents are insufficiently localised. Moreover, there are no records of child accidents, only of child injuries. These data tend to describe the consequences of an accident rather than its environmental *antecedents*. Children as young as 7 who took part in a Safe School project (CAPT and Roberts, 1993) were able to identify risks and dangers, and suggest practical measures to alleviate them. Effective accident prevention draws on the specialist local knowledge of children and parents in order to educate them into accident prevention, rather than treating them as part of the problem.

exploring the city

Child pedestrian injury arising from road accidents is the leading cause of death for children in the UK. Social deprivation is strongly associated with child pedestrian injuries (Wazana et al, 1997). Children from social class V are five times more likely to be killed in a road traffic accident than children from social class I (Roberts and Power, 1996; Roberts, Norton et al, 1996). The risk of injury increases with traffic volume, absence of play areas, poorly protected play areas, and high levels of kerbside parking (CAPT, 2003; Roberts, 1995). London's child pedestrian casualty rate is higher than the national average (Hood, 2001).

Children themselves identify outdoor safety as important. A report by the Children's Play Council found that 'general fears for personal safety' and 'traffic' were among the things that stop children from playing outdoors (Cole-Hamilton, 2002). When asked how outdoor play space could be improved one child said: "No cars in my street so that I can play outside." Recent evidence indicates that the most effective ways to improve health through transport interventions are traffic calming and drink driving legislation and enforcement (Morrison et al, 2003).

Traffic calming

It has been estimated that traffic calming can reduce the number of injury accidents by 15% (25% on

residential streets and 10% on main roads). Evidence indicates that area-wide traffic calming schemes are more effective in reducing the number of accidents involving injury than those with a more traditional "black spot" focus (Bunn et al, 2003; Elvik, 2001). It is unclear at present whether traffic calming schemes increase the number of pedestrians in the area, but an intervention aimed at improving the safety of cyclists found that cycling increased in the area where the scheme was introduced (Garder et al, 2003). This may indicate that as well as the short term effect of reduced accident rates in the area, traffic calming may boost the number of child pedestrians or cyclists, which in turn would impact on children's physical health in the longer term (Liabo and Curtis, 2003).

Drink driving legislation

Evidence indicates that legislation to reduce drink driving works. A north American study showed that a maximum legal blood alcohol concentration of 0.02% in younger drivers (under 21) reduced night time injuries and road fatalities (Zwerling and Jones, 1999). Random breath alcohol testing is associated with a 20% reduction in alcohol related hospital admissions, deaths, injuries, night time crashes and drink driving charges (Peek-Asa, 1999). Lighter sanctions against drink drivers have been associated with a 7% increase in road traffic incidents (Wells-Parker, 1995).

Health promotion approaches

Studies of the effects of road safety health promotion campaigns, such as mass media campaigns are less clear about whether they deliver positive outcomes (Morrison et al, 2003). A

good deal of evaluation in the child safety area has looked at whether or not health promotion messages about safe play have been received and remembered rather than whether behaviour has changed (let alone whether the child accident rate is affected). The emphasis of road safety work, moreover, has traditionally focused particularly on the child's behaviour, rather than, for instance, the behaviour of motorists (Ampofo-Boateng and Thomson, 1989). Ampofo-Boateng and Thomson's review of approaches to child pedestrian accidents in the UK suggests that verbal instructions to children can be hazardous when used in isolation.

Behaviour changes advocated by posters and other printed materials are rarely evaluated, and the evidence suggests that changes in knowledge in this area do not readily lead to changes in behaviour. Even when evidence is produced to suggest that

health education messages are translated into behaviours, the net result does not seem to be a reduction in injury (Roberts and Coggan, 1994). Two before and after studies evaluating the 'Play it Safe' campaign on television found no evidence of reduced hospital admissions, or reduced use of accident and emergency departments (Williams and Sibbert, 1983; Naidoo, 1984).

The traditional approach to the prevention of child pedestrian injuries is pedestrian education. However, a New Zealand study suggests that none of these programmes has been shown to reduce injury rates. Roberts and colleagues (1994) estimates the number of serious child pedestrian injuries which might be prevented if

the resources allocated to pedestrian education were allocated instead to environmental approaches, in particular, to traffic calming. It is estimated that approximately 18 hospitalisations of child pedestrians could be prevented each year under this alternative resource allocation, disregarding any other benefits of traffic calming. These results emphasise the need to consider the potential sacrifices involved in the allocation of scarce resources to child pedestrian education.

Drink driving legislation

Evidence indicates that legislation to reduce drink driving works. A north American study showed that a maximum legal blood alcohol

concentration of 0.02% in younger drivers (under 21) reduced night time injuries and road fatalities (Zwerling and Jones, 1999).

Random breath alcohol testing is associated with a 20% reduction in alcohol related hospital admissions, deaths, injuries, night time crashes and drink driving charges (Peek-Asa, 1999). Lighter sanctions against drink drivers have been associated with a 7% increase in road traffic incidents (Wells-Parker, 1995).

Health promotion approaches

Studies of the effects of road safety health promotion campaigns, such as mass media campaigns are less clear about whether they deliver positive outcomes (Morrison et al, 2003). A good deal of evaluation in the child safety area has looked at whether or not health promotion messages about safe play have been received and remembered rather than whether

behaviour has changed (let alone whether the child accident rate is affected). The emphasis of road safety work, moreover, has traditionally focused particularly on the child's behaviour, rather than, for instance, the behaviour of motorists (Ampofo-Boateng and Thomson, 1989). Ampofo-Boateng and Thomson's review of approaches to child pedestrian accidents in the UK suggests that verbal instructions to children can be hazardous when used in isolation.

Behaviour changes advocated by posters and other printed materials are rarely evaluated, and the evidence suggests that changes in knowledge in this area do not readily lead to changes in behaviour. Even when evidence is produced to suggest that health education messages are translated into behaviours, the net result does not seem to be a reduction in injury (Roberts and Coggan, 1994). Two before and after studies



evaluating the 'Play it Safe' campaign on television found no evidence of reduced hospital admissions, or reduced use of accident and emergency departments (Williams and Sibbert, 1983; Naidoo, 1984).

The traditional approach to the prevention of child pedestrian injuries is pedestrian education. However, a New Zealand study suggests that none of these programmes has been shown to reduce injury rates. Roberts and colleagues (1994) estimates the number of serious child pedestrian injuries which might be prevented if the resources allocated to pedestrian education were allocated instead to environmental approaches, in particular, to traffic calming. It is estimated that approximately 18 hospitalisations of child pedestrians could be prevented each year under this alternative resource allocation, disregarding any other benefits of traffic calming. These results emphasise the need to consider the potential sacrifices involved in the

allocation of scarce resources to child pedestrian education.

A safe route to school

Many child accidents take place on the way to, and more often, on the way home from school. As a result, parents with a car may feel that they should drive their child to school to protect him or her from danger. This not only increases the traffic risk to pedestrians, but also increases the pollution related to some respiratory problems in children.

The reduction in exercise in children, and the restriction on freedom to walk alone or with their friends as a result of fears, traffic, or human predators has an effect on children's overall well being.

An intervention which shows some promise in relation to this is site specific advice from school travel co-ordinators on improving the safety of

school travel patterns (Rowland et al, 2003). Schools were offered 16 hours of expert assistance over one school year from one of two part-time school travel coordinators who had teaching qualifications and road safety experience. Co-ordinators facilitated key stakeholders (including children) to identify road safety problems and collate solutions in a school travel plan. The researchers found that having a school travel coordinator increased the production of school travel plans but there was no evidence that this changed travel patterns or reduced parental fears. Further trials are needed to understand what works, why and how.

Unwanted outcomes

In relation to young people and transport, there is also evidence of what doesn't work. Well intentioned interventions to teach young people to drive earlier may have an effect on driving skills, but also increase the number of inexperienced drivers on the roads. Driver improvement and education courses have been associated with *increases* in crash involvement and violations (Morrison et al, 2003).



having fun and creativity

It has been suggested that there are benefits to play which extend beyond the individual child to the wider community (National Playing Fields Association et al, 2000). These include developing independence, self-esteem and respect for others, supporting healthy growth and development, and increasing knowledge, understanding, creativity and capacity to learn. Suggested benefits for the community include reducing the involvement of young people in anti-social behaviour, supporting informal networks and communities and offering opportunities for exploring cultural identity.

Children's opportunities for play have been affected by the loss of public space, the impact of technology, such as television and the motor car (Hillman et al, 1990) and changing attitudes to risk, reflected, for instance, in the increase in parental anxiety about child safety (Valentine and McKendrick, 1997; DiGuseppi and Roberts, 1998).

Interventions which reduce danger to children on roads and promote provision of green, open spaces can go some way towards counteracting these trends.

Green, open spaces

Children and teenagers have called for "more space to do things" (O'Brien et al, 2000), "more clean, green spaces" (Imagine London, 2002).

Obesity and being overweight is increasingly a problem for children and adults both in the UK and worldwide (WHO, 1997). There is debate around why this is so. Possible explanations include an increase in sedentary

lifestyles and changes in dietary patterns and eating habits (CRD, 2002). Unfortunately, we still don't have enough good research to know how best to tackle the problem (CRD, 2002; Campbell et al, 2003). However, family-based programmes which involve parents and increase physical activity as well as provide dietary education may be helpful. It is likely that green, open space for children to play can only complement strategies to encourage more physical activity.

Inclusive play

Recent estimates suggest that just over 3% of London's 1.65 million children are disabled (Hood, 2001). It can be difficult to get funding for inclusive – rather than specialist – play resources.

However, Better Play, a collaboration between Barnardo's and the Children's Play Council is currently supporting the development of a range of inclusive projects. Findings from case studies indicate benefits for disabled children such as increased confidence, and developing social and emotional skills. Non-disabled children have had a chance to learn about disability. Both non-disabled and disabled children have had opportunities to discover how to interact with each other and play together (Better Play, 2003).



creating strong neighbourhoods

Poor communities may find themselves between the rock of complete neglect and the hard place of scrutiny from professionals assessing needs which conveniently turn out to be aligned with the services that those particular providers offer. We know too little about the extent to which community development, or regeneration projects are community led (or even community accepted), and the ways in which they use and generate evidence. National evaluations of schemes with a similar underlying philosophy but differing local contexts such as the national HAZ evaluation and the work of Youth Offending teams may provide helpful pointers.

Neighbourhood regeneration

A recent review recommends that any health impact assessment of regeneration initiatives include the following questions (Douglas et al, in press):

- When will planned regeneration be confirmed to the residents?
- Will delays in regeneration impact on routine maintenance in the area?
- Is the regeneration area surrounded by similarly disadvantaged neighbourhoods currently not benefiting from investment?
- Are other regeneration initiatives planned aiming to improve economic and educational opportunities for existing residents?

A review of the evidence for neighbourhood regeneration (ODPM, 2000) suggests the importance of area-based initiatives in targeting benefits to the most disadvantaged households in deprived areas. These initiatives address the needs of specific groups such as the elderly, disabled, single parents and young people. Targeted, tailor-made projects managed through community groups have been associated with



success. For example, many deprived neighbourhoods no longer have Job Centres nearby, but area-based initiatives have set up training projects to address the numeracy, literacy, personal development and work experience difficulties of the most disadvantaged – problems which Job Centres have often found difficult to achieve.

Programmes aimed at land and property issues have also played a role in improving neighbourhood identity, image, and attracting employment opportunities into the area. However, most jobs in these areas have not been secured by residents of deprived neighbourhoods (ODPM, 2000).

As with other interventions, there is potential for unwanted outcomes. One study identified the potential for neighbourhood improvement to increase social exclusion and area division. Levels of stress and depression experienced by residents on the margins of the regeneration area were reported to be exacerbated by their experience of being left out (Ambrose 2000, Elliott et al, 2001), while individuals within the regeneration area experienced stress as a result of uncertainty, delay and disruption (Elliott et al, 2001).

Involving children and teenagers in community development

In his *What Works in Community Development*, Craig (2000) summarises what helps and what hinders in terms of community development with children. He suggests that projects need to have a specific child/youth focus, not just an add-on to adult programmes. They must be age-appropriate and

reflect children's lives and their concerns. It takes time for trust to build up, and for children and young people to have confidence in participating. It is important to balance adult support for children's projects with adult control. As a project becomes established, the balance may change as children and young people become more confident and develop their skills.



supporting children and their families

Children born into poverty are more likely than their better off neighbours to be born small, be born early, or both (MacFarlane and Mugford, 2000), to be bottle fed (Garcia et al, 1994) have a parent who smokes and in due course, become a smoker (Jarvis et al, 2000) and have or father a child sooner than they would like to (CRD, 1997). Moreover a child in the lowest social class is twice as likely to die before the age of 15 as a child in the highest social class (Botting, 1995). Rates of income poverty for children in London have been found to be much higher than in any other region of the UK. Poverty rates are especially high for some minority ethnic groups

(Greater London Authority, 2002). A recent report from the Institute of Fiscal Studies (Brewer et al, 2003) suggests that using the current definition, the government is unlikely to meet its target of ending child poverty.

Income supplementation

Projects dealing with the effects of poverty, even when they are evidence-based, are elastoplast on a gaping wound. A focus on projects and a whole range of interventions (some more evidence-based than others) can be used to avoid having to confront the reality that child poverty may be

reduced by political and economic action. This means poor people getting more money, a measure which has a degree of public support in the UK. There is a gap in the evidence on the effects of income supplementation on health outcomes. Many previous studies have failed to collect data in this area. However, a randomised controlled trial on income



maintenance shows that a guaranteed minimum income to pregnant women in low income families (by using negative income tax) is associated with a significant increase in birthweight in the intervention group (Arblaster et al, 1997; Kehner and Wolin, 1979). The high cost of income supplementation studies mean that future experiments are unlikely. Conner and colleagues' (1999) suggestions for a prospective study of lottery winners could provide some evidence that policy makers need to make more informed decisions about taxation, benefits and minimum wage levels. Meanwhile a recent study draws on a naturally occurring experiment to cast light on the relationship between income and child health (Costello et al, 2003). A representative sample of 1420 rural

children aged 9-13 years were given psychiatric assessments for 8 years, from 1993-2000. A quarter of the sample were American Indian, and the remainder predominantly white. About half way through this study, a casino opening on the Indian reservation gave every American Indian an income supplement that increased annually. This increase moved 14% of study families out of poverty, while 53% remained poor, and 32% were never poor. Incomes of non-Indian families were unaffected.

Before the casino opened, the persistently poor and ex-poor children had more psychiatric symptoms than the never-poor children, but after the opening levels among the ex-poor fell to those of the never-poor children, while levels among those who were persistently poor remained high. The effect was specific to symptoms of conduct and oppositional defiant disorders. Anxiety and depression symptoms were unaffected. Similar

results were found in non-Indian children whose families moved out of poverty during the same period. This indicates that an income intervention that moves families out of poverty for reasons that cannot be ascribed to family characteristics can have a major effect on some types of children's psychiatric disorders, but not on others. This study supports a social causation explanation for conduct and oppositional disorder, but not for anxiety or depression. One would hesitate, on other health and welfare grounds, to promote gambling as an indirect means of raising income, but the indicative findings here deserve attention.

There is good evidence on the effectiveness of other kinds of interventions to support children and families, such as home visiting, parenting education, provision for very young children and their parents and interventions to provide welfare benefits advice.

Welfare benefits advice services in primary care

As part of local strategies to reduce health inequalities, primary care trusts and health action zones have shown considerable interest in commissioning welfare benefits advice services in primary healthcare settings. Recent longitudinal research has found that this provides good access to advice services for people in middle and old age, but not to other groups (Abbott and Hobby, 2003). Advice services outside of primary care settings are best placed to begin to identify other population groups who might benefit from easier access to advice services, such as families with young children. Better data collection by all advice services on the needs of those they serve would help identify and target under-served groups.

Group-based parenting programmes

Most children experience behaviour problems as a normal part of their development and grow out of them. However, behaviour problems in early childhood have been associated with later difficulties including criminal behaviour, drug and alcohol misuse, mental health problems, relationship breakdowns and poor work histories (Underdown et al, 2003). Parenting and family interaction factors account for as much as 30-40% of the variation in child antisocial behaviour (Patterson et al, 1989; Yoshikawa, 1994). Group-based parenting programmes have been shown to reduce behaviour problems in children aged 3-10 years (Barlow, 1998). There is evidence that group programmes are more effective than those run on an individual basis (Webster-Stratton, 1999; Barlow, 1999). Behavioural programmes, as opposed to “relationship approaches” have

consistently produced the largest changes in children’s behaviour, with Webster-Stratton’s videotape modelling programme being the most rigorously evaluated and consistently showing good results (Scott et al, 2001; Barlow, 1999).

Reducing child injury

Injury is the most important cause of child death in the United Kingdom (Roberts, 2000) and children living in areas of deprivation are particularly at risk (Roberts, Kramer et al, 1996). Studies of a number of groups (Roberts, Kramer et al, 1996; Elkan et al, 2000) including disadvantaged first time mothers (Johnson et al, 1993), poor inner-city mothers (Hardy and



Streett, 1989) and teenage, unmarried or low-income first-time mothers found that home visiting can reduce levels of childhood injury (Olds et al, 1986). This is when a trained nurse comes to see the mother at home either before and/or after birth to provide social support, education on child development and child health, facilitation of mother-child interaction, and the promotion of parenting (Markenco and Spence 1994; Elkan et al, 2000). The majority of work in this area considers young children (up to the age of 2 years); the potential benefit to older children is therefore unknown. Home visiting may have a role as part of a wider accident prevention initiative or as part of a family-focused intervention in this older age-group (Lucas, 2003). The

intervention has also been found to have significant effects on adult and child alcohol and drug misuse problems and child anti-social behaviour and criminality (Olds et al, 1998).

Despite recent moral panics, the risk of non-accidental injury which children face from strangers (other than from strangers driving the cars which may run them down – or speedophiles as one journalist has aptly put it) is small. The evidence we have that could better protect children from this kind of danger is rather poor. Likewise, despite given the large investment of professional time and resources devoted to the problems presented by parents who provide less than adequate care for their children or who abuse them physically or sexually, studies which robustly assess the effectiveness of interventions in this area are few and far between. A number of critical public inquiries explains to some extent the preoccupation of professional staff

with investigation and monitoring in the child protection field. It is likely that more resources for primary prevention would shift the emphasis of work towards children's overall wellbeing and encourage good parenting within supportive communities. Good evidence exists for the protective effect on families with young children of community social networks (Gibbons, 1990; Garbarino and Kostelny, 1992).

Home visiting, as described above, has been shown to reduce levels of child injury, including non-accidental injury. In the UK and Ireland, the Child Development Programme, while not explicitly designed to combat child abuse, also reports good results in this area. A detailed study of statistical data, across a sample of more than 30,000 children in twenty four health authorities, trusts and boards, suggests that those families involved in the Child Development Programme have a 41% lower rate of registration on the

Child Protection Register, and a 50% lower rate of physical abuse, than adjusted levels for the relevant populations in the same health authorities (Barker et al, 1992). However, the authors caution that the intervention is not an *'anti-child abuse programme. Its success has come about because parents have been supported to become better parents.'* They warn that should the programme be targeted at specific families, they will recognise this and simply refuse the intervention (Barker et al, 1992:41).

Physical punishment

'[A smack] is like very hard hitting and it hurts you.' (6 year old girl) (Willow, 1998)

"You don't kill people by smacking them"
(Marie-Therese Kouao cited at www.victoria-climbiie-inquiry.org.uk, 2003)

The "reasonable chastisement" defence in section 1(7) of the Children and Persons Act 1933 denies children equal protection under the law on assault. The government is under increasing pressure to remove this (Press Association, 2003). There is a strong evidential public health argument, based on Geoffrey Rose's work, which can be mobilised to this end. Rose and Day (1990) found that across many different populations average blood pressure predicted the number of hypertensive people, average weight the number of obese people and average alcohol intake the number of heavy drinkers. Might this also apply to other behaviours? If we were to plot on a graph people's aggression scores it would probably show a normal distribution – a few very aggressive people, a few exceptionally inoffensive people at either end of the scale, and most people in the middle of the range. Henry Kempe, who first used the term "battered baby syndrome" may have

been wrong when he suggested that child abuse is the difference between a smack on the bottom and a fist in the face. They may simply be different parts of the same distribution. We condemn frank violence, but fail to discourage in law some kinds of behaviour towards children which falls short of injury. If Rose and Day are right, focussing some of our remedial efforts on 'normal' violence, as well as the extreme, despite the latter being more newsworthy, the entire distribution of violence towards children could be shifted, and the violent extremes reduced (Roberts and Roberts, 2000).

learning and tools for life

Pre-school programmes

The most important protective factor for children from poor socio-economic circumstances is parental interest in, and enthusiasm for, their education (Wadsworth 1991; Pilling, 1990). Children fortunate enough to have this help display a strong tendency to do better in cognitive tests, and in educational attainment (Douglas, 1986). In due course, such children, as adults, are more likely than were others to be

enthusiastic about their own children's education (Wadsworth 1986; 1991). The positive outcomes of the US Headstart and Perry Pre-School programmes in terms of education, employment and beyond have been very influential in the UK (Schweinhart et al, 1993). The success of the Perry Pre-School programme may be related to the parent involvement and interest in their children's education.

Many of the services we believe to be most effective in reducing inequalities in childhood by providing support to children and their parents early on in children's lives were pulled together to form the Sure Start initiative (DfEE,

1999). It was unusual for a UK policy initiative to take as a starting point robustly evaluated interventions (Utting, 1999, Glass, 1999, 2001). There is much to learn from Sure Start about running services. Part of providing better structures involves recognising that for children and families, fragmented services and interventions don't make sense. 'Joined up thinking' and 'joined up government' are now familiar phrases. Joined-up-real-life is rarer, with services for children frequently fragmented.

One problem with Sure Start's targeted model of intervention is that not all children live in disadvantaged

communities. Most do not. Decent day care and early years provision need to be addressed through a universal service, just as education and health are, if it is to reach all of those in need. As Shaw et al (1999) point out, the relative lack of effectiveness of area based policies has been well documented for over 25 years. Inequalities in health are a national problem which require national solutions.

Learning tools for disadvantaged young people

We were unable to find robust studies of the effectiveness of educational interventions for disadvantaged young people on the databases we searched, but we believe that there are sound studies which we were unable to identify for this review. We did identify a range of small, uncontrolled studies mainly carried out in North America. In relation to young people with learning disabilities these suggest that parental support can improve time spent on

homework (Deslandes et al, 1999). Better communication between teachers, parents and pupils and clarifying respective roles (Kay et al, 1994; Bursuck et al, 1999; Epstein et al, 1999) is needed to facilitate parental involvement.

In terms of young people at risk of school failure because of drug or alcohol use or failure to follow school rules, an intervention to train parents to support their children in self management of homework brought about some improvement in completion and quality, although sample sizes were too small to reach firm conclusions (Callahan et al, 1998).

Learning tools for black and minority ethnic young people

Minority ethnic children are greatly over-represented within local populations of children excluded from school. There has been a particular focus on Black young men. African-

Caribbean young people have been found to be six times more likely to be excluded than White pupils (SEU, 1998). However, there are indications of rising rates in other populations, such as African-Caribbean girls (Gilborn and Gipps, 1996) and Bangladeshi boys (Kinder, 2000). While achievements of Black African pupils at GCSE level are currently rising faster than their white peers, there is hardly any increase in attainment levels of Pakistani pupils and that of Bangladeshis is actually falling (DfEE, 2001).

Quantitative studies have highlighted the role of social factors, such as poverty in this (Parsons, 1999). Qualitative studies have identified



difficult teacher-pupil relationships. Gilborn (1990) and Sewell (1997, 2000) have suggested that low teacher expectations may mean that many Black pupils who want to combat these may have to sacrifice the goodwill of their peer group. Meanwhile, Sewell (2000) notes a strong anti-school peer culture, linked to a powerful Black youth culture and its appropriation by consumer culture.

Some community-based responses appear promising. The Black Communities Education Support Group in Bristol works to recruit Black governors and deliver support services to Black parents. A collaboration between the project and Barnardo's led to the development of a new service focussing on school exclusion.

This not only offers support to at risk or excluded pupils and their parents, but also works with the LEA to assist in the development of education policies. Sensitive partnership working, clear lines of accountability on both sides and retention of strong links with other local Black agencies and the Black community contributed to the project (Curtis, 2002).

Looked after children

There is a gap in the evidence about effective interventions to support children looked after in public care. However some messages are clear (Biehal et al, 1995). Placement stability and encouragement of carers is important for achieving educational success. Local authority social workers tend to have low expectations of children in the care system; foster carers on the other hand are generally more aware of the importance of education. Education and employment prospects after the age of 16 can be

improved by a) assessing carefully each young person's capabilities, and b) working with them to increase their employability before they take on the demands of education, training and employment (Polnay and Ward, 2000). The Quality Protects initiatives offer a way to start to monitor and improve the looked after experience for children. Their website offers a Good Practice section, but the interventions described are not evaluated. http://www.doh.gov.uk/qualityprotects/qp_db/index.htm

Developing an inclusive school culture

A recent review of evaluations and descriptive studies considered what mainstream schools might do to respond to student diversity in ways that facilitates participation by all students in the cultures, curricula and communities of the school (Dyson et al, 2002). Evidence showed that some schools are characterised by an

“inclusive” culture. Within these, there is some consensus amongst staff – and sometimes also students and the wider community - around respect for difference and offering all students access to learning opportunities. These schools are likely to be characterised by forms of organisation (such as specialist classroom provision, rather than withdrawal) and practice (such as constructive approaches to teaching and learning).

Life skills training for homeless people

A summary of recent research in Scotland found that repeat homelessness is a significant problem and successful strategies to tackle the problem must include some form of resettlement and tenancy support (Scottish Homes, 2001). An element of this may be provision of life skills training to homeless people. This aims to promote self-sufficiency and assist people in developing or re-developing

the skills then need to sustain a tenancy, such as managing the home, dealing with bills, and developing self confidence and social skills. The study found limited knowledge on resettlement needs of many groups, such as families, people from black and minority ethnic groups, and women. Less is known about their needs for life skills training. A survey of provision in Scotland found life skills training to be embedded in homelessness services, but with wide variations in length of time offered and mostly targeted at young people. Formal service evaluation was scant. There is a need for further research and rigorous evaluation in order to understand more about the effectiveness of this intervention.

staying healthy and happy

While mortality has markedly decreased over the last century, reported ill health among children is rising, with particular increases in respiratory diseases, including asthma, and emotional problems (Prestcott-Clarke and Primates, 1998). Children looked after are very much less likely to be protected from infectious disease through immunisation than other children and have poorer health chances overall (Polnay and Ward,

2000). However, there is evidence on the effectiveness of a range of different interventions to support the health of children and families.

Breast feeding

Breastfeeding is a key determinant of the nutrition, health, development and emotional well-being of infants, and can be a source of pleasure to mothers (Thompson and Westreich, 1989). It is cheap and convenient and is associated with lower rates of infection, and lower rates of sudden infant death. Around two thirds of babies in the UK have some breastfeeding. Better off

mothers are more likely to breastfeed, and to breastfeed for longer. Breastfeeding is clearly more likely to be enjoyable in a relaxed environment where the mother herself has an adequate diet.

Research by the NHS Centre for Reviews and Dissemination (CRD 2000) found educational leaflets to encourage breastfeeding largely ineffective. However, a more recent review found extra professional support effective in supporting mothers to breastfeed (Sikorski et al, 2003). The Health Development Agency had recently been doing work in this area,

and it is clear that further evaluation of interventions, including peer support, is required.

Good, cheap food in the community and schools

Poor diet in childhood is associated with poor child and adult health. Children in the UK are often deficient in micro-nutrients and regularly miss meals, which may hinder cognitive performance (Lucas, 2003) The movement (probably best developed in Scotland) (HEBS, 1999) to promote cheap food in the community, and community cafes, appears to be a promising approach, promoting general well being and social cohesion (sitting at the same table), stress reduction for those who purchase and prepare food in the household as well as improved diet. Nutrition education by telling people to change their diets does not appear to have the desired effect.

Some food initiatives in US schools have reported success in changing diet (Franco, 2001). Increased participation in US school breakfast schemes has been shown to be associated with increased school achievement and decreased absenteeism (Murphy et al, 1998). In the UK, pilot work is being carried out, funded by the government, of both breakfast schemes and fruit schemes. Preliminary findings from the evaluation of the breakfast schemes suggest that teachers are finding improvements associated with the schemes (School of Social Work & Psychosocial Studies, UEA 2002). Participants in the breakfast schemes found that the breakfast clubs were a place where children of different age groups and school staff could mix in a friendly atmosphere. Parents identified breakfast clubs as a safe source of childcare, and felt that attending breakfast clubs improved their morning routines and provided

children with extra choice of food items (Shemilt et al, 2002). The evaluation of the pilot National Fruit Scheme suggests that schools are positive about its effects and its implementation. They report that children are happy to eat the fruit provided and schools do not find the organisation of distribution to be over-burdensome (DH, 2001). Both breakfast and fruit pilots report qualitative findings that the schemes have promoted social as well as nutritional outcomes. Fruit was often given out in class in the format of "circle time" when children had the chance to sit together and talk as group (DH, 2001). However, we need to be aware of process and implementation issues. Handing out oranges to a class of very young children brings its own challenges.

Mental health

One in every five children suffers from mental health problems (Audit Commission, 1999). More needs to be known (and used) about promoting positive emotional and mental health in children, and on the effectiveness of services to children and young people with emotional problems and/or challenging behaviour.

Current evidence suggests that mental health promotion programmes may have a positive influence on mental health and that whole school approaches can be particularly effective (Wells et al, 2001). A review from the World Health Organisation recommends that primary prevention programmes are developed in schools

for prevention, early detection and intervention of psychosocial problems and mental disorder.

In relation to conduct disorders or antisocial behaviour, cognitive behavioural approaches appear helpful. The effectiveness of problem solving skills training in conjunction with parent training to address severe conduct disorders in 8 – 12 year olds has been demonstrated (Fonagy et al, 2002) as have parent training interventions for pre-school and primary aged children.

Babies of depressed mothers may be at risk of poor emotional adjustment. Evaluation of an intervention delivered in Edinburgh, Staffordshire and Lewisham (Cox et al, 1987; Holden et al, 1989; Gerrard et al, 1993) found that counselling in the home by health visitors may be helpful in managing non-psychotic postnatal depression (Holden et al, 1989). However, we still do not know exactly which components

of a home visiting programme are critical to improve child and mother mental health.

Alcohol

A large proportion of older UK teenagers drink more than the recommended safe limit (Marsh 1986, Goddard 1998) and there is a trend for those who drink alcohol to consume larger quantities (Donaldson, 2001). The potential consequences of this include alcohol related violence and crime, and damage to the heart, liver brain and immune system (Goddard and Ilkin, 1988). Age of onset of alcohol use has been shown to predict unintentional injury after drinking (Hingson 2000) and lifetime alcohol dependence (Grant, 1997)

In line with previous research (Foxcroft et al, 2003), a recent review (Foxcroft et al, 2003) of interventions to reduce alcohol use found only a small number of the many studies identified in the

literature search to be well-designed and adequately evaluated. Of these, nearly half showed interventions which were clearly ineffective. There was no firm evidence of effectiveness amongst the remaining studies, with the exception of the Strengthening Families Programme in USA. This showed some promise compared with a control group who received only information leaflets (Spoth et al, 2001, cited in Foxcroft et al, 2003).

The programme comprised 2 hour family sessions delivered weekly over 7 weeks, with 4 similar booster sessions one year later. These helped parents and children clarify expectations, identify appropriate discipline, manage strong emotions and communicate effectively.

In order to promote better quality evaluations, authors of this review called for policy makers to establish a register for the adoption and use of drugs and alcohol prevention

programmes based on what is known about the safety, efficacy and effectiveness of the intervention.

Drugs

Twenty-per cent of 11 to 15 year olds used illicit drugs in 2000 (DH, 2002) – most commonly, cannabis (13%). Twenty-six per cent of 16 to 24 year olds used cannabis in this year, and 9% reported using a Class A drug. Reports of London drug users under 20 suggests an increase of 35% during the period 1995-8 (Sondhi et al, 1999).

One of the more well-known and evaluated interventions is the LifeSkills Training (LST), a North American school-based prevention programme. However, Coggan et al (2002) warn that though it is one of the few interventions with some (limited) evidence of effectiveness, this has been overstated by promoters. Indeed, evidence from recent reviews (White

and Pitts, 1998) casts doubt on the effectiveness of universal school-based approaches in general, suggesting that the best that may be achieved using these approaches is a reduction in use by current users and short-term delay in the onset of substance use by non-users. Brown and Kreft (1998) argue that rather than helping young people particularly at risk, many school-based programmes can cause confusion between the “no use, all drugs are harmful” messages they receive and what they observe outside school (Brown et al, 1997). Certainly Windle and Windle (1999) found universal prevention programmes more effective for lower-risk than higher risk young people.

More recent recommendations (HDA in press) reflect a shift away from universal school-based drug prevention to more targeted interventions, with a call for research into the links between specifically vulnerable / at risk groups and illicit drug use. Current evidence suggests that the effects of existing drug prevention programmes are small and likely to decrease over time.

Peer-led health promotion interventions

A recent review from the EPPI Centre at the University of London Institute of Education (EPPI-Centre, 1999), suggests that peer-delivered health promotion for young people may be effective. However, methodologically sound studies are disappointingly

scarce. Because of this it was not possible to identify specific characteristics of an effective model of peer-delivered health promotion.

Smoking

Smoking during pregnancy is associated with low birthweight in babies. Trial results show that behavioural self help strategies are more effective than advice and feedback in reducing smoking in pregnancy. There is no evidence that counselling is effective (Arblaster et al, 1996; Enkin et al, 1989). Interventions involving additional group sessions during pregnancy have been reported as being extremely poorly attended in nearly all trials of effectiveness and should probably be abandoned (Lumley et al, 2003). A review of smoking cessation in general (not just in pregnancy) by Sanders (1992) reported in Arblaster et al, found that healthcare settings are a useful site for smoking cessation interventions. Brief advice from a GP to

stop smoking can help some (about 3%) but a significant number of smokers each year stop smoking with no professional help and remain non-smokers for at least a year. Given that cigarettes are the most widely used drug among young people, there is a disappointing lack of good quality evidence on smoking cessation in children and young people.

National Healthy Schools Standard (NHSS)

Information from Ofsted inspections suggests that “there are a number of key areas where schools [involved in the NHSS] are making improvements at a rate faster than schools nationally” – for example, in terms of pupil behaviour, standards of work, quality of PSHE, and management and support of pupils. This is encouraging, although there is no way of knowing whether or not it is linked to NHSS (DH, 2003). <http://www.wiredforhealth.gov.uk/cat.php?catid=848&docid=7059>

safety and justice

Because I am white I get more respect than Black people or Indian people.

12 year old boy from Newham.
(OCRCL 2001:59)

In 1992 one third of 12 to 15 year olds surveyed stated they had been assaulted on at least one occasion in the previous 6-8 months, with most assaults occurring at or near home (Maung, 1995). Qualitative work with children in London suggests that bullying is often experienced by those from disadvantaged groups, most notably refugees and asylum seekers and people from black and minority ethnic groups (OCRCL 2001:59, Katz et al, 2001). Young people described racist bullying in schools and though some teachers were picked out for praise, many thought teachers (and

police) ignored the problem – or in a few cases, were actively racist themselves (Hood, 2001).

Tackling bullying and racism

In the USA, school-based violence prevention programmes that target high-risk young people have been found to be effective in reducing aggressive behaviour. Programmes were equally effective whether they focussed on training in skills of non-response, such as conflict resolution and anger control, or on training in social skills or social context changes. Interventions that used mixed-sex groups worked better than those using single-sex groups. Programmes appeared to work equally well in primary and secondary settings.

A Cochrane review of school-based violence prevention is likely to be on the Cochrane website at the end of this year, based on an update of a 2002 study (Mytton et al, 2002).

Young people at risk of offending

A number of reviews (Farrington, 2002; Utting and Vennard, 2000; Petrosino et al, 2003) have described the effectiveness or otherwise of interventions to reduce juvenile crime. We felt it would be helpful to refer here to an intervention gaining in

currency, but which has a questionmark over its effectiveness for all users and for all outcomes.

Young people at risk of offending – unwanted outcomes

Mentoring children and young people at risk of offending and school exclusion can enable them to build a relationship with a responsible adult. However, on the evidence to date, programmes formalising these relationships and working with young people who are already truanting, involved in criminal activities, misusing substances or who are aggressive have not been shown to be effective in changing behaviour (Lucas and Liabo, 2003).

Where improvements have been reported critical examination suggests flaws that weaken the conclusions (Grossman et al, 1998; Tierney et al, 2000) Caution should be used when recommending an intervention with a group of young people at raised risk of adverse outcomes. Not only should there be evidence of benefit, but negative effects should be reliably excluded.

There is evidence for example that some peer group support for young people with anti-social behaviours may exacerbate anti-social behaviour, increasing criminal behaviour, anti-social behaviour and unemployment in both the short and the long term (McCord, 1978; Dishion et al, 1999; McCord et al, 2001). It has been

argued that these negative effects are the results of negative peer influences, particularly on younger adolescents. These problems may also be the result of labelling those with difficulties. Labelling children as “underaspirers” has been shown to affect school achievement (Defty and Fitz-Gibbon, 2003).



having your say

The literature on young people's participation in public decision-making is mainly anecdotal and based on untested assumptions about what works. The focus has been on the processes of involving young people rather than on achieving agreed goals. However, Perpetua Kirby's (2002) recent review of evaluation and other research evidence in this area collates what we do and do not know about what works in involving children and teenagers. Material in this section draws on her descriptions of participation projects and their evaluations.

Involvement in strategic decision-making

In a Local Government Association survey of local authorities (LGA/IPPR,

2001) about 90% of respondents said they involve young people in identifying problems in the community and three-quarters said they involve young people in developing ideas on new policies and services. Areas where this happened were generally youth-related – for example, youth work, education, leisure and community safety. However, this survey is likely to be biased by those who feel they are doing the most in involving young people. Other research suggests that young people do not have as much influence as this might suggest.

Research into regeneration initiatives indicates that young people's impact at a strategic level remains minimal (Fitzpatrick et al, 1998; Kirby, 2001). Specifically in relation to youth forums, Borland et al (2001:5) suggest that

these are "ineffectual in influencing decisions unless they were given power to hold officials to account". Likewise, youth participation in city councils has been limited, with young people consulted on a range of issues, but only influencing "some" decisions (Geddes and Rust 1999), or feeling that "good ideas are never carried out" and that youth councils are "tokens" (Matthews, 2001). There is limited evidence of children and teenagers influencing areas that are not traditionally considered to do with young people – such as health and transport (Fitzpatrick et al, 1998; Matthews, 2001; Kirby, 2002). If this is

the case, it is unsurprising that only a minority of young people get involved in public decision making and that there is cynicism about the extent to which adults really take young people into account:

“Whatever we say gets changed by the headteacher anyway.”
15 year old girl
Franklin and Madge 2000:54

Outcomes of involvement

There is substantial evidence that good participatory work (as opposed to tokenism) benefits young people in terms of building confidence, knowledge and understanding and changing attitudes, skills and educational achievement. However,

few evaluations have considered other outcomes of participation – for example, the quality of decisions made, or influenced, by young people, or the long-term outcomes of participation. Most current programmes are evaluated via stakeholder views, which, while important, need to be balanced by other objective measures drawing on quantitative, longitudinal and controlled approaches (Kirby, 2002).

Processes

Likewise, many processes remain opaque. What might integrated participatory practice look like on the ground? How can adults best support young people’s involvement? Different young people report different perceptions of power-sharing with adults within the same project (Kirby et al, 2002). Kirby points out that models of different levels of participation – usually set out as a continuum, with children less powerful

at one end and more powerful at the other – do not take account of how and when power shifts between adults and children at different stages in the life of a project.

A way forward

McNeish (Teenage Pregnancy Unit, 2001) describes how organisations wishing to engage the participation of young people need to consider:

- what they can do differently to share some of their power with young people
- what they need to do to motivate young people to choose to participate.

She describes how successfully engaging the participation of young people requires:

- **Explicitly acknowledging your attitudes** to young people’s participation, and underlying beliefs about young people’s competencies

and vulnerability, and adult responsibilities to young people.

- **Creating more participatory structures and processes** within what are often very adult-focused and hierarchical organisations. Key steps in this process include clarifying *why* you are seeking participation, *what* it is to achieve and *how power is to be shared* between adults and young people – Shier's (2001) model of participation may be useful here – see Appendix 1. Other important points include setting a realistic time-scale, deciding on mechanisms for involvement (meetings or what?), investing resources, including provision of support to staff and young people, and building in involvement as soon as possible.
- **Motivating young people to be involved** – for example by ensuring issues are relevant and important to young people, the activities are fun, incentives and rewards are included,

young people feel valued and respected, and there is feedback and results, including tangible results at an early stage.

An important point for any organisation seeking to involve young people is to find out what's already going on in the area – McNeish (Teenage Pregnancy Unit, 2001) provides a checklist to help with this, along with suggestions to ensure an age-appropriate, inclusive approach.

The Children's Strategy

The Children's Strategy is wide ranging, and looks at children as whole people in their environments, rather than as small adults needing particular services. We have summarised the evidence of effectiveness for the interventions in the Strategy in Appendix 2. Where we believe there are gaps in the strategy relates to very early interventions including those which may impact on low birthweight and breastfeeding. We know that improvements in these areas are associated with better results in the longer term. Large gaps in the research literature relate to specific well-

evidenced interventions for particular groups. While there may be a plethora of policies and ideas for working with disadvantaged children, well designed, consistently delivered services for some of these children, including some of the most disadvantaged of all, remains a problem to be solved. Meanwhile, a really robust evaluative culture in the UK is needed, with more emphasis on the 'D' aspect of R&D, and attention to the processes of development and implementation alongside strong research evidence of effectiveness and a strong voice from children as service users.



references

Abbott, S. and Hobby, L. (2003) Who uses welfare benefits advice services in primary care? Health and Social Care in the Community, 11 (2): 168-174.

Allen, T. Housing Renewal - Doesn't it Make You Sick? Housing 2000;15(3): 443-461.

Ambrose, P. A drop in the ocean: the health gain from the Central Stepney SRB in the context of national health inequalities. The Health and Social Policy Research Centre, University of Brighton, 2000.

Ampofo-Boateng, K. and Thomson, J. A. (1989) Child pedestrian accidents: a case for preventive medicine. *Health Education Research*, 5, 265 – 274.

Arlblaster, L. Entwistle, V. Fullerton, D. Forster, M. Lambert, M. and Sheldon, T. A. A review of the effectiveness of health promotion intervention aimed at reducing inequalities in health, NHS Centre for Reviews and Dissemination University of York, 1997.

Audit Commission. Children in Mind; Child and Adolescent Mental Health Services (CAMHS) Briefing. Audit Commission, 1999.

Barker, W. E. Andersen, R. M. and Chalmers, C. Child protection: the impact of the Child Development Programme; Evaluation Document No. 14, Early Childhood Development Unit, Department of Social Work, Bristol; 1992.

Barlow, J. Parent-training Programmes and Behaviour Problems: Findings from a Systematic Review. In: Buchanan,

A. and Hudson, B. L. (eds) Parenting, Schooling and Children's Behaviour. Aldershot: Ashgate; 1998.

Barlow, J. Systematic Review of the Effectiveness of Parent-Training Programmes in Improving Behaviour Problems in Children aged 3-10 years. Oxford: Health Services Research Unit; 1999.

Bennett, T. H. Farrington, D. P. and Holloway, K. R. The effectiveness of Neighbourhood Watch. Protocol for the Campbell Collaboration in Crime and Justice, 2003. Available at <http://www.campbellcollaboration.org/doc-pdf/nwprot.pdf> Accessed June 2003.

Better Play. Examples of inclusive projects funded by Better Play. <http://www.barnardos.org.uk/whatwedo/community/betterplay/casestudy.jsp> Accessed June 2003.

Biehla, N. Clayden, J. Stein, M. and Wade, J. Moving on: young people and leaving care schemes. Barking: Barnardo's, 1995.

Borland, M., Hill, M., Laybourne, A. and Stafford, A. Improving consultation with Children and Young people in relevant aspects of policy making and legislation in Scotland. University of Glasgow; 2001.

Botting, B. (ed) (1995) The Health of our Children. OPCS Decennial Supplement, series DS no. 11, HMSO. London

Brewer, M. Goodman, A. Shepard, A. How has child poverty changed under the Labour government? An update. Briefing Note No. 32. Institute for Fiscal Studies, 2003.

Brothers Big Sisters program. Evaluation Review 1998;22(3):403-426.

Brown, J. H. and Kreft, I. G. Zero effects of drug prevention programs: Issues and solutions. Evaluation Review 1998; 22: 3-14.

Brown, J.H., D'Emidio-Caston, M. and Pollard, J. Students and substances: Social power in drug education. Educational Evaluation and Policy analysis (EEPA) 1997; 19(1):65-82.

Bunn, F. Collier, T. Frost, C. Ker, K. Roberts, I. and Wentz, R. Area-wide traffic calming for preventing traffic related injuries (Cochrane Review). The Cochrane Library. Issue 2, 2003. Oxford: Update Software.

Bursuck, W. D. Harniss, M. K. Epstein, M. H. Polloway, E. A. Jayanthi, M. and Wissinger, L. M. Solving communication problems about homework: recommendations of special education teachers. Learning Disabilities Research and Practice 1999; 14(3): 149-158.

Callaghan, K. Rademacher, J. A. and Hildbreth, B. L. The effects of parent participation in strategies to improve the homework performance of students who are at risk. *Remedial and Special Education* 1998; 19(3): 131-141.

Campbell, K. Waters, E. O'Meara, S. Kelly, S. and Summerbell, C. Interventions for preventing obesity in children (Cochrane Review). *The Cochrane Library*. Issue 2, 2003. Oxford: Update Software.

Canning, U. Millward, L. and Raj, T. Drug use prevention: A review of reviews. Health Development Agency, forthcoming. <http://www.hda-online.org.uk>

CAPT and Roberts, H. A safe school is no accident. London: Child Accident Prevention Trust, 1993.

Centre for Reviews and Dissemination (1997) *Preventing and Reducing the Adverse Effects of Unintended Teenage Pregnancies*, 3(1), NHS Centre for Reviews and Dissemination, University of York. York

Centre for Reviews and Dissemination (2000) *Promoting the initiation of breastfeeding*, 6(2), NHS Centre for Reviews and Dissemination, University of York. York

Centre for Reviews and Dissemination (2002) *The Prevention and treatment of childhood obesity*, 7(6), NHS Centre for Reviews and Dissemination, University of York. York

Child Accident Prevention Trust. Child Accident Prevention Trust Fact Sheet. CAPT website [cited 2003 Apr 4]. [5 screens] Available from: <http://www.capt.org.uk/FAQ/default.htm> <http://www.capt.org.uk/publications>

Cole-Hamilton, I. Something Good and Fun; Children's and parents' views on play and out-of-school provision. London: Children's Play Council; 2002.

Commonwealth Department of Health and Aged Care. National Action Plan for Promotion, Prevention and Early Intervention for Mental Health. Canberra, ACT, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, 2000.

Roberts I. and Power C. Does the decline in child injury mortality vary by social class? Comparison of class specific mortality in 1981 and 1991. *British Medical Journal* 1996, 313: 784 – 786.

Connor, J. Rodgers, A. and Priest, P. Randomised studies of income supplementation: a lost opportunity to assess health outcomes. *Journal of Epidemiology and Community Health* 1999; 53:725-730.

Costello E, Compton S, Keeler G, Angold A. Relationships between poverty and psychopathology, a natural experiment. *Journal of the American Medical Association*, 2003, 290: 2023-2029.

Cox, J. Holden, J. Sagovsky, R. Detection of postnatal depression. development of the ten-item Edinburgh, Postnatal Depression Scale. *British Journal of Psychiatry* 1987; 150:182-186.

Craig, G. What works in community development with children? Barkingside: Barnardo's, 2000.

Curtis, K. Success in the face of adversity: A partnership

project to support minority ethnic pupils excluded from school. In: Sachdev, D. and van Meeuwen, A. (eds) *Are we listening yet? Working with minority ethnic communities – some models of practice*. Ilford: Barnardo's, 2002.

Defty, N. and Fitz-Gibbon, C. Underaspirers: how can we help them? YELLIS website [cited 2003 Apr 23]. [11 screens] Available from: <http://cem.dur.ac.uk/ebeuk/>

Department for Education and Employment. *Sure Start: A guide for second wave programmes*, London: DfEE, 1999.

Department of Health. *National Healthy School Standard*. 2003.

Department of Health. *Statistics on young people and drug misuse: England, 2002 and 2001*. *Bulletin* 2002/15. Department of Health, 2002.

Department of Health. *The National Fruit Scheme: Evaluation Summary*. London: Department of Health; 2001.

Department of Health. *Independent Inquiry into Inequalities in Health (The Acheson Report)*, London, The Stationery Office, 1998

Deslandes, R. Royer, E. Potvin, P and Leclerc, D. Patterns of home and school partnership for general and special education students at the secondary level. *Exceptional Children* 1999; 65(4): 496-506.

DfEE. *Youth cohort study: the activities and experiences of 16 year olds: England and Wales*. DfEE, 2001. Available at <http://www.dfes.gov.uk/statistics/DB/SFR>

DiGuseppi, C. and Higgins, J. P. T. Systematic review of controlled trials of interventions to promote smoke alarms. *Archives of Disease in Childhood* 2000; 82:341-348.

DiGuseppi, C. Roberts, I. Li, L. and Allen, D. Determinants

of car travel on daily journeys to school: cross sectional survey of primary school children. *British Medical Journal* 1998; 316:1426-1428.

Dishion, T. J., McCord, J., and Poulin, F. When interventions harm: Peer groups and

Donaldson, L. The annual report of the Chief Medical Officer of the Department of Health. Department of Health, 2001. Available at <http://www.doh.gov.uk/cmof/annualreport2001/pdf/publication.pdf>

Douglas, J. W. B. *The Home and the School*. London: MacGibbon and Kee, 1986.

Douglas, M., Thomson, H. and Gaughan, M. *Health Impact Assessment of housing improvements: a guide*. Scottish Health Impact Assessment Network and MRC Social and Public Health Sciences Unit; (in press).

Dyson, A., Howes, A. and Roberts, B. A systematic review of the effectiveness of school-level actions for promoting participation by all students. Inclusive Education Review Group for the EPPI Centre, 2002. Available from http://eppi.ioe.ac.uk/EPPIWeb/home.aspx?page=/reel/review_w_groups/inclusion/review_one.htm

Edholm, F., Roberts, H. and Sayer, J. *Vietnamese Refugees in Britain*. Commission for Racial Equality; 1983.

Elkan, R., Kendrick, D., Hewitt, M., Robinson, J. J. A., Tolley, K., Blair, M., Dewey, M., Williams, D. and Brummell, K. The effectiveness of domiciliary health visiting: a systematic review of international studies and a selective review of the British literature. *Health Technology Assessment* 2000; 4(13): iii-234.

Elliott, E., Landes, R., Popay, J., Edmans, T. *Regeneration and health: a selected review of research*: Nuffield Institute for health, University of Leeds. Kings Fund, London, 2001.

Elvik, R. Area-wide urban traffic calming schemes: a meta-analysis of safety effects. *Accident Analysis and Prevention* 2001;33:327-336.

EPPI-Centre. A review of the effectiveness and appropriateness of peer-delivered health promotion interventions for young people. EPPI-Centre; 1999. Available at http://eppi.ioe.ac.uk/EPPIWeb/home.aspx?page=/hp/reports/peer_health/peer-delivered_health_promotion_intro.htm

Epstein, M., H. Munk, D. D. Bursuck, W. D. Polloway, E. A. and Jayanthi, M. Strategies for improving – home-school communication about homework for students with disabilities. *Journal of Special Education* 1999; 33(3): 166-176.

Farrington, D. P. The effectiveness of school-based violence prevention programs. *Archives of Pediatrics and Adolescent Medicine* 2002; 156: 748-749.

Fitpatrick, S., Hastings, A. and Kintrea, K. *Involving young people in urban regeneration*. London: The Policy Press; 1998.

Fonagy, P., Target, M., Cottrell, D., Philips, J. and Kurtz, Z. *What Works For Whom? A Critical Review of Treatments for Children and Adolescents*. New York: Guilford Publications, 2002.

Foxcroft, D., R. Ireland, D. Lister-Sharp, D. J., Lowe, G. and Breen, R. Primary prevention for alcoholic misuse in young people (Cochrane Review). *The Cochrane Library*. Issue 2, 2003. Oxford: Update Software.

Franco, K. Optimizing nutritional health for children through school-based initiatives. *Journal of the American Dietetic Association* 2001; 101(8): 873-874.

Franklin, A. and Madge, N. *In Our View*. London: National Children's Bureau, 2000.

Fried, M. *Grieving for a lost home*. In: Wilson J, (ed). *Urban Renewal*. Cambridge, Mass: MIT Press, 1966.

Garbarino, J. and Kostelny, K. Child maltreatment as a community problem. *Child Abuse and Neglect* 1992; 16:455-464.

Garcia, J., France-Dawson, M.F. and Macfarlane, A. *Improving Infant Health*. London: HEA, 1994.

Gårder, P., Leden, L. and Pulkkinen, U. Measuring the safety effect of raised bicycle crossings using a new research methodology. *Transportation Research Record* 2003; 1636(Paper no 98-1360): 64-70.

Geddes, M. and Rust, M. Involving young people in local government and local democracy; findings from the evaluation of three local initiatives. *The Local Government Centre, Warwick Business School, The University of Warwick*; 1999.

Gerrard, J., Holden, M., Elliott, S. A., McKenzie, P., McKenzie, J. and Cox, J. L. A trainers perspective of an innovative programme teaching HVS about the detection, treatment and prevention of postnatal depression. *Journal of Advanced Nursing* 1993; 18: 1825-1832.

Gibbons, J. *Family support and prevention: Studies in local areas*. London: HMSO, 1990.

Gillborn, D. and Gipps, C. Recent research on the achievements of ethnic minority pupils. OFSTED, 1996.

Gillborn, D. When cultural display is seen as a challenge. *Times Educational Supplement* 1990; 30 November: 10.

Glenn, N. What works for children: the political issues. *Children and Society* 2001; 15(1): 14-20.

Glenn, N. Sure Start: the development of an early intervention programme for young children in the United Kingdom. *Children and Society* 1999; 13(4): 257-264.

Goddard, E. and Ikin, C. *Drinking in England and Wales*. London: HMSO, 1988.

Grant, B. F. Dawson, D. A. Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence: results from the national longitudinal alcohol epidemiologic survey. *Journal of Substance Abuse* 1997; 9: 103-110.

Greater London Authority. *London Divided: Income inequality and poverty in the capital: summary*. Greater London Authority; 2002. <http://www.london.gov.uk>

Greater London Authority. *Towards a child-friendly London: The Mayor's Draft Children and Young People's Strategy*. Greater London Authority; 2003. <http://www.london.gov.uk>

Grossman, J. B. and Tierney, J. P. Does mentoring work? An impact study of the Big

Hardy, J. B. and Streett, R. Family support and parenting education in the home: an effective extension of clinic-based preventative health care services for poor children. *Journal of Pediatrics* 1989; 115: 927-931.

Harrington, R. Dubicka, B. Prevention and treatment of child and adolescent depression: recent research findings. Unpublished paper.

HEBS. *Food in the Community*, Directory of Scottish Community Food Initiatives. Health Education Board for Scotland, 1999.

Hillman, M. Adams, J. and Whitelegg, J. *One False Move A Study of Children's Independent Mobility*. Policy Studies Institute, 1990.

Hingson, R. Heerland, T. Jamanka, A. Howland, J. Age of drinking onset and unintentional injury involvement after drinking. *Journal of the American Medical Association* 2000; 284: 1527-1533.

Holden, J. Sagovsky, R. Cox, J. Counselling in a general practice setting: Controlled study of health visitor intervention in treatment of postnatal depression. *British Medical Journal* 1989; 298: 223-226.

Hood, S. *The state of London's Children report*. The Office of Children's Rights Commissioner for London, 2001.

Hughes, M. and Traynor, T. Reconciling process and outcome in evaluating community initiatives. *Evaluation* 2000; 6(1): 37-49.

Imagine London. *Imagine London Manifesto*. Imagine London; 2002. <http://www.imaginelondon.org.uk/manifest.pdf>

Jackson S. and Thomas, N. *What works in creating stability for looked after children?* Barkingside: Barnardo's, 2nd edition 2000.

Jadad, A. R. Boyle, M. Cunningham, C. Kim, M. Schachar, R. Treatment of attention-deficit/hyperactivity disorder. Rockville, MD: Agency for Healthcare Research and Quality, 2000.

Jarvis, M.J. Goddard, E. Higgins, V. Feyerabend, C. Bryant, A. Cook, D. G. Children's exposure to passive smoking in England since the 1980s: cotinine evidence from population surveys. *British Medical Journal* 2000; 321: 343-345.

Johnson, Z. Howell, F. and Molloy, B. Community mother's programme: a randomised controlled trial of non-professional intervention in parenting. *British Medical Journal* 1993; 306: 1449-1452.

Jones, A. Quilgars, D. and Wallace, A. *Life skills training for homeless people: a review of the evidence*. Scottish Homes, 2001. Available from <http://www.scot-homes.gov.uk/indexnext5.html>

Katz, A., Buchanan, A. and Bream, V. *Bullying in Britain: Testimonies from Teenagers*. Young Voice; 2001.

Katz, L. Kling, J. Lieberman, J. *Moving to Opportunity in Boston: early results of a randomized mobility experiment*. Working Paper #441. Unpublished manuscript, Princeton University, 2000.

Kay, P. J. Fitzgerald, M. Paradee, C. and Mellencamp, A. Making homework work at home: the parent's perspective. *Journal of Learning Disabilities* 1994; 27(9): 550-561.

Kehner, B. H. and Wolin, C. M. Impact of income maintenance on low birthweights, evidence from the Gary experiment. *Journal of Human Resources* 1979; XIV: 434-462.

Kinder, K. Halsey, K. and Kendall, S. *Working out well: effective provision for excluded pupils*. NFER, 2000.

Kirby, P. Involving young people in regeneration: Learning from 'Young Voices'. Birmingham: Groundwork UK and Save the Children; 2001.

Kirby, P. Save the Children and Shoreditch Our Way, children and young people's participation project: Interim evaluation report (May 01 – April 02). PK Research Consultancy, 2002.

Kirby, P. with Bryson, S. Measuring the magic? Evaluating and researching young people's participation in public decision making. Carnegie Young People Initiative, 2002. Available from http://www.carnegie-youth.org.uk/html/documents/2643_MeasuretheMagic_001.pdf

Kirby, P. with Mann, G., Pettitt, B. and Woodhead, M. Child to child in south London: Evaluation report. Lambeth, Lewisham and Southwark HAZ; 2002.

LGA/IPPR. Involving young people in decision making: a survey of local authorities. IPPR/LGA; 2001.

Liabo, K. and Curtis, K. Evidence nugget: Area-wide traffic calming schemes reduce childhood injuries from road accidents and respond to children's own views of what is important. What Works for Children group 2003. Available from <http://www.whatworksforchildren.org.uk>

Lowry, S. Housing. British Medical Journal 1991; 303: 838-840.

Lucas, P. and Liabo, K. Evidence nugget: One-to-one, non-directive mentoring programmes have not been shown to improve behaviour in young people involved in offending or other anti-social activities. What Works for Children group, 2003 Available from <http://www.whatworksforchildren.org.uk>

Lucas, P. Evidence nugget: Breakfast clubs and school fruit schemes: promising practice nugget. What Works for Children group 2003. Available from:

<http://www.whatworksforchildren.org.uk>

Lucas, P. Evidence nugget: Home visiting can substantially reduce childhood injury. What Works for Children group 2003. Available from: <http://www.whatworksforchildren.org.uk>

Macfarlane, A. J. and Mugford, M. Birth Counts: statistics of pregnancy and childbirth. London: The Stationary Office, 2000.

Marcenko, M. O. and Spence, M. Home visitation services for at-risk pregnant and postpartum women; a randomized control trial. American Journal of Orthopsychiatry 1994; 64(3): 468-477.

Marsh, A. Dobbs, J. White, A. Adolescent drinking. London: HMSO, 1986.

Marshall, F. Keating, A. Annan, J. Oyefesco, A. Phillips, T. and Morris, S. Lind, J. Ghodse, H. Executive summary of the substance misuse (drugs and alcohol) review to support the development of the London Health Strategy. <http://www.londonhealth.gov.uk/rtf/drugalco.rtf>

Matthews, H. Citizenship, youth councils and young people's participation. Journal of Youth Studies 2001;4(3):299-318.

Maung, N.A. Young People, Victimization and the Police: British Crime Survey findings on the experiences and attitudes of 12 to 15 year olds. (Research study Number 140) HMSO; 1995.

McCord J. A thirty year follow-up of treatment effects American Psychologist, 33, 3, 284-289, 1978.

McCord J, Widom, C.S., & Crowell, N.A. (Eds.), Juvenile Crime, Juvenile Justice, Washington, DC: National Academy Press, 2001.

McGonigle, G. and Kirby, J. Poverty, nutrition and the public health. Poverty and Public Health. London: Gillencz, 1936.

Morrison, D. S. Petticrew, M. and Thompson, H. What are the most effective ways of improving population health through transport interventions? Evidence from systematic reviews. Journal of Epidemiology and Community Health. 2003; 57(5): 327-333.

Morrow, V. Networks and neighbourhoods: children's and young people's perspectives. Health Development Agency; 2001. <http://www.hda-online.org.uk/downloads/pdfs/netneigh.pdf>

Murphy, J. M. Pagano, M. E. Nachmani, J. Sperling, P. Kane, S. and Kleinman, R. E. The relationship of school breakfast to psychosocial and academic functioning: cross-sectional and longitudinal observations in an inner-city school sample. Archives of Pediatrics & Adolescent Medicine 1998; 152(9): 899-907.

Mytton, J. A., DiGiuseppi, C., Gough, D. A., Taylor, R. S. and Logan, S. School-based violence prevention programs. Archives of Pediatrics and Adolescent Medicine 2002; 156: 752-762.

Mytton, J. and DiGiuseppi, C. School based prevention programmes for reducing violence (Protocol for a Cochrane Review). The Cochrane Library, Issue 2, 2003. Oxford: Update Software.

Naidoo, J. Evaluation of the Play it Safe campaign in Bristol. Child Accident Prevention Trust; 1984.

National Healthy School Standard. A review of evidence of the impact on schools of the implementation of the National Healthy Schools Standard drawn from the Ofsted Database of schools in England inspected September 2000 – July 2001. National Healthy School Standard, 2002. Available from <http://www.n-yorks.net/curriculum/inclusion/docs/NHSSfeb2002.pdf>

National Playing Fields Association. PLAYLINK & Children's Play Council. Best Play; what play provision should do for children. National Playing Fields Association; 2000. <http://www.ncb.org.uk/resources/bestplay.pdf>

NHS Centre for Reviews & Dissemination, York University. Promoting the initiation of breastfeeding. *Effective Health Care* 2000;6(2):1-12.

NHS Centre for Reviews and Dissemination, York University. The prevention and treatment of childhood obesity. *Effective Health Care* 2002; 7(6): 1-12.

Office of the Children's Rights Commissioner for London. Sort it out! Children and Young People's Ideas for Building a Better London. (Report by the Office of the Children's Rights Commissioner for London and 3,000 young Londoners). OCRCL; 2001.

Office of the Deputy Prime Minister. Regeneration Research Summary; A Review of the Evidence Base for Regeneration Policy and Practice (Number 39). UK Office of the Deputy Prime Minister; 2000. <http://www.urban.odpm.gov.uk/research/summaries/03900/index.htm>

Olds, D. L. Henderson, C. R. Chamberlin, R. and Tatelbaum, R. Preventing child abuse and neglect; a randomised trial of nurse home visitation. *Pediatrics* 1986; 78(1): 65-78.

Olds et al, 1999

Olsen, E. O. and Barton, D. M. The benefits and costs of public housing in New York City. *Journal of Public Economics* 1983; 20(3): 299-332.

Parsons, C. Education, exclusion and citizenship. London: Routledge, 1999.

Patterson, G. R., DeBaryshe, D., and Ramsey, E. A Developmental Perspective on Antisocial Behaviour. *American Psychologist* 1989; 44(2): 329-335.

Petticrew, M. and Roberts, H. Evidence, hierarchies and typologies: Horses for Courses, *Journal of Epidemiology and Community Health* 2003; 57: 527-529.

Pilling, D. *Escape from Disadvantage*. Brighton: Falmer Press, 1990

Platt, S.D., Martin, C.J., Hunt, S.M. and Lewis, C.W. Damp housing, mould growth, and symptomatic health state. *British Medical Journal* 1989; 298: 1673-8.

Polnay, L and Ward, H. (2000) Promoting the health of looked after children, *BMJ editorial, British Medical Journal* 2000; 320: 661-662.

Prescott-Clarke, P. & Primates, P. (eds) (1998) *Health Survey for England: The Health of Young People '95-97*.

Social and Community Planning Research /Department of Epidemiology and Public Health, University College London, The Stationery Office, London.

Press Association Smacking leads to child abuse, MPs agree. Tuesday June 24, 2003. http://www.guardian.co.uk/uk_news/story/0,3604,984075,00.html Accessed June 2003.

problem behavior. *American Psychologist* 1999;54(9):755-764.

Quality of Care and Health Outcomes Committee, NH&MRC The effectiveness of prevention strategies for adolescent depression. *Auseinet*.

Ramsay, M. Baker, P. Goulden, C. Sharp, C. and Sondhi, A. Drug misuse declared in 2000: results from the British Crime Survey. Home Office Research Study 224. Home Office Research, Development and Statistics Directorate, 2001.

Raw, G. *Building regulation health and safety*. Watford: Building Research Establishment, 2001.

Reeder, W. J. The benefits and costs of the Section 8 existing housing program. *Journal of Public Economics* 1985; 26(3): 349-377.

Roberts, H. and Roberts, I. Smacking. *Child: Care, Health and Development* 2000; 26(4): 259-262.

Roberts, H. What works in reducing inequalities in child health. *Barkingside: Barnardo's*, 2000.

Roberts, I. Adult accompaniment and the risk of pedestrian injury on the school-home journey. *Injury Prevention* 1995;1(4): 242-244.

Roberts, I. and Coggan, C. Blaming children for pedestrian injuries. *Social Science and Medicine* 1994; 38(5): 749-753.

Roberts, I. and Power, C. Does the decline in child injury mortality vary by social class? A comparison of class specific mortality in 1981 and 1991. *British Medical Journal* 1996;313:784-786.

Roberts, I. Ashton, T. Dunn, R. and Lee-Joe, T. Preventing child pedestrian injury: pedestrian education or traffic calming? *Australian Journal of Public Health* 1994; 18(2): 209-212.

Roberts, I. Cause specific social class mortality differentials for child injury and poisoning in England and Wales. *Journal of Epidemiology and Community Health* 1997;51:334-335

Roberts, I. Kramer, M. S., and Suissa, S. Does home visiting prevent childhood injury? A systematic review of randomised controlled trials. *British Medical Journal* 1996; 312: 29-35.

Roberts, I., Norton, R., and Taua, B. Child pedestrian injury rates: the importance of 'exposure to risk' relating to socioeconomic and ethnic differences, in Auckland, New Zealand. *Journal of Epidemiology and Community Health* 1996; 50: 162-165.

Rose, G. and Day, S. The population mean predicts the prevalence of deviant individuals. *British Medical Journal* 1990; 301: 1031-1034.

Rosenbaum, J. Black pioneers- do their moves to the suburbs increase economic opportunity for mothers and children? *Housing Policy Debate* 1991; 2(4): 1179-1213.

Rowland, D. DiGiuseppi, C. Gross, M. Afolabi, E. and Roberts, I. Randomised controlled trial of site specific advice on school travel patterns. *Archives of Disease in Childhood* 2003; 88(1): 8-11.

Rowland, D. DiGiuseppi, C. Roberts, I. Curtis, K. Roberts, H. Ginnelly, L. Sculpher, M. and Wade, A. Prevalence of

working smoke alarms in local authority inner city housing: randomised controlled trial. *British Medical Journal* 2002; 325: 998-1001.

Shier, H. (2000) Pathways to participation: openings, opportunities and obligations in *Children and Society*, vol.14

School of Social Work & Psychosocial Studies. A national evaluation of school breakfast clubs. Evaluation summary, part 1. Norwich: University of East Anglia; 2002.

Scott, S. Spender, Q. Doolan, M. Jacobs, B. and Aspland, H. Multicentre controlled trial of parenting groups for childhood antisocial behaviour in clinical practice. *British Medical Journal* 2001; 323: 194-197.

Scottish Homes. Life skills training for homeless people – a review of the evidence. *PRECIS* 2001; No. 141.

Sewell, T. Black masculinities and schooling: how black boys survive modern schooling. Chester: Trentham Books, 1997.

Sewell, T. Identifying the pastoral needs of African-Caribbean students: a case of critical "antiracism". *Education and Social Justice* 2000; 3(1): 17-26.

Sharp, C. Keys, W. Benefield, P. Flannagan, N. Sukhnanandan, L. Mason, K. Hawker, J. Kimber, J. Kendall, L. and Hutchinson, D. Recent research on homework: an annotated bibliography. *NFER*, 2001. Available at <http://www.nfer.ac.uk/research/HResIND.asp>

Shaw, M. Dorling, D. Gordon, D. and Davey Smith, G. The widening gap: health inequalities and policy in Britain. Bristol: The Policy Press, 1999.

Shemilt, I. O'Brien, M. Thoburn, J. Harvey, I. Belderson, P. Robinson, J. Camina, M. and School of Breakfast Clubs

Evaluation Group. School breakfast clubs, children and family support. *Children and Society* 2002; 17(2): 100-112.

Silkorski, J. Renfew, M.J. Pindoria, S. and Wade, A. Support for breastfeeding mothers (Cochrane Review). The Cochrane Library. Issue 2, 2003. Oxford: Update Software.

Social Exclusion Unit. Truancy and school exclusion: report by the Social Exclusion Unit. SEU, 1998.

Teenage Pregnancy Unit. A guide to involving young people in teenage pregnancy work. Teenage Pregnancy Unit. 2001. Available from <http://www.teenagepregnancyunit.gov.uk>

Thompson, M. and Westreich, R. Restriction of mother infant contact in the immediate postnatal period. In: Chalmers, I. Enkin, M. and Keirse, M. J. C. (eds) *Effective care in pregnancy and childbirth*. Oxford: Oxford University Press, 1989.

Thomson, H. Petticrew, M. and Morrison, D. Housing Improvement and Health Gain: A summary and systematic review. MRC Social and Public Health Sciences Unit; 2002. (Occasional Paper No 5).

Thunhurst, C. Using published data to assess health risks. In: Burridge R, Ormandy O, editors. *Unhealthy housing; research, remedies and reform*. London: E & FN Spon, 1993.

Tierney, J.P., Grossman, J. B., and Resch, N. L. Making a difference. An impact study of Big Brothers Big Sisters. Philadelphia, PA USA: Public/Private Ventures; 2000.

Tooke, J. Young people's participation in Lambeth Southwark and Lewisham Health Action Zone (draft report). Centre for Urban and Community Research, Goldsmiths University of London, 2002.

Underdown, A. Gibbs, J. Liabo, K. Evidence nugget: Group-based parenting programmes can reduce behavioural problems of children aged 3-10 years. What Works for Children group 2003. Available from <http://www.whatworksforchildren.org.uk>

Utting, D. Sure Start: a guide to evidence-based services, "Trailblazer" edition. DfEE, 1999.

Valentine, G. and McKendrick, J. Children's Outdoor Play: Exploring Parental Concerns About Children's Safety and the Changing Nature of Childhood. *Geoforum* 1997; 28(2):219-235.

Wadsworth, M. E. J. and Maclean, M. (1986) Parents' divorce and children's life chances. *Children and Youth Services Review* 1986;8:145-159.

Wadsworth, M.E.J. *The Imprint of Time: Childhood, History and Adult Life*. Oxford: Oxford University Press, 1991.

Walker, R. Bradshaw, N. The Oakdale renewal scheme: use of prescribing data to assess the impact on the health of residents: Gwent Health Authority & Welsh School of Pharmacy, 1999.

Washington, DC: National Academy Press; 2001.

Wazana, A. Krueger, P. Raina, P. and Chambers, L. A review of risk factors for child pedestrian injuries: are they modifiable? *Injury Prevention* 1997; 3: 295-304.

Webster-Stratton, C. Researching the impact of parent training programmes on child conduct problems. In: Lloyd, E. (ed) *Parenting Matters*. Barking: Barnardo's, 1999.

Wells, J. Barlow, J. and Stewart-Brown, S. A systematic review of universal approaches to mental health promotion in schools. Oxford: University of Oxford, Health Services Research Unit, 2001.

White, D. and Pitts, M. Educating young people about drugs: a systematic review. *Addiction* 1998; 93(10):1475-1487.

Williams, H. and Sibert, J. *Medicine and the Media*. British Medical Journal 1983; 286: 1893.

Windle, M. and Windle, R.C. Adolescent tobacco, alcohol and drug use: current findings. *Adolescent Medicine* 1999; 10(1).

World Health Organisation. Obesity, preventing and managing the global epidemic: Report of the WHO consultation of obesity. Report of the WHO consultation of obesity. Geneva, World Health Organisation, 1997.

Yoshikawa, H. Prevention as Cumulative Protection: Effects of Early Family Support and Education on Chronic Delinquency and its Risks. *Psychological Bulletin* 1994; 15(1): 28-54.

Yuchtman-Ya'ar, E. Spiro, S. E. Reactions to Rehousing: Loss of Community or Frustrated Aspirations? *Urban Studies* 1979; 16: 113-119.

Zwerling C and Jones MP. Evaluation of the effectiveness of low blood alcohol concentration laws for younger drivers. *American Journal of Preventive Medicine*. 16(1 Suppl): 76-80, Jan 1999.

Acknowledgments

The London Health Commission is grateful to Barnardo's who published Helen Roberts' report *What Works in Reducing Inequalities in Child Health* in 2000, on which this work draws.

The authors are grateful to colleagues in the Child Health Research and Policy Unit, City University, and to Melissa Harden from the Institute of Child Health, University College London, for her assistance with literature searching. Dr Elizabeth Waters, Director of the Cochrane Health Promotion/Public Health field and the Research and Public Health Unit, Centre for Community Child Health, Murdoch Children's Research Institute, Royal Children's Hospital, Melbourne, Australia provided key advice and support to this project.

We are also grateful to the peer reviewers of the report, and in particular, Dr Catherine Law from the Institute of Child Health.

About the London Health Commission

The London Health Commission seeks to improve the well-being of all Londoners and reduce inequalities in health. The LHC promotes a co-ordinated approach to the factors that influence health in London, and will do this by:

- Building partnerships involving the health sector, local and national government, the private sector, community and voluntary groups
- Influencing decision-makers
- Supporting local action

To find out more about the work of the London Health Commission, see our website: www.londonhealth.gov.uk

or contact:

London Health Commission,
City Hall, The Queen's Walk,
London SE1 2AA
Tel: 020 7983 4120
Email: health.commission@london.gov.uk

Health Impact Assessment (HIA)

HIA is an approach to ensure that decision making at all levels considers potential impacts on health and health inequalities, and identifies actions that can enhance positive effects and reduce or eliminate negative effects.

Although HIA is a new and developing approach, it is increasingly being recognised nationally and internationally.

Developing and promoting the use of HIA is one of the supporting priorities of the London Health Commission.

A number of resources are now available to support those considering or conducting health impact assessments. Please see our website at: www.londonhealth.gov.uk/hia.htm



Published by: London Health Commission
February 2004 ISBN: 1-904340-07-5