

Introduction

Over the last century, the health of children in the UK has improved overall. Nevertheless, there remain major health challenges in reducing inequalities in child health, improving the access of the most vulnerable children to health resources and ensuring that those children who do live with major health problems are able to be all they can be.

Health matters to children, families and communities. Although the media attention given to hospital closures, waiting lists and the like might suggest that 'health' is synonymous with health services, what makes a real difference to health are those things which determine it where many opportunities for change lie beyond the scope of the NHS. In the UK there are large social class, ethnic and other differences in life chances related to health. Children born into poverty and disadvantage miss out on important opportunities for health gain, and accumulate health risks as they grow into adulthood.

This 2005 Health of London report has a special focus on children and young people. This is timely, given the appointment in summer 2005 of the first Children's Commissioner for England, and current policy and practice changes driven by the Children Act 2004, the *Every Child Matters (ECM)* programme and the *National Service Framework for Children, Young People and Maternity Services*. These changes present a major opportunity for all organisations concerned with children and young people to work together to improve outcomes, including the health outcomes so fundamental to children's lives now and in adulthood.

What is a child? A note on terminology

Just as last year's report touched on issues of terminology associated with race and ethnicity, there are also definitional problems relating to children and young people. When does a 'child' become a 'young person' and when does a young person become an adult?

A young person may instruct a lawyer in a criminal case at 10, marry at 16 (though not adopt a child until 21), and join the army at 16. In a health context, 16-18 year olds will normally be asked to consent to treatment or examination on their own behalf. Before then, it will depend on the young person's ability to understand what is involved, (Department of Health, 2001).

Increasingly, even very young children will be asked for a view by those working in health and social care. Those under 16 have the same rights to confidentiality as adults when seeking contraceptive advice. And of course, children and young people themselves have different views on what constitutes a child: most 15 year olds, for example, do not think of themselves as 'children'.

The legal definition of a 'child' in the UK is a person under the age of 18 years. In practice, however, there is a range of working definitions of child and young person across agencies. For example, youth services often work with 'young people' up to the age of 25; some young people in receipt of services including disabled young people or care-leavers may remain eligible for support beyond the age of 18. This results in data being collected and reported differently. Clearly, however, some choice of terms has to be made – for example, in citing official statistics. Accordingly, a range of 'umbrella' terms is used in this publication, and

much of our data are dependent on age categories used for classification purposes by a range of agencies. Not all of these categories are consistent.

For the purposes of this report, we use the term 'children' to encompass younger children up to 12; 'young people' to describe 13-17 year olds; 'young adults' to describe over 18s. We use the generic term 'children and young people' to encompass all these groups. Where possible we specify the age ranges to which any reported data apply.

Current policy for children and young people

The policy context for children and young people has undergone significant and rapid change in the last year. *The Children Act 2004* provides the legislative basis for the ECM programme and the reform of children's services. The key provisions of the *Children Act* are:

- The appointment of a Children's Commissioner to champion the views and interests of children and young people
- A duty on local authorities to make arrangements to promote co-operation between agencies and other appropriate bodies to improve children's well-being and a duty on key partners to take part in the co-operation
- A duty on key agencies to safeguard and promote the welfare of children
- The establishment of Local Safeguarding Children Boards
- Provision for databases of basic information about children and young people to facilitate better sharing of information between agencies
- A requirement for a single *Children and Young People's Plan* (CYPP) to be drawn up by each local authority
- The appointment by local authorities of a Director of Children's Services and a designated Lead Member
- The creation of an integrated inspection framework and the conduct of *Joint Area Reviews* to assess local progress in improving outcomes
- Provisions relating to foster care, private fostering and the education of 'looked after' children.

ECM sets out a framework for radical change in the system of children's services to improve outcomes for all children and young people. The five outcomes are:

- Be healthy
- Stay safe
- Enjoy and achieve
- Make a positive contribution
- Achieve economic well-being.

These outcomes are the basis for a framework of performance targets to be delivered through an integrated approach to children's services, including health, education, social care, housing and regeneration and the voluntary and community sector. Improving the health of children and young people is a vital component of achieving these.

Measures to improve health and reduce child health inequalities not only contribute directly to the 'be healthy' and 'stay safe' outcomes, but indirectly to the others: poor health is a significant

barrier to educational achievement, enjoyment and economic well-being. Improving the health of children and young people is therefore a key objective of all organisations involved in local strategic partnerships for children and young people.

In achieving these priority outcomes, the emphasis is on an integrated approach to strategic planning, commissioning and service delivery. There is a requirement to bring together provision for children and young people in each local authority area in partnership arrangements which in most areas is leading to the establishment of *Children's Trusts*. Other key elements of the integration agenda are:

- The *Common Assessment Framework*
- Information sharing
- An integrated children's workforce strategy with common core competencies for those working with children.

The ECM programme provides opportunities for health organisations to work in partnership with others to improve outcomes for children and young people generally and to keep the health of children and young people high on the agenda.

In particular there is a strong emphasis on: early identification and intervention; strengthening health promotion in local communities; targeting resources to those areas in greatest need; involving children, young people and families in decisions. Further details of ECM can be found at <http://www.everychildmatters.gov.uk/>.

The National Service Framework (NSF) is an integral part of the *Change for*

Children programme. The NSF is composed of 11 sets of standards on:

1. Promoting health and well-being, identifying needs and intervening early
2. Supporting parents and carers
3. Child, young person and family-centred services
4. Growing up into adulthood
5. Safeguarding and promoting the welfare of children and young people
6. Children and young people who are ill
7. Children in hospital
8. Disabled children and those with complex health needs
9. The mental health and psychological well-being of children and young people
10. Medicine management for children
11. Maternity services.

There are four underlying themes of the NSF which are also reflected in ECM:

- A focus on health promotion and healthy lifestyles as well as managing illness and complex needs
- A recognition of the need to address inequalities
- A recognition of the particular needs of children at risk of poor outcome
- An emphasis on promoting the safeguarding of children and young people.

In the remainder of this section we consider the main factors of relevance to these themes, in particular the factors underpinning child health inequalities.

Child health inequalities

Much of the thinking behind current policy initiatives to improve health outcomes and reduce child health inequalities can be traced back to the *Independent Inquiry into Inequalities in Health* chaired by Sir Donald Acheson and published in 1998. A key message in this report was that the action to reduce child health inequalities needs to be taken on broad fronts and not only in 'medical' settings. Despite the fact that the inquiry was chaired by one of the country's most senior doctors, reporting to the Secretary of State for Health, most of what was recommended was not a task for the National Health Service. There is no vaccine against poverty. Effective remedies involve tax and benefits, education, employment, housing, the environment, transport and pollution (Curtis and Roberts, 2004).

Of the recommendations in the Acheson report, ten were, and remain, of particular relevance in reducing health inequalities for children and young people:

- reductions in poverty in women of childbearing age, expectant mothers, young children and older people by increasing benefits in cash or kind
- the development of high quality pre-school education so that it meets, in particular, the needs of disadvantaged families
- measures to encourage walking and cycling and the separation of pedestrians and cyclists from motor vehicles
- policies which reduce poverty in families with children by promoting material support; removing barriers to work for parents who wish to combine work with parenting; and

enabling those who want to be full-time parents to do so

- an integrated policy for the provision of affordable, high quality day care and pre-school education with extra resources for disadvantaged communities
- policies which improve the health and nutrition of women of childbearing age and their children, prioritising the elimination of food poverty and the prevention and reduction of obesity
- policies which increase breastfeeding
- policies which promote social and emotional support for parents and children
- consideration of minority ethnic groups in needs assessment, resource allocation, health care planning and provision
- policies which reduce psychosocial ill health in young women in disadvantaged circumstances, particularly those caring for young children.

Subsequent policy developments, summarised in the introduction to this report, have sought to address the above issues and significant progress has been made. However, the health gap between the 'best-off' and 'worst-off' children and young people remains too wide and much more needs to be done if the vision for children's well-being set out in ECM is to be achieved.

Influences on the health of children and young people

It will be evident from the above that health and wealth are strongly related,

and that in order to reduce inequalities in health, we need to address the determinants.

We have set out the various influences on the health of children and young people beneath one overarching influence – poverty – and then describe some of the influences at different points in the child or young person's life.

Parents clearly play a large part in the well being of their children; we suggest here the need to affirm the heroic efforts most parents living in poverty make to protect the health and well-being of their children. We also raise in this section the relationship between ethnicity and health, whilst sounding a note of caution that the relationship is not straightforward.

Starting with **Early life**, we describe next some of the maternal and family influences, including breastfeeding on the positive side, and smoking as a negative influence; in **Middle and later childhood, and adolescence** important influences include emotional well-being and nutrition. Finally, in **Health behaviours in adolescence**, the influence of, and influences on, sexual behaviour are described.

Poverty

A major influence on outcomes for children is poverty. Roberts' (2000) summary highlights the strong link between health and wealth, with children born into poverty more likely than their better-off neighbours to:

- die in the first year of life
- be born small, be born early, or both
- be bottle fed
- die from an accident in childhood

- smoke and have a parent who smokes
- have poor nutrition
- become a lone parent
- have or father children younger
- die younger.

Despite improved obstetric and neonatal care, babies born early, and babies born small are at risk of a range of poor outcomes both immediately and in later life. Having a premature or very small baby also means an anxious start to parenthood.

As summarised above, children born into poverty are more likely than better-off children to be born small, be born early, or both (MacFarlane and Mugford, 2000), to be bottle fed (Garcia et al, 2000), 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).

At the national level, infant mortality rates have more than halved since the mid 1970s, but babies with fathers in manual jobs are still more likely to die than those of men in non-manual occupations. The differential was particularly marked for babies with fathers in partly skilled or unskilled occupations. Inequalities around infant mortality are more pronounced when a baby is aged over one month, compared with the first month of life. On average, babies of teenage mothers are at greater risk of infant mortality than those born to women in their forties.

Parenting

Mothers – usually the main caretakers of children – and parents in general are frequently a focus of criticism. This may be implied through, for example, the proliferation of parenting courses, or explicit, with the suggestion that the main need for change lies at their door. This is despite evidence that the vast majority of mothers living in poverty bring up their children successfully, and protect and promote their health in unpromising conditions (Blackburn 1992; Roberts et al, 1995; Kempson 1996). The harm which can be done by failing to affirm the majority of good mothers, and failing to recognise the barriers and obstacles to good mothering, sometimes invisible to professionals, cannot be underestimated. The phrase ‘It’s like teaching your children to swim in a pool full of alligators’ (Rice et al, 1994) is all too true of the conditions faced by many families.

None of this is new. In the early 1940s, Richard Titmuss’ *Birth, Poverty and Wealth* (Titmuss, 1943) showed that children’s deaths were related to the occupations of their fathers, and that the gap between the life chances of working class and middle class infants had increased since 1914. Newspapers of the time reported ‘Poor folks’ babies stand less chance’, and ‘Babies beware of poor parents’. A reviewer for the *Evening Citizen* suggested that the book ignored ‘the criminal ignorance and neglect of many mothers’, who were inclined to give their babies ‘fish and chips, pickles, strong tea, lollipops, chocolate biscuits and toffee apples’ (Oakley, 1996:190). In 2000, a reviewer of the BMA’s *Growing up in Britain* asked ‘Why do children from poor families consume such a lot of sweets, fizzy drinks, milk and white bread?’ suggesting a plausible answer: ‘Penny for penny, a chocolate bar provides more

calories than carrots, even from a market stall’ (Thurlbeck, 2000:809).

Ethnicity

Minority Ethnic children and young people are not, of course, a homogeneous group. Some will have better health than white British young people, some worse. Some will have better health behaviours in relation to smoking and alcohol, some worse. However, children and young people from minority ethnic groups are subject to inequalities in health for a number of reasons.

Firstly, there is an association between ethnicity and poverty. It is well documented that socio-economic status is a significant contributing factor to ethnic variations in health and is linked to higher rates of chronic illness in the most disadvantaged ethnic minority communities (Nazroo, 1997). National data suggests that more than half of African Caribbean children live in areas of high unemployment, and that Bangladeshi and Pakistani children are consistently amongst the poorest of the poor with a higher proportion of these groups living in deprived neighbourhoods and in poor housing (Arora et al, 2000).

Secondly, children and young people from minority ethnic groups suffer both individual and institutional racism. Racism is a reality in the UK today, as suggested by Nazroo’s 1997 study in which around a quarter of white people interviewed admitted to racist feelings against black and Asian groups. Racism contributes to a climate of anxiety and fear which can directly impact on the health and emotional well-being of children and young people. Institutional racism may be a contributory factor in increasing inequalities in access to health care provision.

This can play out in a variety of ways: in stereotypical assumptions about South Asian families not requiring health care because 'they look after their own', to beliefs about African and Caribbean cultures being threatening or in need of control (Ahmed & Atkin, 1996) or a colour blind approach to service provision which fails to meet the specific needs of ethnic minority communities in a misguided attempt to 'treat everyone the same' (Alexander, 1999). Nazroo (1997) and Karlsen & Nazroo (2002) argue that poverty and racism play a greater role than cultural differences in health inequality: social disadvantage plays a key role in determining ethnic inequalities in health; while health differences cannot be understood just by knowing someone's ethnic group.

Data from the *2001 Census* provide some information about the associations between health status and ethnicity. Based on parental reports, Census data show that the highest proportion of parents reporting good general health of their children were parents of white children (91%) and African children (92%) with the lowest being parents of Caribbean (85%), Pakistani (86%) and Bangladeshi (86%) children (ONS, 2003).

Early life

This developmental stage is critical for the brain development and mental health of children. Secure attachment to the mother confers an ability to manage feelings and to cope with difficulties encountered in life. In addition, secure attachment to the father influences the child's ability to function well in relationships with others as well as improved educational attainment. Secure attachment may be disrupted by poor housing conditions, demanding work patterns or by post-natal depression (in either the mother or the father).

Breastfeeding

Breastfeeding is a key determinant of the health, development and emotional wellbeing of infants, and of long-term health gains extending into adulthood, yet there are marked socioeconomic, ethnic and regional differences in starting to breastfeed, and keeping it up. These differences can contribute to both initial and persistent inequalities in health.

Breastfeeding is associated with a number of benefits to children, 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.

Despite efforts to encourage breastfeeding, there are strong social class differences in breastfeeding. National breastfeeding statistics hide considerable differences relating to the age and educational status of the mother, the social group to which she belongs and the geographical area in which she lives (Hamlyn et al, 2002).

- Mothers in manual social class groups are less likely to breastfeed than those in non-manual groups (63% as opposed to 83% at birth) – only 13% of babies whose mothers were classified in the 'lower occupations' group are receiving any breastmilk at six months, compared with 31% in the 'higher occupations' group
- Mothers who remained in full-time education until they were 18 are more than three times more likely to breastfeed their babies to 4-6 months of age than mothers who left school aged 16 or under
- More than three quarters of mothers

aged 30 or over breastfeed their babies compared with less than half of mothers aged 20 or under.

Smoking

Smoking during pregnancy is associated with low birthweight in babies. In addition, about 41% of British children are exposed to environmental tobacco smoke. This increases children's susceptibility to respiratory tract infections, ear problems, asthma and Sudden Infant Death Syndrome (Hovell et al, 2000). Exposure to passive smoking among children in England has approximately halved since the late 1980s. This reduction is mainly accounted for by reductions in exposure in children from non-smoking homes, and a fall in the percentage of parents smoking (Jarvis et al, 2000).

Nutrition

Research indicates that nutrition in foetal life and the very early months may critically influence adult behaviour and learning (Barker 1994). While a number of interventions have been developed in promoting healthy diets as well as changes to drinking and smoking patterns during pregnancy, these have met with varying degrees of success. We do not yet know the true impact of maternal nutrition on foetal development. Even famine conditions produce surprising small effects on foetal growth (BMA, 1999).

Folic acid supplements around the time of conception for women at increased risk of having a child with neural tube defects (NTD) reduce the risk of recurrence by more than two thirds (Enkin et al, 1995). Clearly, unplanned pregnancies are a challenge in this respect.

A good diet for the mother, and a well-fed infancy and childhood are vital, and all children (and adults) have a right to a decent diet, irrespective of their current or future parental status.

Middle and later childhood, and adolescence

An important causes of death and disability in middle and later childhood, adolescence and young adulthood is injury on the road. On the more positive side, play and play spaces discussed below, can have a positive effect.

Injury and illness

After the first year of life, the most common causes of death in childhood are external causes including injury, poisoning and cancers (ONS, 2004). The mortality rate for childhood cancer has continued to decline with around 70% of children now successfully treated (Cancer Research UK, 2003).

Accidents

Relevant studies have demonstrated the following key points:

- The social, geographical and gender patterning of accidents suggests that accidents are not a matter of chance
- Children from poor background are far more likely to be killed in an accident than their "better-off" neighbours
- Boys are at greater risk of accidents than girls
- Some areas of the country, largely those with significant areas of deprivation, have high accident rates
- Children in poor housing, including bed and breakfast accommodation, are at greater risk
- Children from large families, or families where there is only one parent to supervise are more likely to be involved in an accident

- Child pedestrians are more at risk than children transported in cars. Car transport for some children increases the risk to others.

Deaths from accidents have also steadily declined, but there are major social class variations associated with deaths due to injury (Towner, 2002). The rate of deaths by fire is 15 times higher for children in the lowest groups than for the highest socio-economic groups. The most disadvantaged children are five times more likely to die as a child pedestrian.

Whilst these deaths are relatively rare, it has been estimated that for every death due to injury there are numerous non-fatal accidents causing injury (Conway & Morgan, 2001). Children in lower-income and lone parent households are more likely than other children to sustain injuries requiring a visit to a doctor or a hospital (Department of Health, 2003).

If parents and children do not have confidence in the safety of spaces for outdoor activities, it is harder for parents to support their children in the task of growing independence and managing risk – this leaves children more vulnerable to accidents.

Mental health and positive emotional well-being

At a national level, mortality rates for adolescents from injury and suicide have increased fivefold over the last century – rising from 11% of total deaths for 15-19 year olds in 1901-10, to 57% in 2003. Rising suicide rates among young men, and an increase in mental health problems in children and young people indicate a need to focus on improving social and emotional health. Mental health is more profoundly affected by socio-economic factors than many other dimensions of health (Carr-Hill et al,

1994). Mental health of parents is also an important determinant of children and young people's health and well-being.

Self-harm

Deliberate self-harm is a term used when someone injures or harms themselves on purpose. Common examples include 'overdosing' (self-poisoning), hitting, cutting or burning oneself. It can also include taking illegal drugs and excessive amounts of alcohol. According to the Royal College of Psychiatrists, self-harm is always a sign of something being seriously wrong.

The Royal College's factsheet on self-harm gives some of the reasons young people provide for injuring themselves:

- Some say that they have been feeling desperate about a problem and don't know where to turn for help. They feel trapped and helpless. Self-injury helps them to feel more in control.
- Some people talk of feelings of anger or tension that get bottled up inside, until they feel like exploding. Self-injury helps to relieve the tension that they feel.
- Feelings of guilt or shame may also become unbearable. Self-harm is way of punishing oneself.
- Some people try to cope with very upsetting experiences, such as trauma or abuse, by convincing themselves that the upsetting event(s) never happened. These people sometimes suffer from feelings of 'numbness' or 'deadness'. They say that they feel detached from the world and their bodies, and that self-injury is a way of feeling more connected and alive.

Bullying

Bullying is a factor which appears to be related to poor self-esteem and is certainly associated with misery for those children unfortunate enough to experience it. Research has demonstrated the extent of bullying and a recent report suggests that homophobic bullying may be a particular problem, and one related to self-harm. One UK study found that more than 50% of lesbian, gay and bisexual women and men who had been bullied at school reported having contemplated self-harm or suicide; 40% had made at least one attempt to self-harm, and three quarters of those made subsequent attempts (Rivers, 2001).

Play

One way of promoting better health is through play (Mayor of London, 2004) – a key part of the Mayor's strategy for children and young people.

A practical tool to assist local boroughs to meet the play and leisure needs of children and young people living in London is the *Mayor's Guide to Preparing Play Strategies – Planning inclusive play spaces and opportunities for all London's children and young people* (2005). It sets out the basis for providing children with accessible spaces offering free, high quality, inclusive play opportunities throughout their environment – a need commonly identified by parents/carers as well as children and young people.

Developed by London Play on behalf of the Mayor of London, this guidance is a companion document to the Mayor's *Guide to Preparing Open Space Strategies*. It is also part of the Mayor's policy (London Plan, 3D.7) to work with strategic partners to protect and promote London's network of open spaces, and realise their value for communities and protect their many benefits, including children's play.

During consultation by the Mayor, children were asked their advice on making London a better place for children to play.

- Make sure there's at least one park in every estate. Make it safe
- Keep London tidy
- Make big toys cheap
- Make streets where children can play
- Free access to leisure centres
- Better football grounds, swings and playgrounds
- More activities after school. Closer activities to school. New things like different playgrounds
- More ramps and pools
- More parks, fewer cars
- Larger play areas
- No bad people, more parks
- More benches to hang out with my friends.

Some of the ways by which the health of children and young people might be improved are listed in the box below.

A better place for children and young people

- Provision for teens – free and affordable leisure facilities, hang out areas/skate parks etc. A lot of the issues will be addressed through the *Youth Green Paper*; the *White Paper* must make links to planning in order to deliver services that meet needs.
- Emphasis on inclusive play. In London, as across the UK, there is evidence that disabled children do not enjoy equality of access to play and leisure facilities.
- Quality play and leisure provision within nurseries, schools and colleges to inspire creative learning and more physical activity.
- The importance of innovative

designs aspects of play spaces and play equipment – with children and young people involved as much as possible – to build in risk and challenge at a design stage without compromising safety.

- Highlighting the new statutory status of recreation in ECM in order that it is 'not sidelined' by other priorities.
- More guidance on play in schools and on improving school grounds.
- Opportunity to deliver more play and leisure through the *Building Schools for Future* programme.

Health behaviours in adolescence

Many adolescents in the UK are at the peak of their health, and it would be a mistake to stigmatise them in terms of their health behaviours. However, there are some causes for concern. A BMA publication on the health needs of adolescents reported that problems include overweight, smoking, psychological problems, sexually transmitted diseases, early conception, poor intake of fruit and vegetables and drug use (BMA, 2003).

Information available from health surveys (such as the *Health Behaviour of School-aged Children* (HBSC) survey – see <http://www.hbsc.org/overview.html>) provides some trend data on lifestyle factors relating to health.

Alcohol and smoking

Nationally, key trends show the proportion of young people drinking alcohol increasing with age, particularly among boys.

An area of concern is the proportion of young people 'binge drinking' which presents health risks both in its own right and because of its association with risky behaviour. The prevalence of smoking varies between regions of the

UK and there are gender differences, with girls being more likely to smoke than boys.

Sexual health

Sexual health is about more than avoiding getting pregnant or having a sexually transmitted infection. However, we highlight these aspects of sexual health in this report because they are areas where bringing about change is likely to affect the health of children and young people not only immediately, but in the longer term as well.

Conception and birth rates in the UK are the highest in Europe and second only to the United States in the developed world. While by no means all teenage pregnancies are unplanned or unwanted, there is a strong association between poor outcomes and having (as well as being) a teenage parent.

Pregnancy

Compared with their peers in more affluent areas, young women in poorer areas of the UK are more likely to conceive (Coleman and Schofield, 2001), less likely to have abortions and more likely to give birth (SEU, 1999). Socially excluded teenagers in these settings are particularly at risk – for example, those excluded from school (Allred, David and Smith, 2002), those 'looked after' by local authorities (Corlyon and McGuire, 1997) and those in contact with the criminal justice system (SEU, 1999).

Sexually transmitted infections

The Department of Health's *National Strategy for Sexual Health and HIV* indicates that the most common conditions now at a national level are chlamydia, non-specific urethritis and wart virus infections, but almost all sexually transmitted infections (STIs) are becoming more common. The number of visits to departments of genito-urinary

medicine (GUM) in England has doubled over the last decade and now stands at over a million a year. Diagnoses of genital chlamydia also almost doubled during the 1990s, with a particularly marked increase in men and women aged under 20. Recent surveys of women indicate chlamydia infection rates of up to 12% and there are more reports of outbreaks of syphilis.

Teenagers and young adults bear much of the burden of disease (Department of Health (2001). *Better Prevention, Better Services, Better Sexual Health: the National Strategy for Sexual Health and HIV*. London: Department of Health).

Vulnerable groups

Among those most at risk of suffering the effects of health inequalities are 'looked after' children, children from some minority ethnic groups, children in single parent households or households with low incomes, children experiencing abuse and/or domestic violence, homeless families, disabled children, travellers, refugees and asylum seekers.

The section below focuses on 'looked after' children, but children can also be at risk in their own homes from abuse, neglect and domestic violence and the impact of parental health problems, including mental ill-health or substance misuse.

'Looked after' children

A good deal of political and press interest in different family types focuses on the relationship between family formation and particular outcomes. The health and social outcomes for the children of lone parents, divorced parents, or gay and lesbian parents is extensively probed. There is a less substantial research literature on the impact of parenting in a different kind of family type – young people brought up in state care. We do, however, have data

showing that 'looked after' children and young people are more likely to have poor health, including poor mental health (Polnay and Ward, 2000; Richardson and Joughin, 2000) and poor health prospects. This is not, of course, a simple cause and effect relationship but is mediated by other factors including pre-care experiences. It is an area where we need to know more about what can be done to bring about improvement.

Children 'looked after' away from home often have extensive unmet health needs (Skuse and Ward, 1999). Of their sample of 249 children 'looked after' from a representative sample from six local authorities, Skuse and Ward found that 54% had unmet physical health needs, and a high percentage of children had emotional and behavioural disturbances. Children in residential care were significantly less likely to receive immunisations than those in foster homes. For almost two thirds of the children, there were incomplete records on when they last saw a dentist.

As Skuse and Ward point out, many of these children enter the care system with pre-existing risks – factors within their home circumstances may mean that they have missed out on health care in the past. They suggest that children 'looked after' may well need compensatory health care, so that once they become 'looked after', immunisations that had previously been overlooked can be given, dental caries treated and health education attended to. Skuse and Ward also suggest that the main reason why children 'looked after' away from home often have difficulty in accessing adequate health care is likely to be related to the frequency with which they move placements.

In their own study, only 44% of the children had stayed in the same

placement throughout the first year of their care episode, 26% had two placements and 28% three or more. Fifteen children (6%) had had five or more placements in this period. The most common age group in their sample was admitted under the age of one, and these had the second highest mean number of placements (Skuse and Ward, 1999:9).

Looking at children and young people brought up in state care, Mike Stein's overview (Stein 1997; 2004) reports that:

- Young people leave care to live independently at a much earlier age than other young people. Whereas the trend for young people in the general population is for delayed household formation, care leavers make an accelerated transition (Biehal et al, 1995).
- The educational qualifications and subsequent occupations of those who experienced care as children are much poorer than for those brought up in other kinds of family (Cheung and Heath, 1994).
- Young women in, and leaving, care have babies much earlier than other women. The study by Biehal and her colleagues showed a half of the sample coping with early motherhood by ages 16-19, whereas in the wider population, only 5% of 16-19 year olds had children.

In a study carried out in Wales (Payne and Butler, 1998), all 593 children 'looked after' by a single local authority on one day were looked at in relation to health care assessment. The authors found that 'looked after' children receive poor health supervision, even though it is required by regulation. In relation to immunisation,

'looked after' children were significantly less likely to be protected from infectious diseases than other 2-5s in the community. It was difficult to tell quite how much less likely they were to be protected because records were incomplete.

'Looked after' young people are also more vulnerable to mental health problems. In a study in Oxfordshire, McCann and colleagues (1996) found that 57% of young people living in foster care and 96% of those in residential care, had some form of psychiatric disorder. More recently, two national surveys of the mental health of young people in England (Melzer et al, 2000; 2003) obtained information on the mental health of young people living in private households and those 'looked after'. Comparisons between these two groups show that 'looked after' young people aged 11-15 years were four to five times more likely to have a mental disorder compared to the private household sample. The survey also established a close association between mental disorders and physical complaints along with an increased likelihood of smoking, drinking and drug use.

Young offenders

Young offenders are three times more likely to have a mental health problem than other young people. Many suffer from psychiatric disorders, anxiety and depression (Hagell, 2002). A study by Hammersley et al (2003) found that a quarter of young people supervised by Youth Offending Teams admit to having a mental health problem, a quarter to having self-harmed and almost a half to being depressed. Two out of five young men and two thirds of young women aged 16-20 who are sentenced in court have some mental health symptoms, compared to one in ten of the general population in this age group (Lader et al, 2002).

Young offenders may also have unmet physical health needs. The study by Hammersley et al (2003) found that a quarter of Youth Offending Team clients had never been to their GP. As Hammersley and his colleagues themselves point out extensive service use can be an indicator of psychosocial problems, whilst evidence of lack of service use can provide information about unmet needs.

There is some evidence to suggest that despite being at greater risk of health problems, particularly mental health difficulties, young offenders are not getting the health services they need. A report on youth justice by the Audit Commission (2004) points out that Youth Justice Board targets for mental health assessments for young offenders are not yet being met in most areas and that there are frequently conflicting priorities between Youth Offending Teams and Primary Care Trusts which militate against young people getting the health services they require. A study published in *The Lancet* found that young male offenders in local authority secure units do not get the mental health services they need, and that detention centres may lead to, or exacerbate health problems (Harrington, 2002). The Audit Commission report (2004) also points out that the provision of mental health care for young people in prisons is particularly poor. According to Youth Justice Board estimates, there are up to 300 young people in secure establishments requiring transfer to specialist mental health facilities at any one time, yet there are only around 30 secure NHS beds for young people with mental health problems (2004: 88).

Drug and alcohol use is also more common among young offenders who are around 10 times more likely to have a serious substance misuse problem than

non offenders (2004: 89). Appropriate specialist support to address these problems is widely reported to be inadequate.

Young offenders frequently have unmet educational needs and are more likely to have been brought up in poverty and/or the care system. A study carried out for the Youth Justice Board by Harrington et al (2005) found that almost a quarter of young offenders had learning difficulties, frequently had a history of social care placements, family breakdowns and school exclusions. The same study found that the provision of mental health services was patchy and variable and that needs often went unrecognised by those working with young people. More systematic mental health screening was a key recommendation.

Disabled children and young people

Families with disabled children have only 78% of the resources of all families with children (NCH, 1999). They are doubly disadvantaged because it costs three times more to raise a disabled child than a non-disabled child (Dobson and Middleton, 1999). Research has shown that overall, families from minority ethnic groups caring for a severely disabled child are even more disadvantaged than white families in similar situations, though families' experiences, needs and circumstances varied across ethnic groups (Chamba et al, 1999).

As Beresford (2002) points out, social exclusion permeates the lives of disabled children with consequences which are long-term and hard to reverse, and the experiences of social exclusion tend to increase as children grow older. Recent studies suggest that disabled children do not view themselves as intrinsically different to other children, but their treatment by others and their experiences of a disabling environment

promote a sense of difference. Disabled children most value services which support or promote 'ordinary', everyday activities and experiences.

There are several factors contributing to the social exclusion of disabled children and young people. These include transport, social and leisure needs, housing issues and involvement in decision-making. Accessible transport systems are fundamental to social inclusion.

Survey data show that disabled children and young people are significantly less likely to participate in sport and leisure activities, particularly out of school (Finch et al, 2001). Disabled children spend far more time in the home than non-disabled children, yet, for many children, the physical and social environment within the home is highly restrictive. The evidence emerging from practice, particularly from inclusive play and leisure projects, suggests that social inclusion can be achieved.

Refugee and asylum seeking (RAS) children and young people

The UK has, for many years, become home to refugees and the majority of refugees live in London. Figures from local education authority (LEA) data and language surveys suggest that almost one child in 19 in London is a refugee, and for a range of reasons, this is likely to be an underestimate. Reports from practitioners, researchers and young people suggests that provision needs to be urgently improved in a number of areas – for example, housing, education and training – if they are to have a fair chance of leading full and independent lives.

Poverty

Recent research commissioned by the GLA on the health of asylum seekers in temporary accommodation found that,

of asylum seeker respondents who had children, one in five could not afford books or toys for their children, a warm waterproof coat or fresh fruit and vegetables. The withdrawal in 2002 of the concession allowing asylum seekers to work after six months if waiting for a decision has undoubtedly increased levels of poverty.

Unemployment

Refugees are highly under-represented in the labour market. The situation of most young refugees and asylum seekers who are employed (illegally in the case of the latter) is that they work long hours, for little money, in a restricted number of occupations.

Housing

Research commissioned by the GLA in 2003 found that two fifths of asylum seeker households were living in overcrowded conditions (Mayor of London, 2004). The research highlighted serious safety concerns particularly for households with young children, for example:

- 60% of respondents had not been told what to do in case of fire or emergency
- Half of the respondents with children said that they had nowhere safe for their children to play indoors, and a third said they had nowhere safe outdoors
- About a third said that they did not think their accommodation had smoke detectors.

Concerns about fire safety were also raised, including gas leaks, electrical faults, faulty fire extinguishers and inadequate means of escape. Respondents described a range of serious accidents, fires and health

problems relating to their accommodation. The use of bed and breakfast and hostel type temporary accommodation raises child protection concerns as children often share facilities with other adults who are not their carers.

Education

Schools can play a crucial role in helping RAS children and their families to rebuild their lives and settle into their local communities. As Ofsted has noted, many refugee children do well at school because they are determined to succeed and have parental support. There is evidence to suggest, however, that Somali, Turkish Kurdish boys and Eastern European Roma are underachieving (Osted, 2003).

A recent GLA report revealed that around 10 per cent of RAS children are without a school place, rising to 14.2 per cent in inner London, compared to 5.6 per cent for England as a whole. London has high rates of mobility at secondary as well as primary school level. This poses particular challenges to schools and may make demands on staff, systems, resources, and on the more stable community of pupils. Research has pointed to a gap in attainment between the mobile and stable school populations.

Most child asylum seekers are highly motivated educationally and regard school as a sanctuary, but may become so depressed about the uncertainty surrounding their status that they do not see the point of going to school. Removals from school or while children are in transit to and from school are becoming more common (Vevers, 2004).

Health

While most refugees arrive in London in satisfactory health, some have distinctive

health needs (European Refugee Fund, 2004). Available evidence suggests that asylum seekers and refugees generally are in poorer health than the UK population as a whole, both physically and mentally. The experience of being a refugee, which may include exposure to violence and persecution, fleeing traumatic events, living as a marginalised exile and being separated from family can leave refugee children with health problems.

In a survey of 140 asylum seekers in one London borough, it was reported that 95 per cent had been refused GP registration at least once in the preceding 12 months. PCT officers further noted that poor access to GP services was reflected in high use of hospitals' A & E facilities by asylum seekers in London.

Organisations working with refugees and asylum seekers identified difficulties in accessing language support as a particular problem in accessing primary care in London.

Problematic drug use

A recent report by the GLA detailed how the lives of young refugees and asylum seekers in the UK are likely to be affected by particular circumstances which have been identified as risk factors for the development of problematic drug use (Mayor of London, 2004). For instance, young refugees and asylum seekers, especially unaccompanied minors, are frequently affected by social and economic exclusion which have been shown to be risk factors for problematic drug use.

Young people with a strong desire to learn and who have positive experiences of education are less likely to develop drug-related problems. However, some young refugees and asylum seekers face barriers to accessing or achieving in education. Therefore the role that

education can play in protecting these young people from drug-related problems is diminished.

The link between mental health problems and drug use is well documented and many young refugees and asylum seekers report depression, loneliness, and isolation. Homelessness and problematic drug use are also closely linked, and of particular concern is that some young refugees and asylum seekers have been, or risk becoming, homeless in the UK.

Children and young people's views on health and health services

There have been a large number of consultations on children's views on health and health services and social care (for example, Morgan, R (2005) *Younger Children's Views on Every Child Matters* – see references). Researchers are getting better at accessing children's views, but there is some scepticism about the extent to which these views feed in to policy and practice.

We therefore include in this section some of the views expressed by children and young people, in response to the consultation on the Mayor's draft *Children and Young People's Strategy*. The children at Northview Primary School who sent in their thoughts on making London a child-friendly city illustrate that children understand the importance of addressing the determinants of health and reducing inequalities. For example:

"I think it would be good if we have nature reserves because children would be learning about nature and having a good time."

"We think that smoking should be banned as it can cause lung cancer and can also tempt children to smoke when they're older."

"We could make more places for children like funfairs, more children's shops, cleaner swimming pools, football pitches and tennis courts."

"No more poor."

"More traffic lights, street police, street lights..."

"More car free streets so children can play sport on the street."

"Crime has to stop."

Children & young people's priorities

The priorities children and young people themselves identify vary in the same way as they do for adults. When asked specifically about their health priorities, most people (adults and children alike) will tend to focus on health care concerns (views on hospitals or what they think about their GP) or on the commonly understood lifestyle factors such as diet, smoking, exercise and sexual health.

Yet there are some important public health priorities which are consistently identified by children and young people in a range of community surveys and consultations. Probably the most important of these is access to play and leisure activities. The consultation involving 3,000 children and young people as part of the *Every Child Matters* process was no exception. Asked about the kinds of services they would like to see provided in their school (apart from education), sports activities and social events were the most popular.

In addition to structured activities such as after school and youth club

facilities, successive consultations have shown the importance to children of being able to play out safely and freely, whilst a number of recent studies have highlighted the restrictions placed on children's freedom due to fear of traffic and 'stranger danger' (for example, Demos/Green Alliance, 2004). A study carried out by Barnardo's & Transport 2000 (2004) similarly found that many children interviewed were fearful of walking and cycling in their neighbourhoods because of speeding cars.

There are obvious links between access to play and sports activities and health concerns such as child obesity. These are being recognised in government policy both through the inclusion of 'enjoyment' as well as 'achievement' in the ECM outcomes framework and in the emphasis on places to go and things to do for young people in the recent *Youth Green Paper*. However, we still have some way to go before children and young people's need for better access to public space is fully recognised and acted upon.

There have now been many consultations with children about health in general, about their own health and health care, and the health and health care of their families. Many familiar problems (food, cleanliness, noise, respect, time, friends, privacy and confidentiality) arise time after time.

In one London consultation (Liabo et al, 2002), children and young people appreciated the fact that the vast majority of health care is not provided by the health services but by their families. In that sense, children and parents are providers as well as users of health care.

*And how is it like when the doctor is examining teddy?
He feels like he's at home
Why is that?
'Cause sometimes when he's at home his mum might be his doctor and the doctor help him to get better.*

Girl in group of 6-7 year olds

One group of young people felt that health care facilities could be cheerier:

*Young man 1: You see white innit?
Young man 2: Exactly and the only posters they have up say you could die if you don't take this – and that's supposed to lift your spirits!
Young man 1: You just see white.
It feels like you're dead already man!*

Group of 14 and 15 year old young men

According to a group of learning disabled children and their teacher, not only were some of them under-consulted (while other groups were sometimes over-consulted), there were gaps in age appropriate, and sensitive services. It was clear from their accounts that a degree of sensitivity is required on the part of health professionals with this particular group. Most of the young people described how visiting the doctor made them feel "sad", "embarrassed" or "scared".

Because I had to lift my top.

In this study, a group with some of the highest expectations (and lowest opinions) of the health services were young people at risk of poorest health outcomes in the longer term – 'looked after' children, children in contact with the law, children from asylum seeking

families and so on. Lack of access to interpreting and translation, lack of continuity of care for some 'looked after' children, including unaccompanied asylum seekers and a lack of mutual respect between some of the more challenging young people and health care workers all presaged poor health care both now and in the future for precisely those groups at greatest risk.

They don't talk to you. They do what they got to do and scruff you out the way...

They think, especially kids like us, they think we're faking it. We're lying: 'Just shut up and get on with it!'

What do health inequalities mean for children?

Children and young people are not simply objects of concern, they are active citizens with views and rights. In order to provide services that will be effective, we need to understand children's own experiences and evaluations of services and resources. Abstract health issues are not, on the whole, ones which children themselves raise. But there is no doubt that they are aware of the links between health, wealth and well-being. A study carried out by Newman (2000) illuminates children's concerns with their present and future circumstances by asking a large sample of junior school children: "If you had one wish come true, what would it be?"

Children tend to have an instinctive understanding of injustice and inequality – "That's not fair!". On the whole, they appear to believe in equal shares. Responses to Newman's question were infused with generosity and altruism:

'If I had a wish I would wish that my house was not being repossessed.' (Girl, 10)

'I wish I would not suffer from asthma so my mother doesn't have to do so much dusting. I wish my dad could have more time off work' (Boy, 10)

'That my family could be safe all their lives in a safe street' (Boy, 11)

'I wish that I could help the poor people who haven't got no food, water or nothing.' (Girl, 8)

'I would wish for a big house for all the homeless and money for the homeless and some clothes and shoes because it is nasty for people to be on streets.' (Girl, 11)