

Scottish Parliament Health and Sport Committee Inquiry into Health Inequalities - Early Years

March 2014

CELCIS is the Centre for Excellence for Looked After Children in Scotland, based at the University of Strathclyde. Together with partners, we are working to improve the lives of all looked after children in Scotland. Established in 2011, CELCIS has been committed to further improving the outcomes and opportunities for looked after children through a collaborative and facilitative approach focused on having the maximum positive impact on their lives. The rights of looked after children and care leavers are central to our work, particularly the need to be directed by the child's best interests and the meaningful participation of children and young people in decisions affecting them.

The Health and Sport Committee's scoping exercise into health inequalities highlighted that most of the causes of health inequalities are related to wider societal inequalities and outside its remit. As a result, other subject committees will be involved in the process. This is important: reports on Health Inequalities, from Black *et al* (1980), Acheson (1998), Wanless (2004) through to Marmot (2010) have all underlined the need to undertake a wide strategy of social policy measures to combat inequalities in health, with a particular emphasis on working with families with children. The Inquiry should take a broad approach to health inequalities and bring in learning from education, social work and child development as well as health. In addition, most of the causes of health inequalities are related to wider societal inequalities and socio-economic position; policies and measures which address these are likely to be more successful.

The Committee's attention is focused on early years interventions and current early years policy in addressing health inequalities, the barriers and challenges faced by early years services when working to reduce these, and the role the health service can play. Early years outcomes are powerful indicators of later morbidity and mortality that persist into older adult life, so inequality in the early years is important in and of itself and for the longer term. Research indicates that looked after children and care leavers generally have poorer health outcomes than their peers and remain one of the most vulnerable groups in society. This signifies an important health inequality which should be prioritised.

Context

As of July 2012¹, there were 16,248 looked after children in Scotland. A total of 2,706 children were on the child protection register, of whom 730 were also looked after. The total number of looked after children in Scotland has increased by 49% since 2001, but growth has largely been restricted to community-based placements such as foster care and kinship care (friends and relatives), which now constitute 59% of the total population. A further 31% are 'looked after at home' by birth parents, and 9% are accommodated in residential establishments.

There are multiple and complex reasons why children and young people become looked after, including neglect, abuse, parental substance misuse, involvement in the youth justice system or due to complex disabilities requiring specific care. Whilst looked after children and young people share many of the same health risks and difficulties as their peers, this is often to a greater degree and their long-term health outcomes are considerably worse. Hill et al (2006) note that despite the adverse factors in the backgrounds of looked after and accommodated children, physical health is generally good, but offers two important qualifications: many of the young people have lifestyles which present major threats to their present or future well-being and secondly, there is a high incidence of mental health problems. Some health problems and disabilities may be identified later in life; this includes physical health issues such as foetal alcohol syndrome (FAS) which may be particularly prevalent in children who become looked after because of parental substance use. A number of studies, including those conducted in Scotland, have identified that the mental health problems for looked after children are markedly greater than their peers. The first national survey of the mental health of young people looked after in Scotland found that:

- 45% of children and young people aged 5-17 looked after by a local authority had a diagnostic mental health disorder;
- Amongst children aged 5-10, 52% of accommodated children had a mental health disorder compared to 8% of children living in private households;
- 44% of children placed with birth parents, half of children placed in foster care and
- Two-fifths of children in residential care have a mental health disorder;
- Over 22% of looked after children surveyed had tried to hurt, harm or kill themselves; this rate was higher for children living in residential units (39%) compared to those with birth parents (18%) or foster carers (13%)

¹Scottish Government (2013) *Children's Social Work Statistics, Scotland, (2011-2012)*. Edinburgh: The Scottish Government

Key messages

- Looked after children share many of the same health risks and difficulties as their peers, but often to a greater degree. Their long-term health outcomes are considerably worse;
- Article 24 of the United Nations Convention on the Rights of the Child recognises the right of the child to the enjoyment of the highest attainable standard of health;
- Preventing health inequalities for looked after children requires investment in population-based programmes as well as in more targeted services ;
- Exposure to early adverse life events can affect the developing brain, exerting powerful effects on neural structure and function which can affect a child's life course. The brain develops rapidly in the first two years, but the majority of neurons are formed pre-birth ;
- There is often a mismatch between child development timeframes in the early years and timeframes or decision-making in children's services;
- Interventions which focus on building attachment and developing nurturing and supportive environments are important, particularly in the early years;
- Young people tell us that that stable placements and consistent, supportive relationships with carers had a huge influence on their emotional wellbeing, their achievements at school and their motivation to lead healthy lifestyles;
- Appropriate support provided to caregivers in the early years is important, particularly for those caring for disabled children; disabled children are more likely to be looked after, remain in care for longer and have a higher risk of being placed inappropriately compared to non-disabled children, which will affect their health and wellbeing;
- The health service has a key role in addressing health inequalities and ameliorating the health damage caused by disadvantage. Where looked after children have access to specialist health practitioners, their health outcomes improve;
- Barriers faced by early years services working to reduce health inequalities include: limited quantitative information on looked after children's health; short-term funding and support for initiatives; limited understanding about the role of the corporate parent and lack of understanding of children's rights and what this means in practice.

1. How effective are early interventions in addressing health inequalities?

There is often an assumption that policies tackling the determinants of health automatically tackle those of health inequalities; however, addressing the determinants of health inequalities requires consideration of the unequal distribution of health determinants (Graham & Kelly, 2007). Policies that have achieved overall improvements in key determinants of health have not always reduced inequalities and can have the opposite effect. Understanding this helps to determine the interventions and policies pursued. Objectives for health are likely to focus on reducing overall exposure to health damaging factors, whereas those tackling health inequality will focus on levelling up the distribution of health determinants. The drive for health improvement can result in an ‘inverse care law’ effect whereby the benefits of policies accrue to more advantaged groups and overall improvements in health mask continuing inequalities. Some policies may do both, but clarity of purpose is important. Preventing or reducing health inequalities for our most vulnerable members of society, including looked after children, requires investment in both population-based programmes as well as more targeted services. Marmot (2010) suggests that to reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity proportionate to the level of disadvantage: ‘proportionate universalism’. His report concluded that reducing health inequalities would require action on six policy objectives, the first being to ‘give every child the best start in life,’ crucial to reducing health inequalities across the life course. The rationale is clear:

The foundations for virtually every aspect of human development - physical, intellectual and emotional - are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and wellbeing - from obesity, heart disease and mental health, to educational achievement and economic status. To have an impact on health inequalities we need to address the social gradient in children’s access to positive early experiences. Later interventions, although important, are considerably less effective where good early foundations are lacking.²

Understanding the impact of adverse conditions

There is strong evidence to show that exposure to early adverse life events can affect the developing brain and exert powerful and potentially long-term effects on neural structure and function, which can affect a child’s life course. The impact on the brain is not constant throughout life with early experiences exerting a particularly strong influence in shaping the functional properties of the immature brain³. Many looked after children are exposed to adverse experiences, including pre-natal exposure to alcohol and/or other harmful drugs, neglect, sexual

²Marmot, M et al (2010). *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010* (The Marmot Review) London: UCL.

³The effects of early life adversity on brain and behavioural development Charles A. Nelson, III, Ph.D., Boston Children’s Hospital/Harvard Medical School, Harvard Center on the Developing Child

abuse, exposure to violence and parental instability (e.g. criminal behaviour, substance abuse etc.). The adverse childhood events study in California looked at the impact of nine types of adverse events and subsequent outcomes. It found that a young person who has experienced four or more adverse events in early life is eight times more likely to become an alcoholic and four times more likely to misuse drugs. A boy who experiences physical violence in early life is eight times more likely to use violence on his partner and four times more likely to be arrested for carrying weapons, a cycle of persistent harm which Scotland's Chief Medical Officer refers to as 'intergenerational mayhem'⁴. This needs to be understood in the context of environmental factors and parenting that undermine healthy development and their impact on outcomes for children as well as the mitigating impact of protective factors. Effective intervention in the early years can help to break this intergenerational cycle.

Decision-making timeframes

One of the most challenging issues in intervening effectively and promoting better outcomes for abused and neglected children is a mismatch between timeframes i.e. that of the child's development and those of the decision makers. Children who remain with parents who have not made substantial progress in overcoming adverse behaviour patterns and providing a nurturing home within a few months of birth may continue to experience maltreatment for lengthy periods. In families where children are abused or neglected, social work interventions can be effective if they are decisive, proactive and fit in with children's developmental timescales (Ward, 2011). Ward points to numerous intensive, evidence-based interventions shown to be effective, but notes that the longer that children experience abuse and neglect without sufficient action being taken, the less effective are even the most intensive interventions in promoting their long-term wellbeing. Furthermore, if these children are to remain at home, proactive engagement from social workers and other professionals must begin early.

Building attachment/ relationships

Young people tell us that stable placements and consistent, supportive relationships with carers had a huge influence on their emotional wellbeing, their achievements at school and their motivation to lead healthy lifestyles. Conversely, they note how detrimental unstable or changing placements can be upon their health and wellbeing⁵. Interventions which focus on developing nurturing environments are crucial, particularly in the early years. The bond between a child and primary caregiver in the first year of life is usually seen as the template for future relationship experiences, and children with secure attachments have developmental

⁴Presentation By Chief Medical Officer at the Early Years Collaborative October 2013

⁵The Regions Tackling Health Inequalities Project' (2013) *What have we learnt about health inequalities amongst children and young people in and leaving care in the West Midlands?* (National Children's Bureau)

advantages.⁶ If children have not developed emotional competence, they will struggle to manage the learning environment at school and into later life. There are various evidence-based attachment-promoting interventions in pregnancy and the early years e.g. *Mellow Bumps* aims to reduce maternal stress and increase pregnant women's awareness of the emotional needs of babies and *Circle of Security* works with high-risk pre-school children and their caregivers, using an attachment based intervention to help adults understand the concepts of a secure base (Furnivall: 2011).

Young people with care experiences are also more likely to have children at a younger age (Chase et al., 2009). This can pose challenges for young parents, due to limited finances, a reluctance to engage with professional services, little help from the wider family and a lack of residential provision to support these mothers (and sometimes fathers).⁷ Supporting pregnant teenage girls through pregnancy and the first couple of years of the baby's life can transform the lives of baby and mother. A mother who receives high-quality maternity care in pregnancy is in a good position to provide a good start for her child. Regular contact with health professionals and early antenatal booking is important as many vulnerable women may delay seeking maternity care until well into the pregnancy. Whilst universal services provide support for all pregnant women, some mothers may not take up these services. Targeted interventions such as the *Family Nurse Partnership* can be particularly effective: the aim is to improve pregnancy outcomes through better health-related behaviours and improved parenting. Nurses develop trusting relationships with mothers and family members and review their own experiences of being parented whilst promoting sensitive, empathetic care of their children. Evaluations have shown improvements in women's pre- and postnatal health; reductions in smoking during pregnancy, higher levels of breastfeeding and increased self-esteem. Breastfeeding provides optimal nutrition and is good for the health of the child and the mother. It also helps to build attachment. Whether the child is breastfed or other arrangements are made, it is essential that safe and sufficient food is provided. This can be an issue if a decision has been taken to take the baby into care, due to the risks being considered too great for the baby to be cared for by the parent. 'The ultimate priority is to ensure the baby receives adequate nutrition from the person responsible for providing the nutrition and ensuring sterilisation of feeding equipment. Alternatively if the priority is breast feeding, baby and breast should be together and social work needs to manage the risk'.⁸

⁶Furnivall. J., on behalf of Scottish Attachment for Action, Insights, IRISS

⁷ CELCIS (2013) Written Evidence submitted to the Scottish Parliament Health and Sport Committee: Teenage Pregnancy Inquiry

http://www.celcis.org/media/resources/publications/Response_Inquiry_into_teenage_pregnancy.pdf

⁸ Interview with LAAC nurse 28 March 2013

Support to caregivers

A further consideration is the support provided to caregivers in the early years. Furnivall (2011) points to a consistent theme in effective intervention for children looked after away from home, namely, the caregiver's capacity to reflect on the child's behaviour to help them understand the child's thoughts, feelings and needs. 'This apparently simple caring task can become overwhelming and frightening if children refuse to be confronted, despite every attempt to identify and respond to their needs and support from family and friends can be crucial to survive such moments of crisis' (p.8). The main factor alleviating stress for foster carers is support from professional or social networks. Attachment security of foster carers and adoptive parents can affect a child's outcomes and the quality of support provided is key particularly for those caring for disabled children. Equally, for children at home, timely and focused intervention that supports the development of secure attachments is important. Furnivall underlines the nature of this: 'Monitoring families cannot promote change and may undermine existing positive parenting strategies, as parents become de-skilled through fear of being judged. For infants and very young children, early intervention can be very effective, particularly where parents' own emotional and practical needs are also given attention' (p.6).

Types of interventions

If we wish to address inequalities in health for looked after children, we need to consider which interventions work. McIntyre (2007) notes that these can be directed at one or more of three levels: the structural or regulatory level; the local level and at individual or family level. More advantaged groups with better access to resources find it easier to access health promotion advice and preventative services (e.g. immunisation, dental check-ups). Disadvantaged groups tend to be harder to reach and can find it harder to change behaviour, e.g. a mass media campaign intended to reduce socio-economic differences in women's use of folic acid to prevent neural defects in babies resulted in more marked social class differences in use than before the campaign (McIntyre: 2007). McIntyre suggests that interventions with more disadvantaged groups will need to be more intensive and targeted: information-based approaches such as pamphlets in GPs surgeries, media campaigns or those requiring individuals to 'opt in', may be less effective amongst these groups. An interesting intervention is *Mellow Parenting*, a programme aimed at parents of children under five. It has a theoretical basis in attachment theory, behavioural theories, cognitive behavioural therapy and social and experiential learning, and was originally developed to meet the specific needs of vulnerable, hard-to-reach families, many of whom have experienced abuse and disruption in their own childhoods. Evaluations have shown improvements in mother-child interaction, mothers' effectiveness in parenting and children's language and non verbal abilities.

2. What are your views on current early years policy in Scotland in terms of addressing health inequalities?

The commitment to addressing health inequalities in Scotland is demonstrated by the range of initiatives, policies and frameworks produced over the last few years. Four of the Scottish Government's 15 National Outcomes (2007) relate to health inequality in the early years and the three social policy frameworks: *Equally Well (2008)*, the *Early Years Framework (2008)* and *Achieving Our Potential (2007)* reinforce this. The move away from screening and health promotion to prevention is welcome, and a preventative approach is reflected in the *Children and Young People (Scotland) Bill 2014*. This enshrines GIRFEC in statute, ensuring that health and wellbeing will be assessed from birth and joint planning arrangements will be strengthened through Children's Services Plans. Feedback on the Early Years Collaborative, working through Community Planning Partnerships (CPPs) suggests that it is fostering a learning approach, helping front line practitioners to think through solutions, although there is some concern around how the various plans and frameworks sit together. An important message, sometimes missed, is that the Collaborative will support implementation of GIRFEC to take forward the transformational change set out in the *Early Years Framework*, through a quality improvement framework.

The re-introduction of the 27-30 month check on developmental milestones is also welcome, as developmental delay can indicate that things are not well at home and interventions can be put in place to help a child enter school socially and emotionally ready and able to learn. There is, however, a danger that in focusing too heavily on developmental milestones, we can miss seeing children in their wider context. The *National Practice Model* provides a useful framework, allowing information to be analysed and shared appropriately to understand a child or young person's needs and for a consistent chronology to be developed. 'Good assessment may be as much part of an intervention as the intervention itself...without intelligent sensitivity and engagement, professionals risk falling into the trap of allowing these to become mechanistic, and ultimately counterproductive, tick box exercises' (Davies and Ward, 2012, p.64).

Children and Young People (Scotland) Bill 2014

In the Stage 3 debate of this Bill, the Minister for Education and Young People stated that the Bill took a universal approach, noting that 'if we begin to recognise some groups of children, this undermines universality'. Notwithstanding this, key provisions were made to the looked after sections of the Bill, a recognition that these children face the greatest challenges and need extra support. The continuing care provisions, whilst not addressing early years directly, will enable young people to remain in their current care placement beyond 16 and up to 21. Young care leavers are particularly vulnerable, their health and wellbeing much poorer than those who have never been in care. These provisions recognise that the pressures associated with

independent living can have a detrimental impact on the health of young care leavers and potentially place them at risk. These are the parents of the future, more likely to be parents than their peers, so considering this within the context of the early years is relevant, notwithstanding the fact that they have a right to good quality health care. Their stability at 18 and upwards in both placement and in relationships is an acknowledgement of the corporate parent role - that we have a responsibility to look after our young people in the way that any good parent would do and ensure that these young people are not placed at a disadvantage compared to their peers. The Bill also defines Corporate Parenting in statute and clarifies the public bodies to whom this applies. It is essential that this role is understood in practice and we hope that a statutory provision will help to move this on.

Overall, early years policy in Scotland has the potential to make inroads into health inequalities in Scotland. These policies apply equally to looked after children, but major inequalities continue to exist for these children. Of particular concern are the specific needs of looked after disabled young people. Evidence shows that they are more likely to be looked after, remain in care for longer and have a higher risk of being placed inappropriately compared to non-disabled children, which will have an impact on their health and well being. Davies and Ward (2011) note how difficult it can be to recognise neglect and emotional abuse amongst disabled children and agencies may fail to recognise indicators of neglect, or be reluctant to act in the face of concerns. The *Recognition of Adolescent Neglect Review (2011)* also found that disabled children are more vulnerable to abuse and neglect because inadequate or poorly coordinated services can leave their families unsupported and isolated. Children with a learning disability are over-represented amongst looked after children; it is essential that we establish how many of these children there are to allow provision to be targeted appropriately (Allerton et al, 2011).

3. What role can the health service play in addressing health inequalities through interventions in the early years?

The health service has a key role in addressing health inequalities and ameliorating the health damage caused by disadvantage. Universal health services have a preventative and inclusive effect: antenatal care, health visiting, free obstetric care, vaccination programmes and school health services are important for preventing inequalities (Macintyre, 2007). Many looked after children will have missed vaccinations because of frequent moves or failing to turn up for appointments and flexible approaches and consistent record keeping will be needed to improve and monitor take up. The need for a specific focus on looked after children's health has been recognised by the Scottish Government. In 2010, the Ministerial Task Force called for a shared sense of responsibility for the outcomes of looked after children, stressing the role of NHS Boards in health and health improvement. Two important pieces of guidance have also been

produced: *We Can and Must Do Better* (2007) stressed that ‘the health of our looked after children and young people remains poor when compared to other children and young people: this has the potential to have a serious and negative impact upon educational outcomes and future lives’. Action 15 of the guidance called on Health Boards to assess the physical, mental and emotional needs of all looked after children and young people and put in place appropriate measures to take account of these assessments. The National Residential Child Care Initiative (NRCCI) (2009) saw this as a matter of urgency and it became a requirement in CEL16 (2009). The recognition that Health Board Directors have a responsibility for looked after children and young people and care leavers in their area, including those looked after at home is an important recognition of their essential role as corporate parent. *These Are Our Bairns* (2008) called on local authorities, health services and other agencies to focus on their corporate parenting duty ‘to promote health, to protect health, to assess and identify health-related risks and to treat health problems’. Despite this requirement, provision is patchy.

Evidence shows that where looked after children have access to specialist health practitioners, their health outcomes improve. Looked After and Accommodated Nurses provide a key service and can adopt flexible approaches to service delivery. A rights-based approach which puts the best interests of the child at the centre is particularly important at the birth of the child when other interests may conflict, for example breast feeding and the testing for blood-borne virus exposure for babies and young children. Inequalities in health are not just for the health service, they are an issue for the whole of society. The issue will not be addressed satisfactorily if it is seen as a job only for the NHS.⁹

3. What barriers and challenges do early years services face when working to reduce health inequalities?

Limited quantitative information on looked after children’s health or needs: In 2013, the Scottish Public Health Network undertook a health needs assessment of looked after children in Glasgow and Scotland, recognising that these children are likely to have poorer outcomes relative to the general population. However, unlike educational outcomes, there is no requirement to collate health outcome data. It found that although case management, driven by GIRFEC, had improved multi-agency information sharing and there was good ‘tacit’ knowledge on the health needs of looked after children, there was little evidence of quantifying health outcomes for looked after children and young people as a group, impeding efforts to assess population needs and evaluate the effectiveness of interventions. A further barrier was the variability of IT systems which limited the ability to collect and report on health data. In addition, multiple IT systems across services and multiple unique identifiers presented a

⁹Harry Burns, Chief Medical Office, Evidence to the Health & Sport Committee, Scottish Parliament, 22.01.13

challenge in linking data effectively, a barrier to increased understanding of this group of children. The report also noted that there is currently no routinely accessible information on the reasons young people become looked after, making the point that established grounds for referral are not the same as reasons for entering care. A more consistent typology of 'reasons for care' was recommended to enable analysis to be carried out in a way that would help to direct preventative action. The importance of basing service planning on high quality information was emphasised in *Delivering a Healthy Future* (2007) and in *GIRFEC* (2006). We welcome the forthcoming Scottish Government guidance on *Health Assessments for Looked After Children*, which will set out the health data which should be collected on looked after children.

Short term funding and support for initiatives: In evidence to the Audit Committee, a health visitor from Govanhill commented on targeted funding provided in 2008 in South East Glasgow for an infant feeding team: 'just as we were getting up and running and what we were doing was beginning to work, the money was removed and our team went'.¹⁰ There is a need to stop allocating short-term funding to problems which require long term attention. This is especially the case with early years initiatives, which by their nature have a constant flow-through of new children and families.

Workforce capacity and quality: Workforce capacity and quality is an important part of ensuring positive health for looked after children. Health visitors, midwives and LAAC nurses are vitally important in reducing inequality in child outcomes.

Improving the role of the corporate parent: Responsibility and accountability for the wellbeing and development of looked after children and young people rests with the corporate parent. A good corporate parent should offer everything a good parent would, including stability and care and should confront the difficulties these children experience. An understanding of children's rights is an essential component of this role.

Children's rights: Children's rights should inform all decisions affecting looked after children, the best interests of the child being a key consideration. Anecdotal evidence suggests that children's rights training would be helpful across services: LAAC nurses talk of a failure to understand issues of consent; a failure to ascertain the views of children in decisions affecting them, particularly around health; the over-riding of choices made by children who have capacity to make informed choices; and examples of inappropriate information sharing. A particular failing is in ensuring that disabled children are involved in decisions affecting them e.g. assessment, planning and review. Many of these children will be away from those with whom

¹⁰ Scottish Parliament Public Audit Committee *Official Report*, 30 January 2013, Col 1165

they usually communicate, so facilitating effective communication is important. Argent and Kerrane (1997) argue that no child is too impaired to be informed about what is going to happen in a way she can understand.

5. Are there any specific initiatives or research evidence from Scotland, UK or internationally that you would wish to highlight to the Health and Sport Committee?

CELCIS would be delighted to support the Committee in its work on effective early intervention to reduce health inequalities. We also wish to highlight some of the work referred to within this response which the Committee may find helpful.

Decision-making within a child's timeframe: Harriet Ward, Professor of Child and Family Research, Loughborough University and co-director of the Childhood Wellbeing Research Centre, has a particular interest in the mismatch between timeframes for childhood development and those for decision-making services. Her recent work starts from the premise that we know that the relationship between a child and the primary care giver is key to developing attachment. New research tells us that attachment mediates every aspect of early childhood development and shapes the development of the brain and central nervous system, affecting the child's cognitive development and the child's ability to negotiate key tasks e.g. impulse control and the development of trust and attachment, the basis for social, emotional and behavioural development. She also underlines that what happens in the womb has an impact on the rest of your life which is not sufficiently taken into account (the majority of neurons are formed pre-birth). This has implications for timeframes when making decisions about what should happen to very vulnerable children. Her recent work has been following a cohort of very young children (from birth to five), identified as suffering or likely to suffer significant harm.

The Total Environment Assessment Model of Early Child Development (TEAM-ECD): This was recommended by the Early Child Development Knowledge Hub of the World Health Organisation. This framework places emphasis on the environments that play a role in providing conditions to all children in an equitable manner. These environments, where the child grows up, lives and learns are interconnected and place the child at the centre. They are situated in a broad socio-economic context, shaped by factors at the national and global level. The framework stresses the importance of a life course perspective in decision making regarding child development and recognises that any action taken at any of these levels will affect children not only in the present day, but throughout their lives. All recommendations come from over overarching goal: to improve the nurturant qualities of the experiences of all children. This framework was influential in the deliberations of the Marmot Review's (2011) working group.

General Comments from the United Nations Convention on the Rights of the Child: General Comments are official statements, adopted by the Committee on the Rights of the Child, which clarify aspects of the Convention that require further interpretation. They are particularly helpful for practitioners who wish to ensure that a rights-based approach informs their work. General Comment 7 (2005) *Implementing child rights in early childhood* is particularly relevant.

The work of the Family Drug and Alcohol Court (FDAC) pilots in London: Established as a pilot in 2008, FDAC provides a new model of care proceedings where parental substance misuse is a key factor in causing harm to a child. The new court, based on a successful US model, aims to address the treatment needs of parents to allow families to stay together. Under the FDAC system, parents are getting immediate access to substance misuse services and families are also benefiting from the court's assistance in addressing other issues affecting their ability to parent, such as housing, domestic violence and financial hardship. The Nuffield Foundation and the Home Office have funded Brunel University to carry out an independent first stage evaluation of FDAC. The evaluation team published its interim report in September 2009 and its Final Report in May 2011.

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