Childhood development, education and health inequalities

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Acknowledgements

This review is a joint effort. However, the work for section 2 was led by Clyde Hertzman and Ziba Vaghri, for section 3 by Helen Roberts, and for section 4 by Jane Tunstill. Alan Dyson led the work for section 5 and the introductory and concluding sections.

We would like to express our thanks to a wide range of colleagues who assisted with reviewing and/or shared their expertise with us. These were Josephine Kavanagh, Claire Stanfield and James Thomas in the Eppi-Centre at the Institute of Education, Danny Dorling at the University of Sheffield, Richard Mitchell at the University of Glasgow, Jennie Popay at the University of Lancaster, Susan J Smith at the University of Durham, Frances Gallannaugh, Ian Plewis, Michael Wigelsworth and Anne Lendrum at the University of Manchester, Katherine Weare at the University of Southampton, June Thoburn at UEA, and Derek Colquhoun at the University of Hull. We would also like to thank Jason Strelitz, Ilaria Geddes, and Peter Goldblatt of the Review Secretariat for their help and support. The support and assistance of these colleagues has been invaluable. However, the conclusions we reach and any errors and omissions are, of course, our own.

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Executive summary

1. This review builds on the work undertaken by the Commission on the Social Determinants of Health, and, specifically, on chapter 5 of the Commission's *Closing the Gap* report. That chapter, *Equity from the Start*, focuses on the relationship between what happens to children as they grow up and learn, the services that are provided for them and their families, and health outcomes during childhood and on into adult life. Our task has been to take the broad analyses and recommendations of the Commission's report and to contextualize them for England, drawing particularly on new and under-used evidence.

2. We have focused on evidence that has a direct bearing on the relationship between public policy, childhood, and health inequalities. In the time available, a comprehensive review of the evidence would have been impossible. We have, therefore, relied heavily on our own expertise and prior understanding of the research evidence in this area, and that of various colleagues whom we have consulted. This has been in addition to reviewing as much additional secondary and primary material as has been feasible within a short timescale.

3. Children live, grow up and learn through their interactions with a wide range of interconnected environments – including the family, residential communities, relational communities, and the environment of child development services (such as the childcare centres or the schools that children attend). Each of these environments is situated in a broad socioeconomic context that is shaped by factors at the local, national, and global level.

4. Whether children do well depends to a very significant extent on the 'nurturant' quality of these environments.

5. How well children do during childhood has implications for health outcomes in later life. However, the pathways linking childhood environments, childhood outcomes, and health outcomes are complex.

6. Notwithstanding the important future orientation of the points above, ensuring that children have a good childhood in the here and now is also important. Children in England do not have access to equally nurturant environments, while childhood outcomes and subsequent health outcomes are unequal. Policy which is concerned with reducing health inequalities, therefore, has to be concerned with

these wider inequalities, and has to tackle inequalities in the broad socioeconomic context underlying childhood environments.

7. 'Children's policy' has to embrace not only measures directly targeted at children, but any measures which support and enhance families, communities and neighbourhoods. Single-strand policies, short-term programmes, and one-off interventions may have their place as part of a wide-ranging strategy of this kind. However, on their own they do not offer an adequate basis for an approach to reducing health inequalities.

8. Strong public services have a particular role to play in equalizing access and outcomes. However, that role has to be carried out in partnership with the families and communities who interact most closely with children, and in a context where families and communities have the best possible chance of creating favourable environments for their children.

9. In the light of these considerations, there is much to applaud in the current policy situation in England. In particular, there is a recognition that social inequality matters, that action to improve children's lives needs to be multi-dimensional, and that high-quality public services play a key role in children's lives. Many of the policy tools needed to improve children's lives are, therefore, already to hand.

10. The need beyond 2010 is less to develop new policy interventions and frameworks than it is to ensure that those already in place are working as effectively as possible. In any case, the challenge will be to protect what has already been achieved and to see that it is deeply embedded so that it is proof against financial turbulence.

11. On the other hand, efforts to address inequality have had mixed results, while attempts to marshal strategic, coordinated action are thwarted by fragmented and counterproductive accountability systems, a multiplicity of short term service targets, and over-centralisation.

12. We therefore recommend that, post-2010, policy makers should:

    - *Renew efforts to tackle social inequality*. These efforts should build on current commitments to end child poverty, maintain or increase the minimum wage, keep the adequacy of benefits under review, and narrow the gap between the best and worst off. They should extend these efforts through a more rigorous pursuit of progressive fiscal and welfare policies, together with efforts to combat social exclusion. This strategy should include transport and housing interventions which have been shown to have the potential to reduce the steep gradient in morbidity and mortality in the young.
    - *Develop and pursue a coherent, evidence-informed and values-driven policy narrative about childhood*. This narrative should build on the work that has already been done in the Every Child Matters and children's rights agendas to

offer a clear account of how one aspect of child development informs others, why some children do better than others, how public services work together and work with families and communities, and, above all, why equality matters.

- *Develop coherent policy strategy*. This should build on policy efforts to bring relevant policy together within a single overarching framework, redirect effort from central micro-management to strategy, and redirect resource from short-term disconnected initiatives towards core provision.
- *Devolve more policy development to the local level*. Devolution should build on existing commitments to 'new localism', but reduce the numbers of centrally-generated targets and initiatives.
- *Learn from the local*. This involves shifting the emphasis from centre-periphery to periphery-periphery and periphery-centre policy making, supporting and studying promising local initiatives, and creating structures and processes (like the new Centre for Excellence and Outcomes) for learning from local initiatives.
- *Change the emphasis of control and accountability*. There is a need to build on current moves to develop joint inspection procedures and area assessments, but to reconstruct targets as indicators, develop area assessment as a means of holding local providers and policy makers jointly to account for what happens to children, focusing on the coherence of local strategies as well as immediate outcomes, and extending the time scale for accountability to consider long-term outcomes.
- *Change the professional orientation of the children's workforce*. In developing an integrated workforce, policy should be formulated on training, recruiting, retaining and appropriately remunerating those who work with children. This will involve enabling the exercise of professional judgment at a local level, and resisting the temptation amongst those in senior political positions to vilify the workforce.
- *Develop the evidence base*. Established sources of evidence should be built on through a more coordinated and strategic approach to evaluation, research and monitoring. This would involve raising the standard of evaluation studies, developing focused research programmes, and building local and national research capacity.

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1. Introduction

This paper builds on the work undertaken by the Commission on the Social Determinants of Health, and, specifically, on chapter 5 of the Commission's *Closing the Gap* report[i]. That chapter, *Equity from the Start*, focuses on the relationship between what happens to children as they grow up and learn, the services that are provided for them and their families, and health outcomes during childhood and on into adult life. It argues that experiences and outcomes in childhood have a major impact on later well being, and therefore that 'equity from the start' is an essential component of any attempt to improve health outcomes overall and address health inequalities in particular.

Our task has been to take the broad analyses and recommendations of the Commission's report and to contextualize them for England. We have been tasked in particular with considering new and under-used evidence to make recommendations for action that might be taken both by central government and by decision-makers at local level. This is no simple task. Our field is an extremely broad one. Internationally, much attention has been focused on what happens to children in the care of their families (however constructed) in the early years – what is often known as 'early child development'. However development of this kind is not simply some biologically driven process, nor one that is dependent solely on the micro-level interactions between child and carers. As the next section makes clear, children live, grow up and learn in a range of environments. These most certainly include the family (in all its forms), but they extend much wider and deeper, into communities, social structures, national policies and global changes. Similarly, as children grow older, biologically-driven change continues to happen and families remain important, but new kinds of environments appear – most notably, the school – and new kinds of change take place.

What happens to children can be described in many ways – changing, developing, growing, learning, maturing. So can the contribution of public services and policies – supporting, nurturing, teaching, empowering. All of these terms are necessary, and none of them is sufficient. Even the term 'childhood' is ambiguous. There is no arbitrary point at which childhood ends and adulthood begins, and terms such as 'infant', 'baby', 'pre-schooler', 'adolescent', 'young person', or 'young adult' all have their claims to be used instead of 'child'. What is clear is that our task has been to consider a wide range of

different kinds of change, across a range of overlapping phases, in which a wide range of social practice and public policy are implicated.

With this in mind, we have, therefore, made some inevitably arbitrary decisions about how to tackle our task. In particular:

- We have opted to focus on the period between conception and age 16. The former is the point at which public policy begins to impact on the child. The latter marks the end of the single biggest state intervention in most children's lives, statutory schooling. This is not to say, of course, that what happens to the future family before conception is unimportant, nor that education ceases for many young adults after age 16.
- We have focused on evidence that has a direct bearing on the relationship between public policy, childhood, and health inequalities. There is a vast array of evidence on how children change, why outcomes are unequal, and how public policy might change things. Indeed, there is a strong case for a review of educational inequalities or childhood inequalities more generally, like the review of health inequalities of which our work forms a part. However, we have had to take many of these wider issues as read in order to stick to our task of focusing on evidence that relates more closely to health outcomes.
- Even within these boundaries, a comprehensive (let alone, systematic) review of the evidence would have been impossible. We have, therefore, relied heavily on our own expertise and prior understanding of the research evidence in this area, and that of various colleagues whom we have consulted, supplemented by reviewing as much additional secondary and primary material as has been feasible within a short timescale.

The remainder of this review is organized as follows:

- The next section (section 2), presents a model of how the environments bearing on child development can be understood. This model has been formulated under the aegis of the World Health Organization Commission on the Social Determinants of Health, as a means of conceptualizing early child development and the role of policy in supporting that development. However, the principles on which it is based extend, we suggest, throughout the whole of childhood and therefore provide a powerful framework for our review
- In section 3, we turn more specifically to the English context. We review where England stands in relation to the Commission's recommendations, and what evidence tells us about the kinds of policy interventions that might make a difference.
- In section 4, we pay particular attention to families as the single most important context in which children live, learn and grow up. We address the question of how families can best be supported so that they in turn generate positive outcomes for their children.
- In section 5, we examine the role of the education system during the statutory school years. If families are the most important context for children's development, schools mark the single biggest investment by the state in the lives

of children, and educational outcomes have major implications for life chances and for health.

- Finally, in section 6, we draw out the implications of our review and make some specific recommendations for the direction policy might take from 2010.

2. A model for understanding child development

2.1 Introduction

Current child health related policies in England represent examples of increasingly robust international concepts which recognize that a child's life-chances are shaped by a variety of factors. In England, such concepts have been embodied in the Every Child Matters policy[ii] initiated in 2003, and more recently by the Healthy Child Programme[iii]. England's pioneering status in a series of valuable cohort studies related to child health is a further testimony toward the country's commitment to child development.

Work in the areas of child development, family support and education has generated multiple frameworks within which a working model can be conceptualized. A recent example, which is particularly useful, is the Total Environment Assessment Model of Early Child Development (TEAM-ECD), recommended by the Early Child Development Knowledge Hub of the World Health Organization[iv].

The framework of TEAM-ECD puts emphasis on the environments (and their characteristics) that play a significant role in providing 'nurturant' conditions to all children in an equitable manner. The framework operates as a guide to understanding the relationships between these environments, while it puts the child at the centre. These environments are not strictly hierarchical, but are in fact interconnected. At the closest level is the family environment. At a broader level are residential communities (such as neighbourhoods), relational communities (such as those based on religious or other social bonds), and the environment of child development services (such as the childcare centres or the play groups that children attend). These are the environments within which the child grows up, lives and learns. Each of these environments is situated in a broad socioeconomic context that is 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 recognizes that any action taken at any of these environmental levels will have an effect on children not only in present day, but also all through their lives. The framework also suggests that historical time is crucially powerful for children; large institutional and structural aspects of societies (e.g., government policy-clusters, programmes, and the like) matter for children's development, and these are 'built' or 'dismantled' over long periods of time.

Socioeconomic inequities in developmental outcomes result from inequities in the degree to which the experiences and environmental conditions for children are nurturant. Thus, all recommendations for action stem from one overarching goal: to improve the nurturant qualities of the experiences children have in the environments where they *grow up, live, and learn.* A broad array of experiences and environmental conditions matter. These include those that are intimately connected to the child, and, therefore, readily identifiable (e.g., the quality of time and care provided by parents, and the physical conditions of the child's surroundings), but also more distal factors that in various ways influence the child's access to nurturant conditions (e.g., whether government policies

provide families and communities with sufficient income and employment, health care resources, early childhood education, safe neighborhoods, decent housing, etc.).While genetic predispositions and bio-physical characteristics partially explain how environment and experience shape child development during the early years, the best evidence leads us to consider the child as a social actor who shapes, and is in turn shaped by, his or her environment. Because strong nurturant relationships can make for healthy child development, socioeconomic circumstances, even though they are important, are not fate.

Frameworks of this kind have major implications for the type of policies required to improve children's life chances and, more specifically, to address the issue of health inequalities. If outcomes are affected by and measured within multiple contexts then policies need to reflect these contexts as well. Specifically, these policies need to address the range of multiple contexts in a suitably broad manner. More limited interventions, i.e. interventions relevant to a single context, have their place, however, they are unlikely to maximize life chances for children. A balance needs to be reached between national and local level interventions, and more generally interventions targeting the proximal and distal environments of the children. The implementation of policies that take into account some of these complexities requires a work force with a varied expertise which is able to assess, detect and respond to needs and also make informed policy related decisions.

We explore some of the implications of these values for policy design and implementation in respect to the relationship between child development and education as a strong social determinant of population health and health equity.

2.2 Applying a framework for understanding the social determinants of early child development to England

Healthy early childhood development, including the physical, social–emotional, and language–cognitive domains of development, strongly influences many aspects of well-being, such as obesity/stunting, mental health, heart disease, competence in literacy and numeracy, criminality, and economic participation throughout life. What happens to the child in the early years is critical for the child's developmental trajectory throughout the life course[v] [vi].

In every society, regardless of GDP/capita, inequities in socioeconomic resources result in inequities in child development. The relationship is much more subtle than solely differentiating the rich from the poor; rather, any additional gain in social and economic resources to a given family results in a better projection for positive development of the children in that family. This step-wise relationship between socioeconomic conditions and child development is called a 'gradient effect.' In light of this effect, we need to be concerned with those at the bottom of the gradient – but not solely so. Actually, gradients mean that the highest overall burden of adverse outcome is spread across the middle, and is not at the lower end. This means that the most rational strategy for improving child development is to try and flatten the gradient through spreading the conditions for healthy child development as broadly as possible throughout society. We know that some societies are more successful than others at flattening the gradient and thus promoting

higher levels of child development. Societies accomplish this by providing a range of important resources to children as a right of citizenship, rather than allowing them to be a luxury for those families and communities with sufficient purchasing power. Because the United Kingdom, unlike some other OECD countries such as Canada and Australia, does not have a system of population-based measurement of early child development, at present it is difficult to compare the steepness of UK gradients in child development with other countries.

The environments in which children are born, grow up, and live and learn and the nurturant quality of these environments have a significant impact on children's development. These environments, from the most intimate (the family) to residential communities (such as neighbourhoods), relational communities (such as those based on religious or other social bonds), the Early Child Development (ECD) service environment, the national environment and to the global environment, each insert an effect on child's development through many direct and indirect avenues (Figure 2.1). While this model has been constructed specifically in relation to child development in the early years (0-5), the principles can be applied to the whole of childhood.

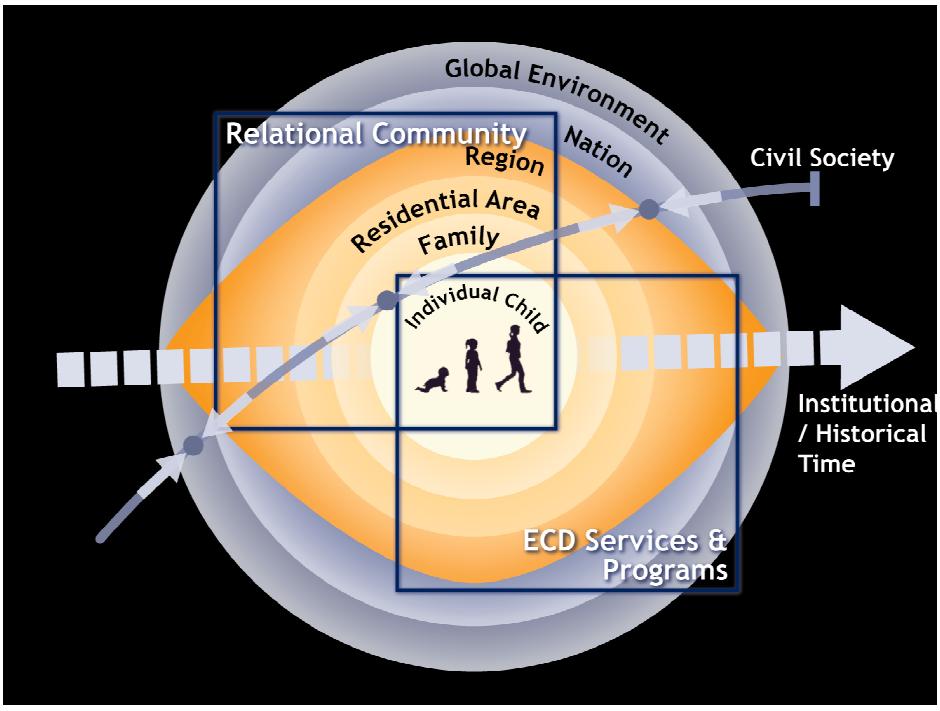

Figure 2.1: Model of the social determinants of early child development

The family environment is the primary source of socioeconomic and relational experiences for a child. Both family members and primary caregivers provide the largest share of human contact with children. In addition, families mediate a child's contact and connection with the broader environment. Family social resources include parenting skills and education, cultural practices and approaches, intra-familial relations, and the

health status of family members. Economic resources include wealth, occupational status and dwelling conditions. Abundant evidence suggests that family socioeconomic status (SES) is associated with a multitude of development outcomes for children all across the world[vii] [viii] [ix] and the tremendous influence of maternal education on providing children with stimulating and supportive, and nurturant environments[x] [xi].

Further, the literature suggests strongly that socioeconomic gradients in early childhood replicate themselves as socioeconomic gradients throughout the human lifecourse[xii]. This gradient effect of family resources on child development during the early years is the most powerful explanation for differences in children's well-being across societies. Young children need to spend their time in warm and responsive environments that protect them from inappropriate disapproval and punishment. They need opportunities to explore their world, to play, and to learn how to speak and how to listen to others. *Families need support from community and government at all levels in order to provide these opportunities for their children.* This contradicts a very different ideology which has often informed policy in many countries in the English speaking world (though arguably less so in the UK) – the ideology of *families versus the state.* That is, families should take care of their own children until they reach school age, or else they are a failure. Only at school age is state-sponsored, universal access to developmental resources (in the form of school) offered. Before this age, the state should only provide compensatory programmes for families and children 'at risk'. This philosophy has resulted in an underinvestment in early child development in the English speaking world, such that only one English speaking country spends more than one percent of its GDP on early childhood development, education and care; while no non-English-speaking wealthy country spends less than one percent.

Children and their families are also shaped by the **residential community** (where the child and family live) in which their **relational communities** may be rooted. Residential and relational communities provide multiple forms of support for families. These supports can vary from provision of goods and services that aid with child rearing, to emotional connections with others that are instrumental in the well-being of children and their caregivers. At the residential level, both governments and grass-roots organizations also play a highly influential role. Many resources available to children and families are provided at a community-level through local recognition of deficits in resources, problem-solving, and ingenuity. There are, however, inequities in the development of children that are apparent between residential communities, which must be addressed in a systematic way. Such differences exist even in OECD countries.

'**Relational community**' refers to the people, adults and children, who help form a child's social identity. This could be within ethnic, religious, or language/cultural networks and often is not confined to a geographically clustered community. Relational communities provide a source of social networks and collective efficacy, including instrumental, informational, and emotional forms of support. However, discrimination, social exclusion, and other forms of subjugation are often directed at groups defined by relational communities. As a consequence this discrimination can lead to indiscernible inequities. Moreover, relational communities can be sources of gender socialization, both equitable and non-equitable. Relational communities are also embedded in the larger socio-political contexts of society; as such, reciprocal engagement with other relational groups, civil society organizations, and governmental bodies, is a means of addressing the interests and resource needs of their members. The relational community is very salient for England, since it is a destination country for global migration.

The availability of **child development programmes and services** to support children's development during the early years is a fundamental element of an overall strategy for success in childhood. These services may address one or more of the key developmental domains (i.e.,

language–cognitive, socio–emotional, and physical development). The quality and appropriateness of services is a central consideration in determining whether they improve outcomes for children. There are principles of child development programmes and services that make them potentially transferable between places. In transferring these programmes from one place to another care should be taken to tailor the programme features to the social, economic, and cultural contexts in which they are placed. Some of these services may be targeted to specific characteristics of children or families (e.g., low birth-weight babies or low-income families), and may occur only in some communities and locales and not others, or may be more comprehensively provided. Each of these is also accompanied by their respective benefits and drawbacks; however, the overarching goal should be to find means of providing universal access to effective child development programmes and services during the early years.

The influence of the **national environments** is significant in determining the quality and accessibility of services and resources to families and communities. They are also most important for understanding the levels of social organization at which inequalities in opportunity and outcome may be manifest, and similarly for understanding the entry points at which actions can be taken to buffer inequities.

The most salient feature of the **national environment** is its capacity to affect multiple determinants of child development during the early years through wealth creation, public spending, child and family-friendly policies, social protection and protection of basic rights. At the level of the national environment, comprehensive, inter-sectoral approaches to policy and decision-making work best for child development. Although child development outcomes tend to be more favorable in wealthy countries than poor ones, this is not always the case. The policy-level commitment made to child development by many resource-poor nations has made it possible for these countries to offer conditions that are far more nurturant for children than their resource-rich counterparts.

The **global environment** can have a great impact on child development during the early years through its effects on the policies of nations and also through the direct actions of relevant actors, such as multilateral economic organizations, industry, multilateral development agencies, non-governmental development agencies, and civil society groups. Monitoring realization of the United Nations' Convention on the Rights of the Child (UNCRC) is a mechanism through which international inspection can be used to support investment in early childhood.

Civil society groups are organized at, and acting on, all levels of social organization, from local residential through global. The capacity of civil society to act on behalf of children is a function of the extent of 'social capital', or connectedness of citizens, and the support of political institutions in promoting expressions of civil organization. There are many avenues through which civil society can engage on behalf of children, if civil society has adequate capacity. For example they can initiate government, non-government organization, and community action on social determinants of child development during the early years. They can also crusade on behalf of children to assure that governments and international agencies adopt policies that positively benefit children's well-being. Lastly, civil society groups can

organize strategies at the local level to provide families and children with effective delivery of child development services, to improve the safety, cohesion, and efficacy of residential environments, and to increase the capacity of local and relational communities to better the lives of children. Research on the direct effect of civil society on child development during the early years is limited; however, the strong association between the strength of civil society and human development in societies across the globe leaves little doubt about its importance to child development in the early years.

2.3 Conclusion

It is evident that good health in the adult is predicated on good health in the child. Many of the key determinants governing health have their roots in the biological and social experiences that span childhood. A healthy child population is not only one of the indicators of a society's present health, but it is also an index of the society's future well being and productivity.

What a child experiences during the early years lays down a critical foundation for the entire lifecourse. A child's development, including physical, social–emotional and language–cognitive domains, during the early years strongly influences basic learning, school success, economic participation, social citizenry, and health. The principal strategic insight of the discussed model is that the nurturant qualities of the environments where children grow up, live, and learn matter the most for their development, however, parents cannot provide strong nurturant environments without support from local, national, and international agencies. In this section we have focused particularly on development from 0-5. However, children do not cease to learn and grow at some arbitrary point. As they grow older, the relative importance of different environments may change – families may become marginally less important, for instance, whilst peer groups and formal educational provision become more so. However, the *principles* that apply to early childhood development apply equally throughout the childhood years. Children of all ages need a range of strong nurturant environments. Therefore, the focus of the remainder of this review is to propose ways in which government and civil society actors, from local to international, can work in concert with families to provide equitable access to such environments. Acknowledging the strong impact of the early years on adult life, it is essential that governments recognize that disparity in the nurturant environments required for healthy child development will impact differentially on the developmental outcomes of children. While in some settings inequities in development during the early years may translate into vastly different life chances for children; in others, these disparities could reach a critical point where they become a threat to peace and sustainable development.

3. Interventions and policies to support children and reduce inequalities

In the previous section, we offered a conceptual framework for understanding and promoting childhood development. In this section, we turn to what we know (and do not know) about the effectiveness of specific policy interventions in the English/UK context. Our starting position is that social interventions are complex and are capable of bringing as much benefit (or doing as much harm), as medical ones. They need to be subject to as much if not more evaluation before, during and after implementation as are pharmaceuticals.

In recent years, work on intervening in childhood for better outcomes has been characterized by a large amount of activity, of which only a relatively small proportion has addressed the structural reforms required to reduce inequalities in life chances and in health. Individualised interventions such as parent education, home visiting, and mentoring, as at least some of their proponents and evaluators would be the first to agree, remain black boxes with a great many unanswered questions about what specific type of intervention may be effective and, if so, how and under what conditions. Meanwhile, a climate has been created in which it is widely held that some of these interventions 'work' and as a result programmes have been established. The questions of who delivers the service, the kinds of children, young people and parents who might benefit, and the content of services likely to be effective can be lost in the drive to get the show on the road. These programmes can gain even more momentum because they have strong face validity. They look like the sort of things that should work, our 'gut' feelings tell us that they will work and we want them to work. Not only may this result in premature roll out on the basis on insufficient evidence or a simplistic interpretation of the evidence but it may be difficult to stop, or change direction after programmes have been launched.

Given our remit to propose *the most effective strategies for reducing health inequalities* in England from 2010, with a focus on *policies and interventions that address the social determinants of health inequalities,* this section looks in particular at interventions and policies likely to impact on the *determinants* of health, rather than interventions with individual children and families. The approach taken in this section is:

- to return to *Closing the Gap* and its recommendations, looking at 'England relevance' and potential 'England actions' in terms of policy and practice
- to flag up ongoing/planned policies where these appear likely to have a beneficial effect
- in the light of the life course work on the long shadow cast forward by adversity in early childhood, to highlight policies and interventions in the early years which are likely to have an effect over the longer term.
- in the light of morbidity and mortality data of children and young people up until school leaving age, to highlight interventions and policies likely to impact on these

3.1 Evidence for action

The paradigm wars in relation to the methods used to populate the evidence base for interventions in the early years are now largely a thing of the past[xiii] [xiv]. It is widely agreed that there is no hierarchy of evidence[xv], although some methods will be more useful than others in answering certain types of question. Qualitative work, a cost benefit study, a randomized controlled trial, observational evidence or a cohort study each have their strengths in relation to specific questions. The most helpful reports for policy makers are likely to synthesize data drawing on whichever of these methods is appropriate to the issue in hand. The following paragraph summarizes an emerging consensus on the evidence:

> *Investment in the early years provides one of the greatest potentials to reduce health inequities within a generation. Experiences in early childhood (defined as prenatal development to eight years of age), and in early and later education, lay critical foundations for the entire life course*[xvi] *…. Mothers and children need a continuum of care from pre-pregnancy, through pregnancy and childbirth, to the early days and years of life*[xvii]*. Children need safe, healthy, supporting, nurturing, caring, and responsive living environments. Preschool educational programmes and schools, as part of the wider environment that contributes to the development of children, can have a vital role in building children's capabilities.*

The modern child in western societies is both economically inefficient and emotionally priceless[xviii]. However, while the rhetoric of investing in children has been heavy on values – the value of children and the value of families – the impetus for action owes more to the well-crafted US trials of early childhood interventions in which children were followed up well into adulthood. In particular, work suggesting that for every $1 spent on the children in a particular programme, $7 was saved and reporting the positive effect on those exposed to the intervention in terms of keeping out of prison (as well as longer lasting marriage, higher incomes and a range of other positive effects) [xix] elicited interest from both the Treasury and the Home Office, and suggests that in the short, medium and longer term, greater investment needs to be made in building the evidence base on the cost effectiveness of non clinical interventions in the early years, taking into account a wide range of outcomes of importance to children and parents, service providers, policy makers and our current understanding of what is most likely to affect long term outcomes.

3.2 Building on the recommendations of *Closing the Gap*

Many of the recommendations of *Closing the Gap* relate at least in part, to the English context.

These recommendations refer to:

- improving daily living conditions;
- tackling the inequitable distribution of power money and resources and
- measuring and understanding the problem and assessing the impact of action

3.2.1 Improving daily living conditions

a) Improve the well-being of girls and women and the circumstances in which their children are born

In terms of the wider circumstances into which children are born in England, there is now more than ample evidence linking inequalities in income and wealth to health and other disadvantages in later life. A child born into poverty is more likely to be born early, born small, die in the first year, die before adulthood, and experience health problems in later life[xx]. Moreover this gap between rich and poor is damaging to those at the top as well as those at the bottom of the social hierarchy[xxi xxii].

The context into which children are born in England, with free medical treatment at the point of need, is, of course, far more favourable than circumstances in most parts of the world. Nevertheless, those born into poverty are disadvantaged from the start (or even before the start), with higher rates of stillbirth, maternal, neonatal and infant mortality among the poorest mothers and their children than among the better off. A range of protocols and guidelines, most recently the NICE guideline on intra-partum care[xxiii] and the Standards for Maternity Care [xxiv] developed by the relevant Royal Colleges in the UK, provide guidance for improvement in the safety and the experience of maternity care for both the infant and the mother. These highlight the over-arching need to have a strong midwifery workforce which provides the infrastructure to support women and their partners during pregnancy, birth and early parenthood, deliver services which avoid unnecessary intervention, and ensure that those women who do, or may, require intervention are signposted at an early stage to specialist care.

While the position of girls and women in the UK and in England is formally equal to that of boys and men, inequalities remain in relation to pay and esteem. In the context of this report, this can be linked in particular to the largely female workforce in health and social care who provide maternity services, broadly-based services to children in the early years and more individualized and intensive services to families living in extreme disadvantage.

b) Major emphasis on early child development and education for girls and boys

The first nursery school in England was started in 1914 by early years pioneers, Margaret and Rachel McMillan – an 'open air' nursery which marked the beginnings of a movement that spread across the world. But whilst the UK has a strong history of practice and scholarship recognizing the importance of early years[xxv], England does not hold a distinguished place in the league table below, notwithstanding the introduction of Sure Start which hugely strengthened the scope and the coverage of services. Child care provision and public spending on the early years are still low by comparison with elsewhere in Europe and the quality of childcare remains a major problem to be resolved[xxvi].

The UNICEF report on *The Child Care Transition*[xxvii] proposes a set of minimum standards for protecting the rights of children in their most vulnerable and formative years. Figure 3.1 below summarizes a comparison of early childhood services in the 25 OECD countries in which data have been collected. It shows that the Nordic countries

and France score consistently more highly on the benchmarks associated with good outcomes (and reduced inequalities in health) for children than the countries on whom we frequently depend for research evidence of effective interventions.

This suggests that while certain kinds of research evidence, particularly trial evidence are stronger in the USA than the UK, and work in Canada[xxviii] has provided compelling evidence of the benefits of early intervention, policy makers need to look closer to home, and in particular to the example of the Nordic countries, if we are to create a fairer society in which children can thrive.

There is, of course, no magic bullet. Looking to other countries for evidence of 'what works' and using these to identify single interventions or policies will be nugatory unless we look at the whole package of income, childcare, family support, schooling, housing, and the way that children and women are valued.

Benchmark		1	2	3	4	5	6	7	8	9	10
	Number of benchmarks achieved	Parental leave of 1 year at 50% of salary	A national plan with priority for disadvantaged children	Subsidized and regulated child care services for 25% of children under 3	Subsidized and accredited early education services for 80% of 4 year-olds	80% of all child care staff trained	50% of staff in accredited early education services tertiary educated with relevant qualification	Minimum staff-to-children ratio of 1:15 in pre-school education	1.0% of GDP spent on early childhood services	Child poverty rate less than 10%	Near-universal outreach of essential child health services
Sweden	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Iceland	9		✓	✓	✓	✓	✓	✓	✓	✓	✓
Denmark	8	✓	✓	✓	✓		✓	✓	✓	✓	
Finland	8	✓	✓	✓		✓		✓	✓	✓	✓
France	8	✓	✓	✓	✓	✓	✓		✓	✓	
Norway	8	✓	✓	✓	✓			✓	✓	✓	✓
Belgium (Flanders)	6		✓	✓	✓		✓			✓	✓
Hungary	6		✓		✓	✓	✓	✓		✓	
New Zealand	6		✓	✓	✓	✓	✓	✓			
Slovenia	6	✓	✓	✓		✓	✓				✓
Austria	5		✓		✓	✓		✓		✓	
Netherlands	5		✓	✓		✓	✓	✓			
United Kingdom*	5		✓	✓	✓	✓	✓				
Germany	4		✓		✓		✓	✓			
Italy	4		✓		✓	✓	✓				
Japan	4		✓		✓	✓					✓
Portugal	4		✓		✓	✓	✓				
Republic of Korea	4		✓			✓	✓				✓
Mexico	3		✓			✓	✓				
Spain	3				✓	✓	✓				
Switzerland	3					✓		✓		✓	
United States	3			✓			✓	✓			
Australia	2			✓			✓				
Canada	1						✓				
Ireland	1						✓				
Total benchmarks met	126	6	19	13	15	17	20	12	6	10	8

*Data for the United Kingdom refer to England only

Figure 3.1 Early childhood services – a league table[xxix]

3.2.2 Progressively increase social protection systems: Tackling the inequitable distribution of power, money and resources

It is unlikely that any intervention aimed at changing individual behaviour, however well-designed and carefully implemented, will significantly reduce inequalities in health,

partly because of the more enthusiastic take up of interventions by those already better off. This suggests that the current proposal to enshrine the commitment to eradicate child poverty by 2020 in legislation during the 2009 session of Parliament[xxx] is likely to be the single most important long term policy in reducing both the gap and the gradient in health. Putting the target into legislation is a major opportunity to shape and drive policy to tackle poverty and improve children's chances and the quality of their childhood. Well designed legislation can offer a solid framework to appropriately direct policy and resources. A robust monitoring framework will be required to ensue that the UK keeps on track to a 2020 free of child poverty.

As Sutherland et al point out however[xxxi], it will be virtually impossible for the government to end child poverty if payments for families with children rise more slowly than other incomes. Their work suggests that today's uprating systems imply substantial long-term reductions in personal disposable incomes relative to earnings. While all groups will be affected, those with the lowest incomes will be hit hardest, causing widening economic inequality. A more open debate is required about this area of public policy.

Closing the Gap suggests this unequal distribution *requires a strong public sector that is committed, capable and adequately financed.* Part of this public sector is the workforce providing social care to children and their families. In the context of this section of the report, the low pay, longstanding problems with the quality and standards of education and training, and the low status of those caring for children in the early years, and those supporting families experiencing particular difficulties need to be urgently addressed.

3.3 Which interventions and policies might make a difference to major causes of morbidty and mortality in childhood?

The single major avoidable cause of death in the early years and beyond in England is unintentional injury – death in the home for under 5s and on the roads for over 5s. There are more deaths from unintentional injury than (for instance) leukemia or meningitis and the social class gradient in child injury is steeper than for any other cause of death or long-term disability. Whilst overall rates of death from injury in children have fallen in England and Wales over the past 20 years, this has not been so for rates in children in families in which no adult is in paid employment. Serious inequalities in injury deaths remain, particularly for pedestrians, cyclists and those involved in house fires[xxxii]. Although England compares well with other European countries in terms of road traffic injuries, this is almost certainly as a result of young people being less likely to use active independent transport (cycling or walking) than was the case in the past. Restricting children's freedom to roam is a high price to pay for lower injury rates, particularly when such restrictions bring in their train other serious health problems, including obesity. Green space, use of the natural environment, and having safe places to play have an impact well beyond reducing injury[xxxiii] [xxxiv]. Improved local environments are reported to have a positive impact on social cohesion and interaction, with light traffic streets associated with more social contact and larger geographical area for which people feel responsible[xxxv].

3.3.1 The environment

In this situation, a number of actions could be taken. *Reducing the speed limit* reduces death, and renders injury, where it occurs, less serious[xxxvi]. In countries where *children and traffic are separated*, children ride bicycles, walk and play with a lower likelihood of injury.

In 2008, NICE produced guidance on *promoting and creating built or natural environments that encourage and support physical activity*[xxxvii] which represents the first national, evidence-based recommendations on how to improve the physical environment to encourage physical activity to improve health. While not specifically directed at children, the recommendations impact on the environments in which children grow up and their parents live and work, and chime in well with children's own view that climate change is the key issue for the future.

The NICE recommendations are not only for the NHS and local authorities, but for all those who have a role or responsibility for a built or natural environment; including planners, transport authorities, building managers, designers and architects. The recommendations most applicable to children and young people include:

- Ensuring planning applications for new developments always prioritise the need for people (including those whose mobility is impaired) to be physically active as routine part of their daily life.
- Ensuring that pedestrians, cyclists and users of other modes of transport that involve physical activity are given the highest priority when developing or maintaining streets

This and other work on interventions to improve health and reduce inequalities suggests that *efforts be made to strengthen the impact of NICE recommendations on sectors beyond the NHS* and that *work on the cost effectiveness of public health interventions beyond clinical medicine be strengthened*. At present, while economic modelling is well developed in clinical areas, particularly for pharmaceutical interventions, both methods and outcomes need further work in public health economics. There is a clear need for a register so that knowledge, including economic evaluations on public health interventions, can be shared[xxxviii].

3.3.2 Housing

Non-intentional injury inside the home is also a substantial contributor to the unequal distribution of child deaths in the UK. Children from low-income families are more likely to live in poor housing and have fewer safe places to play[xxxix xl xli]. However, injury is not the only negative heath outcome associated with deprived housing and overcrowding – other problems including respiratory difficulties including asthma, developmental delay, poor sleep patterns and exposure to other hazards including crime.

New Zealand researchers[xlii] found significant improvements in health-related quality of life in randomised controlled trial (RCT) of home insulation, and concluded that targeting home improvements at low income households significantly improved social functioning

and both physical and emotional wellbeing (including respiratory symptoms). A further study[xliii] indicated the role of adequate heating systems in improving asthma symptoms and reducing days off school.

According to Thomas and Dorling[xliv], in the last 10 years, the 'housing wealth' per child in the 10% best off areas has risen 20 times more than in the worst off areas. Ten years ago, an average house price in Kensington would buy two houses in Leven, Fife. In 2004, it could buy 24. The researchers argued that a slow down in housing wealth would be unlikely to have substantial impact on this inequality. They suggest that housing wealth gives families greater security and opportunity – and that a child cannot earn their way out of this early disadvantage. There will be large areas of the country to which they cannot move in future. In order to do reduce this inequality, they suggest a:

- Review of taxation and housing wealth
- Rebalancing of supply and demand by building affordable homes
- Implementation of the Barker review[xlv] to lower housing price inflation

In terms of general efforts to reduce inequalities in health, a recent systematic review of health promotion, inequalities and young people's health[xlvi] suggests six promising elements to be combined in an evidence-informed approach to tackling inequalities: multidisciplinary teams working in partnership with the people they aim to help, to develop structural and social support interventions that adopt inclusive approaches to delivering and evaluating their processes and impact on health and inequalities.

3.4 Where might we disinvest?

It is common for reports of this kind to suggest where further investment should take place, whilst failing to tackle disinvestment. Practitioners are increasingly told what to add to their 'to do' lists without being told what might be left off. We provide below three examples (one in some detail) where disinvestment - or perhaps, better theorising, planning, and implementation – could be considered.

1. *Mentoring to prevent anti social behaviour in childhood*

Anti-social behaviour in childhood and adolescence is a problem for young people and their families, for health and welfare professionals planning multi-disciplinary services and for general practitioners approached by fraught parents[xlvii xlviii]. Anti-social behaviour in young people is also a problem for the police, for communities, and for politicians. Behaviour problems in childhood can presage more serious problems in later life[xlix]. This makes finding a solution a political as well as a therapeutic imperative - a potent driver to 'do something'[l].

One approach is through mentoring schemes. In a typical non-directive mentoring programme (which is the most common and promoted form of mentoring) a mentor will be a volunteer who provides support or guidance to someone younger or less experienced. The mentor aims to offer support, understanding, experience and advice. Mentoring is non-invasive and medication-free. It is easy to see why it might work, and why it is attractive to politicians and policy makers. There is indeed robust research that indicates benefits from mentoring for some young people, for some programmes, in some

circumstances, in relation to some outcomes [li]. There are also good descriptive evaluations, which suggest that those young people who stay on in programmes are inclined to report favourably on the experience[lii liii].

Where improvements have been reported, critical examination suggests flaws that weaken the conclusions. Mentoring programmes for vulnerable young people may have a negative impact and adverse effects associated with mentor-mentee relationship breakdowns have been reported [liv]. Worryingly, a ten year follow up study of one well designed scheme found that a sub-group of mentored young people, some of whom had previously had been arrested for minor offences, were unexpectedly found to be more likely to be arrested after the project than those not mentored[lv]. On the basis of findings such as these, and on the evidence available at the time, it was concluded that non-directive mentoring programmes delivered by volunteers cannot be recommended as an effective intervention for young people at risk for, or already involved in anti-social behaviour or criminal activities.

This does not mean that mentoring does not work. There are many different kinds of mentoring and some show better evidence of effect than others[lvi]. Our current state of knowledge on the effectiveness of mentoring is similar to that of a new drug that shows promise, but remains in need of further research and development. There is no equivalent of the National Institute for Health and Clinical Evidence (NICE) or Food and Drug Administration (FDA) for mentoring. If there were, no more than a handful of programmes might have realistic hopes of qualifying. And even then, it would have to be acknowledged that a full understanding of the safeguards needed to ensure that young people are not harmed by participation is lacking. For some of the most vulnerable young people, mentoring programmes as currently implemented may become one more intervention that fails to deliver on its promises.

2. *There is limited evidence of effectiveness for leaflets and educational materials directed at parents*[lvii lviii] in the injury prevention and other arenas. Nostrums on what to do, or what not to do, without having the resources to turn these into a reality can be debilitating for parents.

3. A review of UK *area based regeneration initiatives* showed some improvements in average employment rates, educational achievements, household income and housing quality, all of which may contribute to a reduction in inequalities in health, but it also noted that there can be an increase in housing costs which renders residents poorer, and that the original residents in the regenerated areas may have left the area[lix].

It is therefore important to monitor the outcomes of social and public health policies, not only for their overall impact, but also for their potentially differential effects on socio-economic groups and the possibility of actual harm for some groups.

4. Family support

The government intends to put supporting parents and carers at the heart of its approach to improving children's lives...All children deserve the chance to grow up in a loving secure family[lx].

In the wake of Lord Laming's review of safeguarding, we hope the important contribution made by universal and preventative services to keeping children safe will be reaffirmed….we are convinced that better early intervention is vital to reducing the likelihood of child misery and ensuring children's wellbeing[lxi].

4.1 Introduction

To draw a categoric age or professionally related boundary around the topic of family support, is neither feasible nor possible, given the centrality across government social policy of two broad inter-linked, underlying assumptions. One derives from the national and international knowledge base around early childhood development, which shows that the first years of life – traditionally up to age 7, are crucial to later life inter-related outcomes such as health, education and income[lxii lxiii]. Secondly it is increasingly accepted that *early* intervention into any problem will reduce the severity/impact of consequences – in other words a public health- evolved concept of ***prevention,*** which has now been widely embraced across most aspects of social care provision [lxiv lxv lxvi].

So on this basis, in the UK, the development of children must be considered within the context of their family unit, rather than as only 'freestanding agents' as well as within a wider society; and there is no arbitrary age limit beyond which family support will cease to be relevant across the childhood years. The need to address family functioning/parenting capacity, and the relationship between family and state in responsibility for the 'optimum upbringing'of children in respect of a range of improved life chances, are questions which pertain *across the life course of a child or young person*, defined in most social policy provision as up to 18.

To identify ways in which family support services can contribute to the reduction of child health inequalities requires the acknowledgement of some organisational, cultural and methodological tensions between both the *organisational* and the *knowledge* bases of children's social care and health provision. Put simply, organisational arrangements for health are predominantly *nationally* financed and managed whilst children's social care services are predominantly *locally* managed. The 'client' for receipt of health services will be traditionally perceived as an *individual*; whereas in much of children's social care, services will address the *needs of the family* as a means of facilitating the development and welfare of an individual child. Perhaps most importantly, public perceptions of the NHS as a *universa*l service and family support as a targeted one introduce the notion of stigma into the operational obstacles faced by family support, thereby aggravating and complicating the challenge of maximising access to services. Differences in respective

health and social care research traditions also play a part in the design and evaluation of policy and are highlighted in the next section.

4.2 Understanding the outcomes of family support services

Current UK policy emphasises the centrality of *outcomes* and there has been a strong emphasis in recent years on summative ('what works') research. The Children Act 2004 and the accompanying guidance ([lxvii]etc.) require that children's services be organized to improve the well-being of all children living in their area. They define five child well-being outcomes that need to be achieved in order to stimulate long-term improvement in children's health and well-being. The five outcomes are considered key to securing well-being in childhood and in later life (being healthy, staying safe, enjoying and achieving, making a positive contribution, and achieving economic well-being). However, these are too broad to be used by researchers as outcome dimensions for the more complex needs of children within the formal child protection and out-of-home care systems, and instead they tend to use the seven dimensions of child wellbeing developed initially as a research tool and now incorporated into the assessment framework for all child welfare work[lxviii]. A further obstacle to understanding the relevance of a range of family support services to health related outcomes (flagged up above) concerns the different research traditions which have informed health and social care. The former have privileged summative research using experimental methodologies, and in particular the use of randomised controlled trials. In social care/family support research, fewer studies have used experimental designs and a formative (process) approach tends to be adopted, using mixed qualitative and quantitative methodologies[lxix lxx]. Ruffalo et al. (forthcoming)[lxxi] have highlighted the imperatives in 'real world settings' with 'complex, changing organizational structures in the child-serving systems which have limited the use of true experimental designs.' In addition, some of the questions that need to be addressed about service system access and pathways to services need to focus on understanding *what happens*, not just on *outcomes* and this calls for more quasi-experimental or qualitative studies. Coote et al.[lxxii]draw specific attention to the methodological complexities in respect of attributing outcomes in the context of evaluating of complex community initiatives, such as Sure Start. Such programmes figure increasingly largely in the panoply of services designed to reduce social exclusion through the delivery of a range of services including *family support* and mean that narrow notions of 'what works' may not fit, but 'require a sustained investment in developing a wider range of evaluation techniques and working out the best ways of effectively combining multiple methods.' Given the increasing focus on inter-agency working this issue is becoming an increasingly pressing one[lxxiii lxxiv].

A range of outcome *measures* are deployed across studies, which also vary in terms of 'Whose outcome?' i.e. parent, child, neighbours, agency, politicians[lxxv lxxvi]. Outcomes reported in family support service evaluations include: poverty reduced by claiming benefits; educational /employment potential achieved; physical and psychological well-being; self esteem (cultural and ethnic identity); improved adult /child relationships; and improvement in parenting competence. The specific impact of family support on the *health* of children is more limited. Areas explored typically include the value of family support in helping families to deal with mental health problems – both in parents and

children where parental stress has been shown to be linked to their child's behaviour and/or mental health problems. Interventions aimed at reducing the parents' stress as well as working with the child and reduction in parental stress have been shown to be positively associated with improvement in the child's behaviour[lxxvii].

Finally it is important to avoid the pitfall of equating the recorded outcomes of the more straightforward interventions, such as parenting programmes, with outcomes *per se*. The temptation to evaluate only less complex programmes because they are amenable to 'scientific methodologies' may provide a false picture of *what works* and fail families who need a more complex and or flexible package of services.

4.3 What is family support?

Describing the range and identity of activity undertaken under the heading *family support*, is a misleadingly straightforward task. The intention here is to focus on those services whose activity is concentrated on the *parents*, rather than the *child*. However, in reality this focus must be a relative rather than absolute one.

The exercise is complicated by a range of factors of which the breadth of the definition of family support, provided by primary legislation and statutory guidance, is only the most obvious. As is also acknowledged in the introduction, other factors include the inter-relationship between 'child' and 'family'; the range of professional and other groups engaged in the delivery of services; the boundary between 'need' and 'risk' (often synonymous with voluntary or involuntary use of services by parents or carers); and the mixed economy of the workforce involved - which includes volunteer as well as paid workers.

One further consideration is the way in which the *family support activities* will reflect both the actual '*role identity*' of the people carrying out the tasks, in particular the specific professional and/or agency identity, i.e. social care, health or education, but also the current workforce trends in that profession. A major crisis in recruitment and retention issues in social work and health visiting is having a current impact on the rationing of services[lxxviiilxxix]. At the time of writing a government commissioned task force on social work is exploring workforce capacity, and is due to report in summer 2009[lxxx]. The wider challenges involved in delineating the *family support role*, and its component activities have been acknowledged over a long period[lxxxi lxxxii] and, perhaps as a result, strategic definitions, have, and still do, err on the side of breadth, as did the Audit Commission in 1994:

> any activity or facility provided either by statutory agencies or by community groups or individuals, aimed to provide advice and support to parents to help them in bringing up their children. [lxxxiii]

As Gardner cautions, *"Family support can mean very different things, depending on where the service is focussed – the child, the child with parent(s) or the whole family within a particular community – and depending o*n *the value base of the observer."* [lxxxiv]

Quinton[lxxxv] reviews the findings and implications of fourteen studies in the Supporting Parents research initiative. He categorises the key *sources* of family support, along the dimensions of informal- semi-formal – formal, and of the main *kinds* of family support as emotional, advice, practical, providing resources, and specialist services.

In the context of most UK provision, the types of intervention reflect the three levels of prevention: primary; secondary; tertiary.

Primary prevention services are directed at the whole population and have the aim of supporting positive developmental outcomes, for every child, and include services such as GPs, health visitors and education, as well as awareness campaigns around issues such as reducing alcohol use.

Secondary prevention interventions are those which are offered to populations that may have one or more risk factors associated with poor child outcomes, such as poverty, parental substance abuse, young parental age, parental mental health concerns, and parental or child disabilities. These services aim both to address the risk factors for maltreatment (for example poor parenting skills) and to promote resilience in the face of risks, so that the risk factors do not themselves translate into maltreatment, or if they do, so that the damage caused by the maltreatment is minimised.

Services may be directed towards individuals, or to communities or neighbourhoods that have a high incidence of any or all of these risk factors. Approaches to prevention programmes that focus on high-risk populations might include:

- Parenting education
- Home visiting programmes that provide support and assistance to expecting and new mothers in their homes;
- Parent support that helps parents deal with their everyday stresses and meet the challenges and responsibilities of parenting;
- Family centres offering support, information and referral services

Tertiary prevention interventions focus on families where maltreatment has already occurred and seek to reduce the negative consequences of the maltreatment and to prevent its recurrence. These interventions may include services such as:

- Mental health services for children and families affected by maltreatment
- Intensive social work support
- Parent support groups that help parents transform negative practices and beliefs into positive parenting behaviours and attitudes
- Removing parental responsibility and taking children out of the home
- The Intensive Family Intervention Project (FIP) – a service currently being evaluated.

Distinctions between primary, secondary, and tertiary prevention, while perhaps useful for some purposes, do not necessarily reflect the way prevention-related services are actually organized and provided on the ground. Rather than sorting prevention initiatives

into mutually exclusive categories, prevention is increasingly recognized as a continuum. Moreover, not all interventions can be neatly classified into distinct categories and in reality span the three levels. For example parenting skills programmes are available as primary, secondary and tertiary interventions, and all three categories of parents might be present in a single group. The classification essentially depends on the target group, and not always necessarily on the nature of the intervention itself. Moreover, some interventions can be viewed as crossing the levels even with the same target group. Thus, for example, therapeutic interventions for maltreated children can be considered tertiary interventions (as maltreatment has already occurred) and also secondary interventions (aiming to reduce the likelihood of that these children will go on to maltreat others).

In the UK, the 'prevention typology' is reflected in the explicit organization of agency services within the operational concept of 'the Tier':

'*Tier 1*' services are universal services (whether free at the point of delivery or publicly subsidised) provided to all citizens who chose to use them (e.g. GP services, public libraries) or available to all in a particular age group (e.g. schools for those of compulsory school age) or in a particular need group, e.g. midwifery services for expectant mothers, job-centres for those seeking employment.

'*Tier 2*' services are targeted at groups or communities where research indicates that there is an additional level of need or vulnerability, but where the choice to use the service remains with the family. For example Sure Start projects were originally sited in areas of known deprivation, but most services were based on the principle of 'open access' to local families, without the requirement to establish 'need'. They did, however, provide some 'Tier 1' and 'Tier 3' services. With the establishment of Sure Start Children's Centres in most areas, these have become 'Tier 1' services also providing some 'Tier2' and 'Tier 3' services. Other examples are open access community based services for refugee families, or families with disabled children.

'*Tier 3*' services (sometimes referred to as 'targeted' or 'referral based') services are 'targeted' at identified families known to be vulnerable, who may refer themselves or be referred by a worker within a universal service such as a teacher or GP, for a more specialist service. There is usually a needs 'threshold' (legally or administratively established) for access to these services They aim to prevent identified problems from causing harm to parents or children, but may involve therapy for established difficulties. They are mainly provided within the family home or neighbourhood, but could include, for example, support foster care for disabled children.

'*Tier 4*' services are 'remedial', or 'rehabilitative', 'heavy end' support and/or therapy services for referred families, and sometimes involve court orders or an element of coercion (such as a child protection inquiry; a young person convicted of an offence being placed in a treatment foster family; a health service placement in an addiction treatment unit; or a residential unit for a family evicted as a consequence of anti-social behaviour).

4.4 What do we know about 'what works' in family support at each level?

As the above sections imply, disentangling the specific *organisation of services* from the apparent outcomes generated is complicated by the current patterns of access to services. In England this is driven by worker ratings of need and risk, via the Common Assessment Framework and the child protection system. In other words there is an interlocking system of thresholds to services, whereby a family with 'lower and/or less complex needs' may not be offered services at all, in the expectation that universal services alone will suffice to maximise the developmental needs of the child in the family. This differential access, earlier or later in the trajectory of a problem will have inevitable consequences for outcomes.

The overall picture which emerges across the knowledge base is, as Statham[lxxxvi] concludes, that *a range of services is needed to support families with different levels of need, with clear referral routes between them.* Less intensive services offering advice and support at an early stage, before problems become severe, need to be part of a strategic approach, and although some short term interventions may help, some families are likely to need longer term support from a variety of agencies. These ideas increasingly underpin the overall tenor of recent policy initiatives, including the continued roll out of Sure Start Children's Centres, and the Healthy Child Programme[lxxxvii].

Since much of the research on outcomes of family support work cited in recent years in English policy documents has been conducted overseas, it is important to understand the approach taken in the 'originating countries' to the delivery of family support across the 'tiers'. In particular, there may be an impact on reported outcomes on cost and effectiveness depending on whether the broad approach to helping families under stress is needs and rights- based, or is predominantly a response to identified risk[lxxxviii]. These contextual differences also have an impact on the type of research that is conducted in different jurisdictions. In most European countries, including the UK nations, there is more likely to be continuity of services, often with several different services and interventions provided concurrently or sequentially, often by different agencies. In North America and Australia, where much of the research on parenting interventions has been undertaken, the model of delivery is insurance based or based on the commissioning of specific 'programmes' or 'interventions'. Since the contracts are usually time limited, these services (having a beginning, middle and end) are more easily evaluated using an experimental methodology, and most of the experimental design research has, to date, taken place in these countries.

What do we know about tier 1 interventions?

The main universal (open access) services to support children and families in England are provided by GPs, health visitors and other members of the primary health care team, Children's Centres, schools and community and faith groups, or self-referral advice services such as the CAB or ParentlinePlus. The open-ended nature of these services makes them less amenable to experimental design research since families cannot be randomly allocated to a service which is available as of right. The evidence base tends to come from studies about what parents and children find helpful about these services, and

high on the list is always the quality of the relationship with the person/s providing the service (whether formal support provided by professionals or trained volunteers or members of the community or faith groups)

What do we know about Tier 2 interventions?
Some of these also target vulnerable groups (Tier 2) as when health visitors, or extended schools, Sure Start Children's Centres or community centres provide additional services to families under stress. Some 'referred' families receive an enhanced service and have a 'lead professional' allocated to them to co-ordinate the 'team around the child and family', or access child development centres for disabled children and their families. The National Evaluation of Sure Start found that the *facilitation of access* played a big part in the successful engagement of the families, on which the subsequent achievement of outcomes depended[lxxxix]. High quality services may well be delivered on a universal basis from a centre but will only reach an additional target population with a range of flexible outreach strategies[xc].

The on-going expansion of the successful Family Nurse Partnership Programme, also based on targeted outreach, provides intensive support from highly trained nurses for the most vulnerable first-time mothers and reflects promising findings[xci]. It will be expanded from 30 to 70 sites by 2011, with a view to rolling out this support for the most vulnerable mothers across England over the nest decade. It should perhaps be noted that within the UK, the concept of 'a pilot intervention' remains an ambiguous one: it could be argued that policy roll-out ought to await the outcome of an evaluation, but this, as Jowell amongst others has commented, is not always the case.[xcii]

In recent years, routinely available universal services have been complemented by more specialist short term programmes, for instance parenting education programmes such as the USA (Webster Stratton) devised *Incredible Years*[xciii] and the PPP programmes devised in Australia[xciv]. When these programmes are manualised, they can be evaluated using RCT research designs. There is evidence that they lead to more positive outcomes for a majority of those who take up and complete the programmes (mostly those at the level 1 or 2 in terms of service needs and problem development).

These programmes are often included in a wide range of support services provided by neighbourhood family centres. These centres have a high service level approval rate, and some evidence of improved child and parent outcomes as demonstrated by process and longitudinal studies[xcv] [xcvi]. A range of home visiting services is available at this level, some having been evaluated as more effective than others[xcvii] [xcviii] [xcix].

These studies raise questions about a number of 'moral' and methodological issues. Quinton frames this in terms of the tension between *effectiveness* and *entitlement*[c], and cautions 'we do not need a demonstration that these behaviours promote better parenting in order to change our approach to service delivery….parents ought to be able to expect such responses even if there are not any demonstrable 'effects ' on them'.

There are related issues about the respective weight to be attached to what parents and children find helpful; and the balance to be struck between services provided by trained volunteers and professionals.

What do we know about what works at levels 3 and 4

As the above sections have shown, current patterns of service organisation complicate the task of disentangling these specific *organisational traits* from the apparent outcomes generated. The recent series of articles in the Lancet[ci] (especially that on interventions by MacMillan et al) concluded that parenting education programmes – including the 'manualised' programmes developed and evaluated in the USA or Australia – have been demonstrated to be effective at the 'Tier 2' level of need, but not in cases where problems have become more entrenched or are more acute. There is as yet no evidence that these programmes are effective in preventing further harm once children have been maltreated or neglected. Utting et al[cii] point to some of the reasons why this may be the case, and particularly highlight that few studies included in systematic reviews report on 'non-starters' and 'non-completers':

> Even the most effective and evidenced programmes do not work for all people under all conditions……What little evidence exists suggests that within a 'treated' population it is generally the most needy, most challenging families and young people who are least helped by these programmes.

More intensive programmes developed in the USA and evaluated as either 'effective' or 'promising' with specific groups are being piloted in the UK and other countries in Europe. Multi-systemic therapy (MST), found to be a promising intervention in the USA with teenagers with challenging behaviour or involved in the criminal justice system and their families, has not been evaluated with families with a wider range of problems. When introduced to countries with a family welfare/needs based approach, there is growing evidence of a tension between the programme originators' requirement for 'programme fidelity', and the service providers' wish to make adaptations to suit local populations and legislative and service delivery arrangements. An experimental (randomised controlled) evaluation in Sweden reported no difference in outcomes (at 7 and 24 months after treatment) between the MST families and the service as usual families. One hypothesis is that this less positive result than that achieved in other trials is a consequence, not so much from any deficit in the MST service, but rather from the higher quality 'service as usual' provided in Sweden (at a lower cost than the MST project) than the 'service as usual' available to the control group in the USA[ciii]

Evidence from a range of UK longitudinal and mixed methods research studies[civ] shows that around half of families referred for an assessment of need to local authority social care services are not referred specifically for a child protection service, but have a range of needs. If not appropriately met, these will lead to a deterioration in the health and wellbeing of the children in the family. The majority will need a short term (though possibly high intensity) service after which time the universal services will be able to meet the ongoing needs. A proportion (around 40%) of all those are referred for an 'in need' or 'child protection' service[cv]. In around 40% of cases, actual or likely significant harm is identified[cvi cvii]. Such families will have long standing and multiple problems, and

will need long term monitoring and 'episodic' social casework and family support services which can be readily accessed at times of increased stress. Brandon and Thoburn[cviii] found that two thirds had had a long term service, and 38% were continuously or intermittently open cases in the eighth year after the identification of significant harm. Tunstill et al.[cix] note a particular advantage of neighbourhood family centres is that families can enter and leave the service as stresses in the family are manageable or escalate, and that the value of *episodic access* to services is viewed by parents as very helpful in their parenting tasks.

4.5 Conclusion: implications for the future

This analysis has enabled a number of conclusions to be drawn, whose implications for the future policy and practice should be noted if there is to be any progress in the reduction of child health inequality.

- The current organisational system in the UK is built around a series of thresholds which can act as either *gateways* or *barriers* to services, including family support services. The assessment process itself is potentially wasteful of resources which might be redirected towards more accessible provision at the 'lower slopes of need '. These 'threshold-problems' will be aggravated in the context of a risk averse environment, such as the current approaches to family support /child protection in the wake of Baby P.
- When a child crosses the 'in need' threshold and is assessed as needing a 'Tier 3 or 4' service, an approach to understanding 'what works' has to take account of a situation in which multiple services are provided by a range of professionals and agencies over extended periods of time. Manualised programmes will be only *one* part (and often of short duration) of these services. It may be that the quality of the professional relationship with the health visitor, the GP, the school nurse, the team at the family centre, is the aspect of the service that is making a difference, rather than any particular method or technique. Workforce capacity and quality is therefore a vital part of ensuring positive child level outcomes.
- There is a very serious crisis of capacity in respect of the key workforce members who can make a difference to reducing inequality in child outcomes, i.e. midwives, health visitors and social workers. Government must act urgently, in a range of ways, to address capacity, whilst maintaining a high quality workforce.
- Mode of delivery can include both centre based and outreach strategies, but for many targeted populations, who are ambivalent about using services, flexible and imaginative outreach is absolutely crucial to family engagement. Major efforts need to be deployed to maximise service access and enable all children to benefit from universal services.
- To deliver optimum outcomes for children, the family support workforce must be a complex one. It will ideally, comprise a range of workers, including health visitors, social workers, early years workers, and trained/supported volunteers. Organisational and managerial mechanisms have a part to play in supporting their input. For example, the development of a common working language across disciplines is a pre-requisite for building collaborative partnerships based on a holistic view of need, and a commitment to meet it. And indeed including in the current list of 150 key

performance indicators (KPIs) for GP services, even one KPI on *safeguarding*, could go some way to facilitating GP collaboration in child protection services.

- In order to develop our understanding of the input of the maximum range of appropriate services for supporting the health and well-being of children and their families, we must acknowledge the need for a range of methodologies. As results from evaluations in other countries such as Sweden indicate, research methodologies have to be developed both for understanding what it is that works, and also identify what modifications are needed. This is particularly true when evaluated programmes are transferred from clinical to community settings, and from one country to another. It also applies when complex multi-agency services are delivered in community settings where health education and social care professionals work together in teams and networks are formed around children and families with multi-faceted needs.
- The welcome increase in emphasis on *child level outcomes* has not paid sufficient attention to the ways in which practitioners and commissioners can make sense of *interim outcomes*. Addressing this task as a matter of urgency is essential, both in terms of methodological rigour and, equally importantly, as a component of continuing professional development and the maintenance of workforce morale.

5. Education

This section is concerned with the relationship between education and health inequalities, and, in particular, with the contribution which education might make to the reduction of health inequalities. For our purposes, 'education' refers to statutory provision between the ages of five and sixteen, though inevitably this interacts with other forms of educational experience (for instance, informal education in the home), and with formal early years and post-sixteen provision.

5.1 Educational inequality in England

Although, as the *Closing the Gap* report indicates, the relationship between education and health is well evidenced internationally, some distinctive features of the situation in England have to be borne in mind. First, statutory education in England is free, universally available, and taken up by the vast majority of the school-age population. This contrasts with the situation in some other countries where large numbers of children do not access, or only partially access formal educational provision. Second, although there are some variations in the quality of provision across the system (and much policy effort has been directed towards reducing these), in *international* terms, very nearly all provision is of a high standard. As Hattie [cx] points out, in economically rich countries such as England, which school a child attends makes *relatively* little difference to the academic outcomes s/he will achieve.

On the other hand, there are significant variations in educational outcomes that are associated with learners' social background, in terms particularly of socio-economic status (SES) [cxi] [cxii]. In this sense, educational outcomes are distributed unequally in this country. There has been much debate in the education world about how SES is linked to educational inequality, and about the impact of successive governments' attempts to reform the education system on these inequalities. These are complex questions and beyond the scope of this paper to address in full. However, the consensus currently would seem to be that SES interacts with and is mediated by an array of other factors – including, gender, ethnicity, family dynamics, place, peer group effects, school quality, school composition – such that the relationship between it and educational outcomes is complex and non-linear. In an interesting analysis of outcomes from primary education, for instance, Duckworth identifies effects from:

- the distal context – background socio-demographic features, such as income, parental education, etc.
- the proximal context – parental support and parent–child relationships
- the school-peer context – the nature of the school and its population
- the child context – individual child ability, measured primarily in terms of prior attainment [cxiii]

Such an analysis echoes the model of interacting environments proposed in section 2 and has similar implications for policy. On the one hand, it would appear that there are multiple possibilities for policy intervention within and across these contexts. On the other hand, it seems unlikely that 'one-shot' interventions will be effective. In particular,

as Raffo et al. [cxiv] point out, single strand interventions targeting specific aspects of attainment or educational provision, are unlikely to remove gaps in educational outcomes unless they form part of an overarching strategy at what they call micro, meso and macro levels.

In this context, the impacts of government policy from the 1988 Education Reform Act onwards, have been ambiguous. There is some evidence that educational outcomes overall have improved, though perhaps not as much or as uniformly as governments sometimes wish to claim [cxv]. However, the unequal distribution of those outcomes across social groups has not been much affected by reforms[cxvi]. It seems that inequalities widened in the aftermath of the 1988 Act, and that the gap may have stabilised post-1997. However, there is no evidence that the gap has reduced to anything like the point of disappearing in the latter period. To this extent the impact of education reform matches that of reform in other parts of the public sector [cxvii]. Moreover, although the education system has become data-rich in recent years, it remains the case that the only outcomes that are routinely measured nationally are children's attainments in tests and examinations, and even then the measures often relate to only a narrow part of the curriculum[cxviii]. Other outcomes – for instance, in relation to personal and social development – which may be important for health and well being, are not measured.

It is worth adding that, although the right to participate in education up to the age of 16 is a universal one, not all children are able to exercise that right to the full. Various aspects of social background play a significant role in determining who will be excluded from their schools for disciplinary reasons, who will truant, who will receive special education provision, and who will be placed in 'bottom sets' (see, for instance, [cxix cxx cxxi]). Likewise, in a situation where participation in education and/or training beyond age 16 is increasingly the norm, social background also influences who will and will not take up these non-statutory opportunities[cxxii]. Above all, the question of school admissions is a running sore in relation to educational equality, with access to schools remaining stubbornly stratified by geography, class, and the interaction between them (see, amongst many others,[cxxiii cxxiv cxxv]).

It follows that inequalities in educational outcomes are paralleled and interact with inequalities in educational access and opportunity. Whilst the latter may not be as stark as in economically poorer countries where universal provision is not available, they are significant nonetheless in terms of the life chances of young people.

Despite the continuing focus on enhancing the performance of the system overall, on attainment measures, and on 'under-performing' schools, governments latterly have recognised these other issues. So, there is a national 'Narrowing the Gap' strategy aimed explicitly at addressing outcomes inequalities, the 'Every Child Matters' strategy recognises the interactions between attainment outcomes and wider outcomes for children, and the extended services agenda facilitates action not only within the school, but also in relation to children's families and communities. It is too early to say conclusively what impacts these strategies will have.

5.2 Education and health inequalities in England

In the context of broad equalities of educational access and provision, but inequalities of educational outcome, it is important to understand some of the complexities of the relationship between education and health outcomes in affluent countries such as England. There is convincing evidence for a relationship between education and health outcomes. As a wide-ranging review by the Centre for the Wider Benefits of Learning puts it:

> Findings show that there are returns to education in the form of health benefits – in terms of **self-reported health, lower mortality rates, lower incidence of depression and obesity**, and in health-related behaviours – **diet, exercise, smoking, and take up of preventive health care** measures.[cxxvi]
>
> (Emphases in original)

In general terms, 'more' education and greater 'success' in education are associated with better health outcomes, where the quantity of education is measured through length of participation, and educational success is measured in terms of attainment and accreditation. The implication is that the sort of educational inequalities in attainment and participation we noted above are associated with inequalities in health outcomes.

There is also evidence that aspects of education other than attainment and participation are associated with differential health outcomes. For instance, Hammond and Feinstein[cxxvii] find an association between 'flourishing' at secondary school, and adult health outcomes. Flourishing in this sense goes beyond attainment to encompass doing well intellectually, emotionally and socially, while health outcomes are understood in terms of physical and mental health, health behaviours and well-being. Whilst those who flourish are more likely also to do well in terms of measured attainment, there is an effect from flourishing that is over and above its association with attainment. Even where attainment is low, those who flourish tend to have better outcomes than those who do not.

However, these associations are surrounded by complexities. First, as the evidence on 'flourishing' indicates, both 'education' and 'health' are multi-dimensional. There is evidence that aspects of education impact on health differentially, that educational effects differ across aspects of health, and that the nature of these effects can be difficult to establish[cxxviii cxxix cxxx]. Second, the relationships are mediated by a wide range of other factors. For instance, education may impact on the self (as in self-concept and emotional resilience), on employment prospects (and hence on income), on information and cognitive skills, on health-related behaviour, on the ability to access health services, and on social capital (which itself may reinforce healthy behaviours and access to services) each of which has implications for health[cxxxi cxxxii cxxxiii cxxxiv]. The implications themselves, of course, might be mediated in complex ways: income might thus be supposed to have implications for access to services, safer environments, and greater self-efficacy.

In this situation, it is difficult to identify simple causal mechanisms whereby some specific aspect of education produces some specific aspect of health, let alone whereby 'education' as a whole produces 'health and well-being' as a whole. If we add to this the

complex processes whereby educational inequalities themselves are produced, it is clear that the relationship between education and health inequalities is best thought of as a network of interactions rather than as a matter of linear causality. This network is not random, in that one set of disadvantaging or risk factors tend to increase the chances that individuals will be subjects to other risks or disadvantages. This is sometimes called the 'accumulation model', which acknowledges the tendency for advantages or disadvantages to accumulate for individuals 'cross-sectionally' (i.e. at any one point in time), and 'longitudinally' (i.e. over the life course):

> Longitudinally, a child raised in an affluent home is likely to succeed educationally, which will favour entry to the more privileged sectors of the labour market, where an occupational pension scheme will provide financial security in old age. At the other extreme, a child from a disadvantaged home is likely to achieve few educational qualifications and, leaving school at the minimum age, to enter the unskilled labour market where low pay and hazardous work combine with no occupational pension, which ensures reliance on welfare payments in old age[cxxxv].

On the other hand, although the tendency towards the accumulation of disadvantage creates regularities in the relationships between education, health and social inequalities, those relationships are not deterministic. Much depends on how the individual interacts with the range of environments in which s/he lives, learns and grows up (see section 2). As a recent study of the factors promoting children's well being in primary school concludes:

> Much of the variation in children's wellbeing remains unexplained. It is likely that the unmeasured, day-to-day experiences of children within their home and school are important constituents of their overall wellbeing[cxxxvi].

This has two significant implications in policy terms. First, in the absence of simple, linear causation, it seems unlikely that simple, single-strand policy interventions are likely to be effective. A multi-dimensional approach would seem to be called for in which the contribution of education to reducing health inequalities is maximised by addressing multiple aspects of education, and the multiple factors contributing to educational inequalities simultaneously. Second, in the presence of variation at the individual level, it seems unlikely that blanket prescriptions will be helpful. As the previous two sections have also concluded, knowing 'what works' in general terms is no guarantee of knowing 'what works' in individual cases. Policy frameworks and interventions, therefore, need to be sufficiently flexible for individual- and context-specific responses to emerge, and the professionals who implement those interventions need to have the skills to use that flexibility effectively.

To a significant extent, post-1997 governments can claim to have taken account of these considerations. They have undoubtedly recognized the importance of educational outcomes for children and young people's life chances, and have pursued vigorous policies to raise attainments – the so-called 'standards agenda'. They have recognized in particular that some children do especially badly in the education system and have put in place a wide range of compensatory programmes and interventions variously targeting

individuals, groups, institutions and areas. Finally, they have recognized the interaction between education and the broader social context in which it is set, understanding – notably through the 'social exclusion' agenda – how poor educational outcomes are part of a cumulative set of disadvantages for some individuals and groups – and, through the *Every Child Matters* agenda, how the education service has to play its part in promoting the overall well being and life chances of its students.

The puzzle, then, is why educational inequalities, as we noted above, remain so persistent in this country, and why education, instead of leading the way to a more equal society, appears to do little other than reproduce existing social inequalities[cxxxvii cxxxviii]. Answering these questions in full would require a review of the social determinants of educational inequalities at least as extensive as the review to which this is a contribution. However, it is worth proposing at least four factors that seem to be at least part of the explanation:

1. Government attempts to create a more equitable education system (and hence a more equal society) have simply been too half-hearted. The reliance on compensatory interventions has failed to address the deep socio-structural inequalities out of which educational inequalities arise. The constant succession of these interventions has, therefore, created an illusion of activity without any significant action.
2. Although governments have attempted multi-dimensional interventions addressing educational and social factors simultaneously, those interventions have tended to be developed cumulatively or in parallel, rather than being coordinated in the form of a coherent overarching strategy. Arguably, this is part of a deep-seated problem with New Labour's discourse of 'social exclusion', in which inequality is recast as a series of loosely-connected misfortunes, requiring customized interventions, rather than as a characteristic of society as a whole, requiring a strategic policy response (see, for instance,[cxxxix]). Arguably, too, the problem has been particularly acute in schooling, where recognition of the wider social context has developed alongside – and often in competition with – aggressive, narrowly-focused policies aimed at raising 'standards'. There is some evidence that, despite the holistic view of children's development presented in *Every Child Matters*, these have in fact cut across attempts to enable learners to 'flourish' in their schools[cxl]. The cost of this in health terms may be high, given that education which in some way injures the self may be positively harmful in terms of health and well-being[cxli].
3. In this situation, no sustained strategy has emerged to reduce inequalities within and beyond education. Instead, policy interventions have tended to take the form of multiple, short-term and disconnected initiatives of doubtful long-term effectiveness[cxlii cxliii].
4. The absence of coherent strategy at the centre has not fully been compensated for by the development of strategic capacity elsewhere in the system. Despite multiple opportunities and imperatives for collaboration, coordinating mechanisms which could involve schools in local strategies continue to promise more than they deliver [cxliv]. Meanwhile the school workforce, driven hard by the standards agenda, appears to have developed a new kind of professionalism –

arguably more effective at delivering on narrowly-focused targets, but less so at developing more holistic approaches to children[cxlv cxlvi].

The implication would seem to be that some longer-term, more far-reaching, more strategic, and better-balanced policy approach is needed. This in turn would require policy to be based on some kind of coherent 'narrative'[cxlvii] capable of organising the evidence on education and health inequalities in some meaningful and actionable form. Such frameworks do exist; the literature on lifecourse studies, for instance, often draws on versions of a risk and resilience framework[cxlviii]. However, although other aspects of public policy may draw productively on such frameworks, they seem to be strangely absent from education policy – an issue to which we shall return.

5.4 Programmes and environmental interventions

Given the complexities of reducing health inequalities by bringing about overall improvements to the education system, an attractive option for policy makers is to focus on more targeted programmes and interventions. These seem to fall into two broad types, called here *programmes* and *environmental interventions* – though there is considerable overlap between the two.

Programmes are delivered in educational settings, and are targeted on particular health outcomes, and, perhaps, particular groups of learners. Such programmes might, for instance, focus on drug misuse, mental health, teenage pregnancy, or obesity. They might run across the whole of the school's population, or be targeted at groups and individuals held to be at greatest risk or in greatest immediate need. There is evidence – in some cases, robust – that such programmes can have significant impacts on certain health outcomes. A review of the international evidence[cxlix] suggests that the evidence is strongest in relation to school-based programmes targeting mental health, healthy eating, and physical activity. In England, for instance, the mental health programme, SEAL ('social and emotional aspects of learning'), has been promoted by government, and there is some evidence of positive outcomes[cl].

However, it seems that the effects of programmes are variable. Stewart-Brown[cli] reports more limited effects from programmes targeting substance misuse and suicide. There are also problems with the robustness of the evidence base. Not surprisingly, many existing evaluations focus on relatively short-term impacts, in terms of changes in attitudes and health-related behaviours during and immediately after participation in programmes. It is less clear whether the impacts of programmes are sustained in the long term and whether, therefore, they have impacts on adult health. As is typically the case with interventions of this kind, moreover, evaluations are of variable quality, and some of the most robust come from beyond England, with no guarantee that findings are transferable.

In policy terms, also, there are questions about the long-term feasibility of an approach to reducing health inequalities based on targeted programmes. The process of scaling up from limited trials in favourable conditions to large scale adoption of multiple programmes is, of course, fraught with difficulties in terms of cost, resistance to adoption, implementation fidelity, additional burdens on schools and other settings, and

the capacity of the education system to deliver long-term support to the delivery of programmes. Whilst there may well be a place for such programmes used in specific contexts and specific purposes, they are unlikely to constitute a viable mechanism for maximising the potential health impacts of education.

In this situation, there is considerable attraction in more *environmental interventions* (part of a family of what are known in the health literature as 'settings' approaches[clii]). These are aimed at creating school environments which have characteristics held to produce better health outcomes. They are more wide-ranging than targeted programmes in the actions they support and look for effects from some overall change in the school environment instead of simply from the delivery of one or other programme. In practice, the distinction between environmental and programmatic approaches is often one of emphasis and some combination of the two may be particularly powerful. The evidence on mental health promotion in schools, for instance, seems to point to the effectiveness of combined approaches of this kind [cliii] – perhaps because schools are able 'sharpen' an overall environment which helps their students to 'flourish' through the use of more targeted interventions.

Internationally, there is considerable interest in 'health promoting schools' initiatives which support schools in taking wide ranging action so that they, for instance, develop a formal health curriculum, a health-promoting physical and socio-emotional climate, and health-oriented school-community interactions [cliv]. Such a combination is currently being attempted in England through the National Healthy Schools Programme[clv clvi], established in 1999, and where the strands include PSHE, healthy eating, physical activity and emotional health and well being. There are some similarities between initiatives of this kind and school improvement programmes which seek similarly wide ranging developments in the characteristics of schools associated with better educational outcomes. Indeed, some of the characteristics of health-promoting schools are themselves similar to those which seem to make schools educationally effective [clvii clviii].

Again, there is some evidence that health promoting schools of this kind have positive impacts. The nature of the school environment would appear to have an impact on health outcomes for pupils[clix clx clxi]. There is also evidence that schools can be enabled to change the nature of their environments and that such changes in turn can impact on health-related behaviours, knowledge and attitudes [clxii]. However, there are sufficient problems and ambiguities with the evidence to cast doubt on the extent to which school change of this kind can be pursued with confidence as a major policy direction. As Inchley et al.[clxiii] point out, for instance, neither the process of school change nor the impact of changed school practices on children are straightforward. It is, moreover, not clear how far impacts in the school years translate into better adult health outcomes[clxiv]. Certainly, impacts in the school years appear to be variable across intended outcomes[clxv clxvi clxvii] and not always easy to identify[clxviii]. Once again, the extent and quality of the evidence base is limited, so that, whilst it is possible to identify promising findings, it is not possible to state with confidence that environmental interventions produce worthwhile improvements in health outcomes – let alone, reductions in health inequalities[clxix clxx].

The evidence informing and emerging from the National Healthy Schools Programme in England seems to paint a similar picture. It:

> …suggests that well designed, broad-based whole-school approaches to promoting health can have an impact on health – as well as education-related outcomes among children and young people[clxxi].

However, the findings are far from straightforward. The quality of evaluations is often poor, the variations in local practices are considerable, and the impacts on educational and health outcomes are neither strong nor uniform. As with programmatic approaches, the implication would seem to be that environmental approaches of this kind have something to offer. As part of a more wide-ranging – and as yet elusive – policy strategy, they may make enable schools to enhance the positive effects they have on health inequalities. However, they cannot take the place of such a strategy. Their effect, at best, is patchy and incremental rather than transformational.

5.5 Education and new forms of service delivery

A further way in which statutory education may contribute to reducing health inequalities is through the opportunities it provides for developing new forms of service delivery. The rationale here is that health inequalities arise, in part at least, because of differential access to and ineffective targeting by health-related services. Even if effective services and powerful interventions are available, they are not accessed not all social groups make full use of them, while service providers struggle to access those groups and individuals that might benefit most. In this situation, schools in particular provide a ready means of access to all children and their families, together with a professional workforce capable of identifying those children most at risk. So, the current *Every Child Matters* agenda, and, within this, the roll out of extended services in and around schools[clxxii], envisages that every school will, to a greater or lesser extent, act as a hub for child and family services, in the expectation that service providers will have easier access to children, and that professionals from different services will begin to coordinate their interventions more effectively at local level.

The evidence on the impacts of these new forms of service delivery is mixed. There is some evidence from England that individual 'full service' schools (as they are sometimes known) can begin to marshal a wide but coordinated range of provision, that this can have significant positive impacts on their most vulnerable pupils and families, and that these impacts occur in relation both to educational inequality and more specifically to health outcomes[clxxiii]. There is also a substantial – though not always robust – international evaluative literature claiming positive outcomes for approaches of this kind[clxxiv clxxv]. However, the evidence on the impacts of reconfigured child and family services is not entirely convincing[clxxvi clxxvii], and the current performance of reconfigured children's departments in local authorities is not encouraging[clxxviii].

The issue seems to be that restructuring in itself does not guarantee better coordinated or more effective services, and, indeed, may undermine service delivery 'on the ground' by focusing attention and energy on organizational issues. However, reconfigured services do create opportunities for new and more coordinated ways of working to emerge at local level. The task for policy makers, therefore, is not simply to mandate structural change, but to encourage local initiatives and to find ways of disseminating the lessons learned

from those initiatives through the system. With this in mind, the Government has recently commissioned a Centre for Excellence and Outcomes in Children and Young People's Services[clxxix] to disseminate evidence of 'what works' in children's services. It remains to be seen whether this approach will prove to be effective or will be too little (in the context of a central target-driven system) and too late (given that service reconfiguration has been under way since 2004).

However, it is clear that the full potential of service reconfiguration and of schools as service hubs has not yet been realized. In a few places, for instance, there are initiatives in which extended services in and around schools form part of a wider strategic development in which education, children's services, community development and economic regeneration are linked [clxxx]. Such developments form part of a long history in this country of area based initiatives but are potentially more comprehensive and powerful than anything that has gone before[clxxxi]. It remains to be seen what developments of this kind deliver, but crucially they are local, and often grassroots, initiatives rather than centrally mandated reorganisations. Moreover, in some cases they promise to address not only the individual and familial causes of inequality, but some, at least, of the structural causes in terms of employment, income and area effects.

5.6 Changing policy narratives?

The evidence surveyed in this brief review points to a deep paradox in education policy over the past two decades. Given the pernicious effects of low educational achievement – not least on health outcomes – governments have been right to pursue improvements in the quality of education provision and the outcomes from that provision. Given the extent of inequalities in educational outcomes in this country, and the likely implications for health inequalities, they have also been right to focus not just on quality, but on *inequality.* Latterly, more forceful attempts to reduce those inequalities, a growing recognition that it is not simply attainment outcomes that matter, and attempts to create more fully integrated child and family services also seem to have been moves in the right direction.

These efforts have not been without success. There is no doubt that on some measures of quality and outcomes, the statutory education system is in better shape than it was in 1997. However, the overall picture is more mixed. Apparent improvements in outcomes relate to a narrow range of attainments, may be somewhat illusory, and may in any case have been bought at the expense of a deterioration in other outcomes that are equally important for health. Above all, educational inequalities remain marked in this country. If some incremental improvements have been achieved, these have stopped well short of the transformation of established hierarchies of achievement and life chances.

There are, we suggest, two competing explanations for this state of affairs. As we noted earlier, post-1997 policy has worked on the assumption that inequalities arise because a minority of citizens find themselves subject to a series of loosely-connected misfortunes which 'exclude' them from an otherwise well-functioning society. In this situation, the appropriate policy response in education is a twin track approach – maximize the functioning of the education system (and hence society as a whole) by improving overall

standards of performance, whilst deploying compensatory strategies for those children at risk of 'exclusion'. As the rationale for one current initiative succinctly puts it, the strategy is one of:

> …'narrowing the gap' in outcomes between 'vulnerable' children and the rest, against a context of improving outcomes for all children.[clxxxii]

However, this is not the only explanation that is available. Educational inequalities can be seen as structural rather than contingent in origin. In other words, they arise not out of specific sets of circumstances that can readily be changed by relatively small-scale policy interventions, but out of deep seated social inequalities reproduced in and through the structures and practices of the education system. On this view, the multiplication of compensatory initiatives targeted towards 'at risk' groups is bound to prove futile unless it is accompanied by sustained and far reaching policy interventions aimed at addressing social inequality per se. As critics of New Labour's educational policy (specifically, of earlier versions of ABIs) put it, the twin track approach is inherently limited:

> Once social and economic disadvantage is redefined as an aspect of the wider inequalities which are characteristic of British society, then these limitations become apparent. The state is not in a position to engage with issues of social inequality, structural shifts in the organization of economic activity and their consequences, except at the margins. The kinds of redistribution which would be necessary to do so simply do not appear on the policy agenda. ABIs and the conceptualizations of disadvantage on which they are based reflect this. They provide a means of presenting the promise of 'active government', but within the highly restricted policy repertoire which in reality is available[clxxxiii].

The implication of this critique is that policies to address educational inequality – and, through that, health inequalities – have also to be capable of addressing social inequality. As Jean Anyon, writing about urban education in the USA, puts it, the very definition of education policy has to be rethought:

> Policies such as minimum wage statutes that yield poverty wages, affordable housing and transportation policies that segregate low-income workers of color in urban areas and industrial and other job development in far-flung suburbs where public transport does not reach, all maintain poverty in city neighborhoods and therefore the schools. In order to solve the systemic problems of urban education, then, we need not only school reform but the reform of these public policies. If, as I am suggesting, the macro-economy deeply affects the quality of urban education, then perhaps we should rethink what "counts" as educational policy. Rules and regulations regarding teaching, curriculum, and assessment certainly count; but, perhaps, policies that maintain high levels of urban poverty and segregation should be part of the educational policy panoply as well…[clxxxiv]

Viewed in this way, there is, in fact, a very wide range of actions that are available to policy makers, ranging from economic and fiscal reform, through the kind of child and family support measures discussed in previous section, and the 'new' kinds of area based initiatives described above, to reconsiderations of curriculum and pedagogy (see, for instance,[clxxxv clxxxvi]).

However, initiating and sustaining wide-ranging actions of this kinds requires the development of an education policy 'narrative'[clxxxvii] around which some degree of social and political consensus can be built. We doubt whether current narratives of 'standards' and 'social exclusion' are capable of this, for the reasons cited above. However, alternative narratives are available. We note, for instance, the growing interest in social policy circles in concepts of risk and resilience[clxxxviii], Sen's[clxxxix] notions of capability, and in the potential for combining these frameworks[cxc]. What these conceptual frameworks offer is a sense that individuals need to 'flourish' across a whole range of domains and that whether they do so or not depends to some extent on what happens to them earlier in the lifecourse and across a range of contexts. Without wishing to suggest that such frameworks could or should be translated straightforwardly into education policy narratives, it is not difficult to see how they open up possibilities for seeing education as a central formative influence across many aspects of adult life, how they locate it within the full range of contexts within which individuals change and grow, and how they position these issues as salient for all individuals, and not only for those 'at risk of exclusion'.

A more coherent approach of this kind, recognising education as a complex system rather than as an aggregation of fundamentally simple causal mechanisms, has implications for where decisions are taken. Since 1988, decision-making in education has tended to become more centralised and reliant on the 'command and control' model of 'New Public Management'. This is not, however, compatible with the formulation of policy interventions which recognise complexity and are sensitive to local variations in complexity. It may be that an increasing reliance on 'public value' approaches is necessary, in which policy makers seek to align the efforts of providers and partners by articulating shared aims[cxci]. At the same time, this implies devolving real decision-making powers to the local level, where complex balances can be struck and coherent, contextually-sensitive strategies formulated[cxcii].

5.7 Beyond 2010

The period between the Education Reform Act of 1988 and the present has been a remarkable one in the history of schooling in England. In a relatively short period of time, the quality of education has moved to centre stage as a national policy concern. Successive governments have taken increasingly close control of what happens in local authorities, schools and, indeed, in classrooms. The capacity of national policy makers to shape what happens to children in schools is probably greater than at any time in the past. At the same time, since 1997 at least, there has been a growing concern with issues of educational inequality and, latterly, with the relationship between children's educational achievements and their well being, and between the education system and other child and family services.

The consequence is that, in the field of education, the tools at the disposal of policy makers for making a difference to children's are more powerful than ever before. If, therefore, educational outcomes remain stubbornly unequal and if these feed into inequalities in other aspects of children's lives, the problem may not be with the tools at

policy makers' disposal, but with the way those tools are being used. In the next section, therefore, we consider what might be done to change this state of affairs.

6. Conclusions

6.1 A view of childhood and health inequalities

Throughout this review, we have emphasized the complex and indirect pathways through which outcomes emerge in childhood and go on to shape outcomes in adult life. Children, we have argued, live, grow up and learn in a wide range of interacting environments. It is the nature of those environments – the extent to which they are 'nurturant' – that really matters in determining whether children will do well or not. It follows that, if public policy seeks to produce better outcomes for children, it has to do so in large part by enhancing the nurturant quality of the environments in which children develop. 'Children's policy', therefore, has to embrace not only measures directly targeted at children, but any measures which support and enhance families, communities and neighbourhoods. In this way, measures to create employment, raise minimum wages, promote community cohesion, and educate adults are as much part of children's policy as policies on assessment in school, or child protection, or standards in child care.

In a situation, moreover, where there are marked inequalities in outcomes for children, and where these are related to broader social inequalities, the aim of public policy has to be to ensure that all children live, grow up and learn in equally nurturant environments. As we have argued throughout this review, strong public services have a particular role to play in this equalization process. However, that role has to be carried out in partnership with the families and communities who interact most closely with children and in a context where families and communities have the best possible chance of creating favourable environments for their children. However excellent public services may be, they stand little chance if they work against the grain of everything else that happens in children's lives, or if they seek to work with families and communities who are themselves struggling against markedly adverse circumstances.

6.2 The current policy context

These tasks present major challenges to policy makers. Making a difference to children's lives is not simply a matter of pulling a single policy lever and seeing improved outcomes follow in short order. Rather, it is a matter of developing a coordinated approach across a wide range of policy domains, tackling fundamental issues of social inequality, working indirectly and uncertainly through intermediaries, and waiting patiently for outcomes to emerge over time. It would be surprising if policy makers were not sometimes tempted to simplify and accelerate the process by looking for 'magic bullets' that might produce an immediate effect.

In this context, our review suggests that there is much to applaud in the current policy context in England. In particular:

- There is a recognition – most notably through the Child Poverty Strategy – that underlying social inequalities have to be tackled if children's lives are to improve.

- There is an understanding that these inequalities are complex, and that 'social exclusion' manifests itself across a series of the environments in which children live.
- There is a corresponding understanding – of which the Children's Plan[cxciii] is the most visible manifestation – that action to improve children's lives needs to be strategic and to be coordinated across a range of policy domains.
- There is a recognition in the 'five outcomes' of Every Child Matters, that children themselves learn and grow up across a range of domains, and that improving children's lives means paying due attention to each of these.
- There is a recognition of the crucial role of public services in working with children and their families and communities. This manifests itself as an attempt to ensure both that individual services are as good as they can be, and that they work together in a coordinated way at local level.
- There is a recognition that inequalities in childhood outcomes exist, and that addressing them requires differential attention and resourcing.

It is important to set out these achievements for two interrelated reasons. First, it seems that **many of the tools that are necessary to improve children's lives are already in place. The need beyond 2010 is less to develop new policy interventions and frameworks than it is to ensure that those already in place are working as effectively as possible**. Second, **the task from 2010 may be to protect what has already been achieved and to see that it is deeply embedded so that it is protected from financial turbulence.**

With this in mind, our review also exposes some of the weaknesses and limitations in the current policy context. In particular:

- Although there is a recognition that social inequality matters, efforts to address inequality, even in the limited form of meeting child poverty targets, have had, at best, mixed results. Inequality remains a marked characteristic of the society in which children in England grow up.
- Although there is a recognition in principle of the importance of strategic, coordinated action at both national and local levels, the extent to which such action actually materialises is doubtful. To some extent this may be attributable to the recent creation of integrated structures – the major reforms embodied in the Every Child Matters agenda, for instance, will only be 6 years old in 2010. However, our review suggests that there are deeper problems to do with the 'new public management' approach of high stakes accountability for individual services and providers, a multiplicity of short term service targets, and a tendency towards central control from loosely-connected government departments, reducing the capacity of local providers to respond in a coherent way to local conditions.
- Although there is a recognition of the need for a long term approach to enhancing children's environments, policy efforts continue to generate a rapid succession of short-term initiatives. As we have argued throughout this review, the chances of most of these initiatives having a significant impact on children's lives are limited. Perhaps more important, the rapid turnover of disconnected initiatives

makes it difficult for service providers on the ground to detect any national strategy or to develop a local strategy, while national resources are consumed in ways that may do little to enhance core provision in the long term.

We argue, therefore, that, while it is essential to protect what has been achieved, **the task after 2010 is also to reshape the style of policy making for children so that it is more far reaching, more strategic, and better coordinated**. This view shapes the nature of the recommendations we make below. It is conventional for reviews of this kind to generate a long list of recommendations for specific measures that policy makers might take. It seems to us that this is not quite what is needed here. This is for reasons both of practicality and of principle:

- In practical terms, the actions that are needed cover a wide range of policy areas. They include, for instance, retaining the commitment to eliminate child poverty by 2020, ensuring an adequately trained and remunerated workforce, developing a banding approach to school admissions, reinstituting the developmental role of Ofsted, issuing new guidance to local strategic partnerships, and any number of other actions that might impact on children and the environments in which children live. Reducing speed limits, and improving housing will impact on the single most important cause of child death in this country. Turning the broad brush recommendations here into policy recommendations with real 'bite' is a task for the Commissioners, working with stakeholders.
- In terms of principle, it seems to us that simply multiplying the number of policy measures would be the wrong thing to do. It would, we believe, feed into the short-termism that has characterised the worst of the current context, rather than into the strategic approach that characterises it at its best. Moreover, if we are right in thinking that most of the policy tools that are needed are already to hand, the future development of policy has to be about how existing tools are used rather than about developing new ones.

6.3 An eight-pronged approach to better policy

What follows is a recommended eight-pronged approach to the development of children's policy post-2010. These are recommendations that demand a fundamental debate in policy circles and amongst the wider public.

We recommend that, post-2010, policy makers should:

1. *Renew efforts to tackle social inequality*

Inequalities in outcomes for children are linked to underlying social inequalities, as indicated by absolute and relative poverty and by income inequality. There is little point putting in place ameliorative and compensatory measures unless these inequalities are tackled head on. Renewed efforts to tackle social inequality are therefore called for. These efforts should *build on* current commitments to end child poverty, maintain or increase the minimum wage, keep the adequacy of benefits under review, and narrow the gap between the best and worst off. However, they should be channeled through a more rigorous pursuit of progressive fiscal and welfare policies, in particular tax allowance and benefits upratings, together with the sorts of measured outlined in Social Exclusion

section of this Strategic Review. The strategy should include transport and housing interventions which have been shown to have the potential to reduce the steep gradient in morbidity and mortality in the young.

2. *Develop a coherent, evidence-informed and values-driven policy narrative about childhood*

This narrative should *build on* the work that has already been done in the Every Child Matters agenda, to articulate how children live, grow up and learn, and the role public services have in supporting children and their families. A coherent narrative should offer a clear account of how one aspect of child development informs others, why some children do better than others, how public services work together and work with families and communities, and, above all, why equality matters. Developing a narrative in this way means:

- articulating the narrative in formal policy texts such as green papers and guidance documents;
- ensuring that policy initiatives and accountability processes are clearly founded in the narrative; and
- using the narrative as the basis for dialogue with local policy makers, providers and citizens, including child citizens, in order to establish consensus around aims and values.

The materials for a better narrative are to hand – not least in the notions of nurturant environments, resilience and capability floated in this review. The processes for developing a new narrative are also to hand, particularly if policy makers centrally are prepared to engage in dialogue with practitioners and citizens at the local level. Again, what matters is the will to build on what has been achieved so far.

3. *Develop coherent policy strategy*

The formulation of a coherent narrative should be part of a refocusing of the efforts of policy makers away from micro-management and towards the development of coherent policy frameworks at the strategic level. This development should *build on* policy efforts to bring children's policy together within a single overarching framework, and, stemming from this, to create integrated children's services. Taking these efforts further means:

- redirecting resource and effort from short-term disconnected initiatives towards core provision;
- disinvesting particularly from initiatives with little evidence of benefit;
- locating high-profile policy concerns ('school standards', 'child protection', 'knife crime') in a strategic policy context so that they do not distort policy efforts;
- matching each policy initiative to an underpinning rationale derived from the policy narrative.

4. *Devolve more policy development to the local level*

Despite the key role of central policy making in shaping the lives of children, the complexity of those lives can only fully be accommodated at local level. It is here that the ways in which particular environments interact with particular children to generate particular outcomes can be understood. It is only by devolving control to local level,

therefore, that effective policy interventions can be constructed. Devolution should *build on* existing commitments to 'new localism' and frameworks (local strategic partnerships, children's centres, extended service clusters, children's trusts and the like) already established for collaborative working between a range of actors at the local level. It should take this further by:

- further reducing the numbers of centrally-generated targets and initiatives to which local providers and policy makers have to respond;
- extending the freedoms for local policy makers to develop their own strategies and set their own targets;
- shifting the emphasis of support for local providers and policy makers away from efficiency in delivering central imperatives and towards effectiveness in formulating their own strategies.

5. *Learn from the local*

It is not enough simply to devolve decision making to the local level. Structures and processes need to be put in place so that the system as a whole can learn from what is happening in particular places. Even in advance of any increase in devolved policy making, there is a growing number of examples of local initiatives bringing child and family services, education, and other public services together to develop strategic approaches that are well in advance of anything that has been developed at the centre. Post-2010, we believe it will be important to *build on* these local experiments in a more systematic way. In particular:

- the emphasis should shift from centre-periphery to periphery-periphery and periphery-centre policy development;
- a range of locally-led initiatives should be identified for intensive support and study;
- structures and processes should be put in place for learning from local initiatives, perhaps building on the work of the new Centre for Excellence and Outcomes which already has a remit to identify and disseminate 'good practice' in local areas.

6. *Change the emphasis of control and accountability*

National policy makers rightly want to ensure that their policies are implemented and that local providers and policy makers are accountable for what they do. However, the current system of disconnected and narrative-free PSA targets, coupled with separate inspection mechanisms, and high stakes accountability for delivery on a narrow range of targets is dysfunctional. In short, it is a recipe for the fragmentation of children's policy on the ground, and for the disabling of attempts to formulate local strategy. Post-2010, there is a need to *build on* current moves to develop joint inspection procedures and area assessments, but to take these much further by:

- deriving what are currently *targets* (at government, service, and institutional level) from a coherent narrative and reconstructing them as *indicators*;
- developing further the methodology for area assessment so that local providers and policy makers are held to account jointly for what happens to the children for whom they are responsible; this might be done in part by monitoring social determinants – such as an increase or reduction in green space, speed limits and a

reduction in notices telling children that they are unwelcome – rather than measuring children.
- holding providers to account for the coherence of their strategies as well as for immediate outcomes;
- extending the time scale for accountability so that long-term outcomes matter as well as short-term gains.

7. Change the professional orientation of the children's workforce

It is now possible to *build on* the fact that there is a children's workforce (as opposed to a series of disconnected professionals working separately with children), and that the quality of that workforce is a matter of policy concern. However, what is needed post-2010 is a workforce that is capable of supporting children's development across a range of domains, able to analyse the environments in which children live and understand their impact, and capable of intervening effectively to ensure that children do well. This means that:

- however diversified the children's workforce may be, it should maintain a critical mass of well-trained personnel who are 'professional' in the sense that they act on the basis of explicit values about children and childhood, are capable of understanding complex issues, and are able to work both collegially and autonomously;
- the pressure on children's workers to act simply as the implementers of centrally-mandated imperatives and programmes should be replaced by a dialogue between locally-developed and centrally-mandated practice;
- narrowly-conceived training for children's workers should give way to more broadly-based 'professional development';
- the pay and conditions of children's workers should keep pace with the demands of their work and the qualities that it demands;
- those in senior political positions should resist the temptation to vilify this or that group of children's workers;
- the positive and negative implications of the mixed economy of provision – specifically, the role of employment agencies – should be reviewed.

8. Develop the evidence base

England is fortunate in the evidence - cohort studies, evaluation of interventions, and outcomes from programme trials for instance – on which it can draw to inform policy and practice. However, not all of the evidence is of high quality. Post-2010, therefore, it will be necessary to *build on* established sources of evidence to make them more comprehensive and better-used. This means:

- ensuring a dedicated funding stream in both the research councils and government departments for a programme of research focused specifically on social, health, and educational inequalities in childhood;
- building the evidence base on the *cost* effectiveness of non-clinical interventions, taking into account a wide range of outcomes;
- focusing on what can be learned from countries (such as some of our European neighbours) with outstanding outcomes for children rather than from countries where outcomes are less good;

- requiring local policy makers and providers to build strong evaluation into their initiatives;
- developing the capacity and willingness of childhood researchers to use of a wide range of research and evaluation methods, stressing fitness for purpose.

There is a further option which we think is worth considering, but which we do not feel able to recommend unequivocally. Between 1999 and 2006, a National Educational Research Forum, sponsored by Government, brought research stakeholders together to develop a national educational research strategy. It would be possible to establish a similar coordinating forum for all childhood research, and this might oversee the developments listed above. However, there is a fine line between coordinating and enhancing research on the one hand, and establishing deadening central control on the other.

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