



8. Deprivation and Disadvantage – Children in Special Circumstances



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This chapter describes how the impact of deprivation and disadvantage can create lifelong challenges for children and families. As the needs of these children and young people are greater, they must always be considered as part of strategies for improving health and wellbeing. Part of the practical difficulty we have is in actually identifying many of these most vulnerable children in our society – there is often no routine data source about how many of them there are or what their experiences are, and yet the impact may be on whole families or communities. Public sector organisations should analyse the effectiveness of their commissioning strategies on the impact they have on these most vulnerable groups if they are serious about tackling inequalities in health of children and young people.

8.1 Children living in poverty

Being born into, and growing up in poverty, has a profound impact not only on health and wellbeing in childhood, but also on future adult life. Before birth, foetal development and outcome can be compromised by poor nutrition and this health burden may then continue into infancy and beyond. Although the number of infant deaths in England is small, children from the most deprived backgrounds are more likely to die before they are a year old than those from the most affluent areas.

The difference in outcomes between those being born in the most deprived areas to those in the least deprived areas extends throughout childhood and into adulthood, and it is striking how many indicators of child health show a marked relationship to socio-economic gradients. Children from poorer backgrounds are less likely to be breastfed, are more likely to be exposed to tobacco smoke and are more likely to be injured on roads. Young adults from poorer backgrounds have lower levels of educational attainment and teenage girls are more likely to become pregnant. In adulthood, men and women from poorer backgrounds are more likely to be affected by the most serious diseases such as heart disease and stroke. This disadvantage from background means that by middle age, people from poorer backgrounds have death rates almost double those seen in people from more affluent circumstances (Association of Public Health Observatories, 2007).

But poverty is not just concerned with those factors that affect material wellbeing, such as income and housing. Also of importance are the childhood experiences and the relationships that children have which support them in developing the characteristics and skills they need for life. Their relationship with their family, significant others and their community; their opportunity to gain a variety of experiences which broaden their awareness, and their access to appropriate education, are part of a whole range of factors that are vital for building the protection, resilience and aspiration necessary if children are to fulfil their potential and the cycle of deprivation is to be broken.



The Government's ambition is for children to grow up free from deprivation and disadvantage and that birth and social background do not hold them back from achieving their potential. Tackling child poverty is a crucial component of this ambition.

Since 1999, the reduction in child poverty in the UK has been a central tenet of Government policy. The pledge to end child poverty by 2020 focuses and consolidates the commitment to ensure that no child's life is scarred by poverty and that every child has the opportunity to fulfil their potential.

Nationally, progress on child poverty is currently measured using three indicators:

- Relative low income (compared to national economic change).
- Absolute low income (finance in real terms).
- Combined low income and material deprivation.

As a result of this comprehensive Government strategy for tackling child poverty, significant progress has been made. Since 1999, some 600,000 children have been lifted out of relative poverty and the number of children living in absolute poverty has halved from 3.4 million to 1.7 million children (see Figure 8.1).

However, it is clear that in order to achieve the 2020 goal, action on child poverty needs a renewed and continuous focus. There are still significant numbers of children in poverty: despite an overall fall since 1999, over the most recent period relative poverty has slightly increased, persistent poverty remains a problem and children living in poverty still do not have the same opportunities and life chances as their peers. Indicators of disadvantage are as follows:

- No parent in the family is in work.
- The family lives in poor-quality or overcrowded housing.
- Neither parent has any qualifications.
- The mother has mental health problems.
- At least one parent has a long-standing limiting illness, disability or infirmity.
- A parent has an offending record.
- The family has low income (60% of the median).

Figure 8.1: Key facts about childhood poverty

- 3.8 million children are living in poverty in the UK today.
- Parental employment is the single biggest determinant of family income:
 - 61% of workless couples households live in poverty, and 48% of all poor children live in workless households.
 - Living in a household where no adult is working heightens a child's risk of living in relative poverty by 63%.
 - 52% of children living with a lone parent are poor. Only 15% of the children of lone parents are poor if the lone parent works full-time.
- 24% of poor children live in a household where one or more adults have a disability.
- 43% of poor children live in families with three or more children, rising to 48% if there are four or more children.
- Over two-thirds of those below the poverty threshold at any one time have been in poverty for at least three of the past four years.
- Child poverty compromises educational achievement and emotional behaviour outcome:
 - Children from the 5% most disadvantaged households are more than 50 times likely to have multiple problems at the age of 30 than those from the top 50% of households.
 - 60% of children in the lowest reading attainment group at age 10 had parents with low literacy scores.
 - The likelihood of becoming a teenage mother is 10 times higher for a girl whose family was in the lowest social class when compared with the highest.

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In terms of what action is possible to help tackle child poverty, there are a number of 'protective' factors: personal characteristics such as high intelligence; good social skills and positive temperament qualities; being brought up in a secure family relationship with a warm empathic adult within the family or community, and controlling the level of exposure to stress and knock on effects.

Building resilience is another protective factor: creating opportunities to build self-esteem and thereby enabling children to cope with adversity; developing a social environment that reinforces and supports positive efforts made by the child, and non-stigmatising access to help and support.

The third component is raising aspiration by enabling opportunities to access a wide variety of experience in a range of settings, providing educational support and mentoring and exposure to positive role models.

Information on children can be collated into an index of child wellbeing. It is constructed using the seven domains: material wellbeing (income); health; education; crime; housing; environment and children in need.

Mapping this index demonstrates where there are pockets of child poverty, based on Super Output Areas (Figure 8.2).

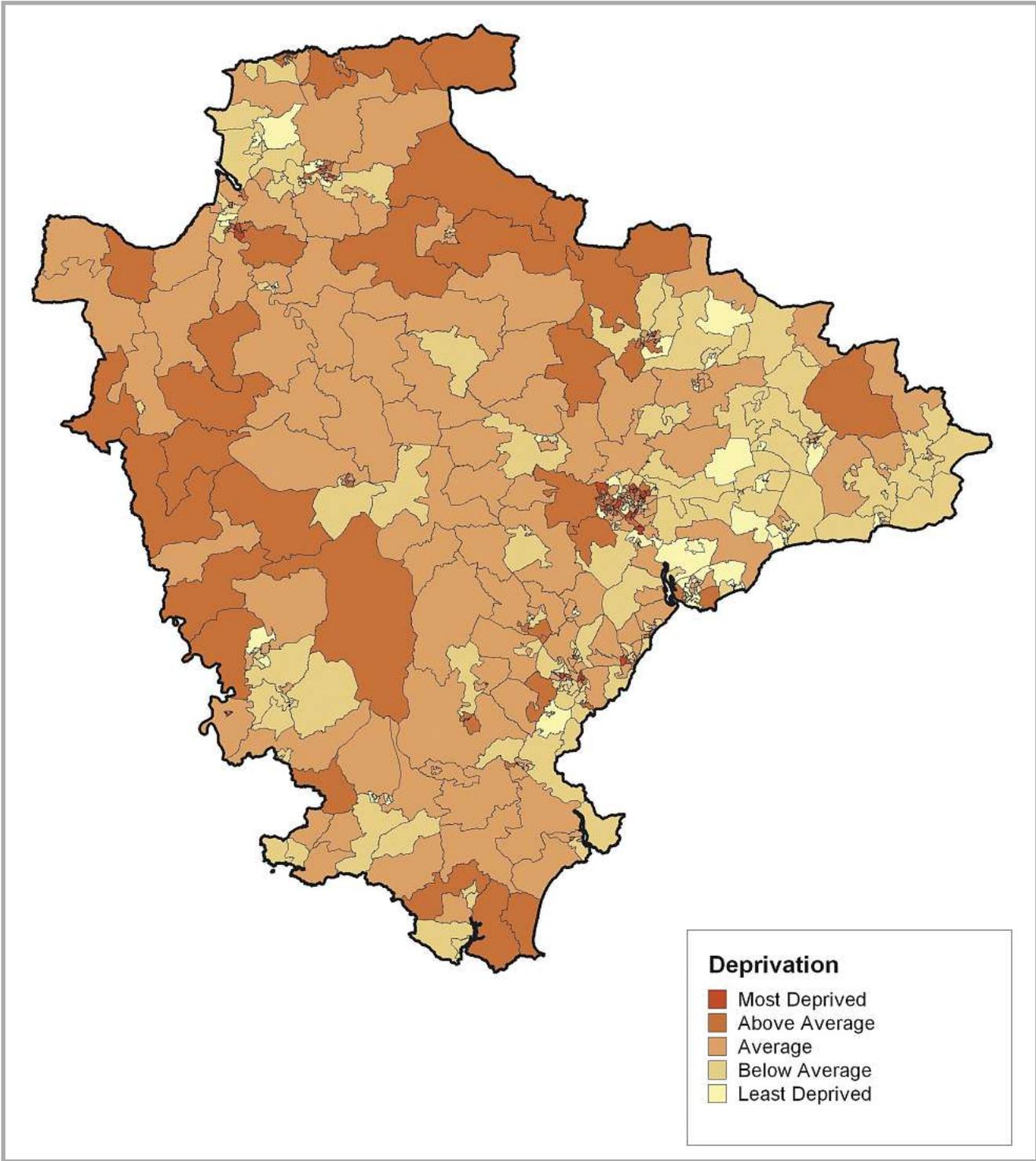
The link between poverty, deprivation and poor outcomes, and the cost to both the individual and wider society is indisputable. The cycle of deprivation must be broken by tackling inequalities and increasing the potential of all children living in poverty. It is therefore vital that sustained effort and investment are targeted to those most in need. Child poverty is of concern for the whole of society. Prolonged periods of poverty and material deprivation do the most damage to children's outcomes, as when children fall behind early on, it becomes increasingly difficult for them to participate in society. The recent global economic shocks have brought tougher times and many families are facing new pressures. There needs to be a renewed focus and effort on children and young people in poverty if we are to avoid a worsening situation for those children who are society's future.

References

Association of Public Health Observatories (2007).
Indications of Public Health in the English Regions 5:
Child Health



Figure 8.2: The Child Wellbeing Index for Devon Primary Care Trust area



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8.2 Vulnerable groups

Many factors are necessary to achieve and maintain good health in addition to the child's genetic inheritance. Individual lifestyle choices; social and community networks; living and working conditions; as well as the surrounding socio-economic, cultural and geographic environments, all contribute. Much depends on a child or young person's ability to integrate with, and be supported by, wider society. But within a society that places value on conformity, and if that society is less aware of the benefits diversity can offer, some groups of children have much more difficulty in achieving the best start to life.

Equal opportunities legislation acknowledges that there is a range of characteristics people may have which makes them more likely to be discriminated against (including age, gender, ethnicity, culture, mental or physical disability), and that a legal framework is needed to protect the vulnerable. However, for those that are most in need of protection, such as children and young people, extra support is needed to ensure that they have an opportunity to reach their potential.

This is particularly so if the factors that contribute to vulnerability are hidden, or individuals are isolated by their context. As young people develop and establish themselves, their choices and sexual preferences may add to both hidden vulnerability and alienation. Children in care; children of offenders; children whose parents misuse drugs or alcohol; children who live in a setting where there is domestic violence and abuse; children with learning difficulties; gipsy and traveller children; as well as those who come from a black or minority ethnic background or who have a physical disability, are some examples (and some will have multiple needs) where isolation compounds the need. Specialised support is required that is tailored to the individual and their circumstances and is sensitive to cultural differences.

The National Service Framework for Children and Young People (2008) describes 'children in special circumstances' as:

- Looked-after children and care leavers.
- Homeless children and families.
- Children living with domestic violence.
- Children who suffer from sexual exploitation.
- Children of parents with specific needs, for example mental health problems, alcohol

and/or drug misuse.

- Children excluded from school or truanting.
- 16-18 year-olds who are not in work, training or education.
- Teenage parents and their children.
- Children from some ethnic minorities and refugees and asylum-seeking children.
- Young people in prison.
- Children with disability (including learning disability).
- Children with mental health problems.

The Department of Children, Schools and Families' assessment is that nationally there are:

- 3 million vulnerable children.
- 386,000 children in need.
- 61,000 children in care.
- 26,000 with a child protection plan.

Parenting and upbringing are recognised as being vital factors in the wellbeing of children and young people. Where the family or main carer is different in some way; where they are separated by their culture; where their circumstance or behaviour is considered unacceptable; or where they are suffering from complex needs, marginalisation and discrimination, may result in the family being socially excluded, making it difficult to engage with the child or young person to support them in developing their potential. Family loyalty may also be an added barrier, for example where the child is a young carer of a disabled adult or where their parent is an offender. It is estimated that nationally there are around 160,000 children with a parent in prison each year and that 63% of boys whose fathers go to prison are eventually convicted themselves and yet there is currently no method for routinely collecting this data.

One barrier for vulnerable children is a lack of basic skills. The Government's Basic Skills Agency defines basic skills as "the ability to read, write and speak in English and use mathematics at the level necessary to function and progress at work and in society in general". Where this ability is compromised, for instance where parents lack basic skills, where there is a learning difficulty, or for non-English speakers, there may be a significant impact on the children and young people.



Accessing services may also be more difficult for vulnerable groups. Families are often unaware of what support services are available and information may not be available in their own language, or understandable to those with basic skill difficulties. The family may have had bad experiences with services or there may be other cultural issues. Whatever the reason, there are additional and significant barriers for those who are most vulnerable to access the help they need, particularly for children and young people.

For socially excluded children, mental and psychological health is a major issue. This can become particularly acute as young people develop and begin to make choices for themselves. It is known that those young people who were vulnerable within their early years are more likely to misuse substances, smoke, commit crimes and are more likely to become teenage parents or become homeless, but there may be additional vulnerabilities brought for example, by their emerging sexuality or gender identification.

For many young people who are perceived as being different in some way, harassment and bullying is a significant factor in their health and wellbeing, and vulnerability may affect their ability to cope. Harassment and bullying is not only an issue for those children or young people who are the recipients: it is also an issue for the perpetrators and the wider population.



In Great Britain, the minority ethnic population grew by 53% between 1991 and 2001; increasing from three million in 1991 to 4.6 million in 2001. Black and minority ethnic groups generally have a younger age structure than the white population, though the extent of this differs between ethnic groups according to history and immigration patterns. Children from black and ethnic minority backgrounds make up about a fifth of the total population less than 20 years of age.

In Devon there are approximately 165,000 children of whom 91% are described as White British, 0.14% as Black or Black British, and 0.16% as Chinese (although it is known that there is a large Chinese community in Exeter). Despite the lack of definitive statistics, all available evidence points to an increase in migrant workers. The official number of new migrant workers in Devon in 2005-06 was 5,960, more than a 50% increase on the previous year. The rate of increase has been accelerating since 2001-02. In January 2006, there were 229 gipsy and traveller caravans reported pitched in Devon on legal and illegal sites. There are other established ethnic minority communities within Devon, for example the Polish community in Mid Devon.

Other important issues in Devon are that in any classroom, between two and four children are likely to be living in a home where domestic abuse takes place; 6,500 children and young people are identified with some form of special educational need, learning difficulty or disability and 2,000 children will have identified mental health needs.

The link between vulnerability, poverty and child health are well-known. This association can be seen using 22 indicators that have been developed by the Child Health Indicators of Life and Development (CHILD) which are divided into three groups: measures of population health status; risk factors and determinants of health, and actions to promote child health. A wide range of sources indicate that children from black and minority ethnic backgrounds are over-represented within virtually all categories of vulnerable children – from child poverty to children in care. For example, young people from minority ethnic groups disproportionately experience many of the known risk factors for developing mental health problems, including exclusion from school, being in care and homelessness. Young refugees and asylum seekers may have significant mental health needs arising from their past experiences of trauma, bereavement, loss and grief.

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However, there is a lack of data on the health of the most vulnerable children in our society, and therefore there is no central source that is able to provide a detailed analysis of any potential variations in the health of vulnerable children across the English regions. This is despite the fact that these children are likely to be the ones in greatest need of service provision. What has been recognised is the need for agencies to work together and offer a collective response that is centred on the individual's needs, circumstance and context.

In summary, there are two different types of groups of vulnerable children: those who grow up exposed to a particular set of circumstances, and those who find themselves in circumstances where they share issues with others, for example young carers or homeless young people. What is common is that there is a lack of information on the health of the most vulnerable young people in our society.

For all vulnerable children, young people and their families, access to appropriate support and advice that takes into account their specific needs and context is vital. This can only be achieved by organisations and services working together and having dedicated and specialist resources targeted at those most in need. Of particular concern are the comparatively hidden groups: gipsy and traveller children; young carers; children of offenders; those that are homeless; those living with domestic violence and abuse, and those discovering whether they are lesbian, gay, bisexual or transgender. Probably the most important aspect is to address their emotional and psychological needs – their mental health and emotional wellbeing, and to actively challenge bullying, harassment and discrimination – wherever it comes from.

8.3 Learning disability

Whatever age group, people with learning disabilities are people first, who should be valued and respected for their differences, who have the same rights as other citizens to healthcare, but who have particular health needs. Their health needs should be met by mainstream health services, but the evidence is that this is frequently not the case. Reasonable adjustments might need to be made to accommodate their needs, which often include communication difficulties.

There is evidence, nationally and locally, that people with learning disabilities suffer from the inverse care law and are not able to access mainstream services, whether this is in respect of general health promotion, disease prevention, screening or treatment.

“Valuing People Now” (Department of Health, 2007) sets out the direction of travel and delivery priorities for the provision of services for adults with learning disabilities over the next three years. The priorities focus on personalisation, what people do during the day, better health, access to housing and making sure change happens. There is a need to raise awareness and understanding among all healthcare professionals of the particular health needs of people with learning difficulties. Professionals need to put in place those ‘reasonable adjustments’ that need to be made to facilitate better engagement to maximise health benefit.

There is a consensus expert opinion that annual health screening should be undertaken to help to identify unmet need. National guidelines pertinent to improving health and quality of life in people with a learning disability have been produced by the National Institute for Health and Clinical Excellence (NICE). Guidance has also been produced by the National Screening Programme for breast and cervical screening programmes (Good Practice Guidance, October 2000) to ensure women with learning disabilities achieve the same level of access to services as other eligible women in the general population. The Royal College of Nursing (2006) has produced guidance for professionals caring for people with learning disabilities which covers specific health needs, specialist services, supporting access to services and signposting to a range of other resources.



About 3,000 people are recorded on General Practice registers in Devon as having a learning disability. Adult care services currently support just over 2,000 people with learning disabilities. The prevalence of people with a severe learning disability is set to rise by around 1% each year due to longer life expectancy (especially those with Down's syndrome), with more children and young people with complex and multiple disabilities surviving into adulthood, the rise in the reported number of school-aged children with autistic spectrum disorder, and the greater prevalence of learning disability in some minority ethnic groups.

The health of people with a learning disability is much worse than the population as a whole. One-third have a sensory impairment, around a fifth have a physical disability, and a quarter will suffer from some form of mental ill health during their life. People with a learning disability are also more likely to be obese, develop epilepsy and have a higher mortality rate and greater morbidity in relation to treatable conditions. Severe learning disability is relatively evenly spread in the population, although mild to moderate learning disability is linked to poverty and rates are higher in deprived and urban areas. Rates may also be higher in areas where large learning disability institutions existed previously.

For an average General Practice of 10,000 patients, about 30 patients will have severe learning disabilities and about 220 with mild to moderate learning disabilities, although rates will vary widely between practices.

In summary, people with learning disabilities have greater health needs than the general population and are at a higher risk of premature death and four times more likely to have a preventable cause of death. There is a need to improve equality of access for all people with learning disabilities to primary care, community and specialist health services, including palliative care.

References

Department of Health (2007). *Valuing People Now: From progress to transformation*. London: Department of Health

Royal College of Nursing (2006). *Meeting the needs of people with learning disabilities. Guidance for nursing staff*. London

8.4 Physical and sensory disability

There are 6,500 children and young people identified with some form of special educational need (SEN), learning difficulty, or disability in Devon. Of these, 4,000 have a statement of special educational need or are known to the Joint Agency Service as a child with special needs, which includes physical, sensory and learning difficulties or disabilities; behavioural, emotional and social difficulties, and mental health difficulties.

A structured series of events has been held across Devon, which included more than 200 parents and professionals, with the aim of producing a detailed needs assessment of the area to develop the vision and way forward for services for children and young people. These are reflected in the "Integrated Commissioning Strategy for Children with Additional Needs, 2008-2011" and the "Integrated Service Specification for Residential Carers Breaks".

The engagement process with parents and carers indicated that they wished their child to receive services wherever possible in their local communities, but that they were prepared to travel to centres of expertise for those highly-specialised assessment services that their child required. The commitment in Devon is therefore to develop three areas of specialised child development assessment services with as many outreach services as safe and acceptable to be provided in local schools, special schools, and nurseries and children's centres, to ensure a consistent pathway of care from pre-school to school provision. The strategy prioritises the vision of developing a 'needs-led' rather than 'service-led' service that is accessible, fair and acceptable to all who need help, particularly children from the more vulnerable or marginalised communities, so that services are available when and where children need help and are delivered in less stigmatising places and ways. The strategy for carers breaks aims to ensure an equitable, consistent service in Devon, with provision being provided as close to home as possible that reflects and responds to their individual needs. A strategy to improve palliative care for children and young people in Devon is being developed during 2009.

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8.5 Young carers

Young carers are often difficult to identify because of their silence. This silence is often the result of fear: fear of coming to the attention of professionals and fear of separation from their families, either by the institutionalisation of the care recipient or by the instigation of care proceedings. Many young carers feel stigmatised because they are different. They do not experience the same type of childhood as other children, and their parents and siblings are in some way perceived as being different. Some young carers are likely to be doubly stigmatised – those caring for parents with mental health problems or problems of addiction, or siblings of someone with a learning disability. Many feel they have no-one to turn to or that they are letting people down if they talk to someone. Schools have a key role, in conjunction with health and social care professionals, in providing a range of opportunities for children to seek help.

When attempting to provide a definition of a carer, one of the challenges is that many people do not see themselves as a carer or undertaking anything other than that which is expected of them, given the circumstances they find themselves in. Caring takes place within a context of culture, love, duty and obligation and carers as such are not therefore a homogenous group.

The national vision is that by 2018 “... carers will be universally recognised and valued as being fundamental to strong families and stable communities. Support will be tailored to meet individuals needs, enabling carers to maintain a balance between their caring responsibilities and a life outside caring, whilst enabling the person they support to be a full and equal citizen...” (HM Government, 2008). The vision is underpinned by a number of principles. Carers will be respected as expert care partners and will have access to integrated and personalised services to support them to have a life of their own alongside their caring role. Carers will be supported and not forced into financial hardship by their caring role, and supported to stay physically and mentally well and treated with dignity. Children and young people will be protected from inappropriate caring and have the support to achieve the five outcomes in “Every Child Matters” (be healthy; stay safe; enjoy and achieve; make a positive contribution, and achieve economic wellbeing).

Core elements of a carer, as defined in the health needs assessment recently undertaken by Devon Primary Care Trust area (Tolley, 2008), includes the fact that extra unpaid responsibilities are undertaken so the person cared can remain in the community. Paid support workers or personal assistants are not considered to be carers in the context of this report.

Research commitments outlined within the national 10-year strategy (HM Government, 2008) include the piloting of models of best practice to improve joined-up service provision between the National Health Service, local authorities and the voluntary and not for profit sector; pilots to improve the support offered by GPs for carers and annual health checks; increased support for young carers via universal services, and improved support to families and flexible employment/caring opportunities.

From the 2001 Population Census it would indicate that in Devon there are just over 2,000 young carers (less than 3% of carers of all ages), although it is believed that there are significantly more than this. Roughly half of the young carers (1,084) are below 16 years of age. Young carers’ health can be severely affected by caring on a daily basis and sometimes through the night. Physical tasks such as repeated lifting and handling with the emotional impact, anxiety, stress, depression, sense of isolation, and feelings of difference, all take a toll on health. The lack of opportunity to socialise, exercise, and a poor diet can lead to an unhealthy and isolated life. Problems with education due to a lack of time for homework or exams; guilt and resentment from reconciling conflicting needs of themselves and their parent; the feelings of no-one to turn to, plus the lack of recognition of their role, all compound the health inequalities that exist. Problems can be experienced in the transition to adulthood affecting further education, finding work, accommodation and relationships.

In summary, defining exactly who is a carer is challenging. Many carers are reluctant to come forward and seek help from the public sector. Carers of all ages are therefore a vulnerable group who are at a disproportionate risk of experiencing health inequalities.



References

HM Government (2008). *Carers at the Heart of the 21st Century Families and Communities – a caring system on your side, a life of your own*. London: Department of Health, 2008

Tolley, F. (2008). *A Health Needs Assessment of Carers*. Devon Primary Care Trust

Recommendations

- 8.1 To increase opportunities for employment such as apprenticeships.
- 8.2 To promote non-stigmatising access to help and support for young people, for example implementation of the “You’re Welcome” criteria.
- 8.3 To focus resources on parenting – both supporting general parenting programmes and providing sustained, targeted support for those most in need.
- 8.4 To provide individual, person-centred support for those who have a complex range of needs that cumulatively have massive impact, but that individually do not meet the current thresholds (early intervention).
- 8.5 To encourage the development of basic skills for children, young people and their families.
- 8.6 To work with partners to raise the aspiration of children and young people in Devon.
- 8.7 To review and enhance definitions of, and accurate data collection about, child homelessness, gipsy and traveller children, young carers, children of offenders, those that are homeless, those living with domestic violence and abuse.
- 8.8 To invest further in culturally sensitive mental health and emotional wellbeing services which address the needs of minority groups.
- 8.9 To demonstrate improved health outcomes for people with learning disability by providing annual health checks in primary care, the provision of appropriate treatment and follow-up in the right environment, with Health Action Plans to enable the client/carer to take better care of their needs.
- 8.10 To demonstrate improved access by people with learning disabilities to public health promotion programmes such as weight management, physical activity, and screening programmes.
- 8.11 To strengthen joint commissioning arrangements so that resources can be targeted to meet needs.
- 8.12 To improve information about, and support for, young people who have a caring role.
- 8.13 To improve support for all carers, irrespective of age, at times of crisis.
- 8.14 To analyse the effectiveness of commissioning strategies in terms of the impact they have, not only on all children, but on these most vulnerable groups to demonstrably improve inequalities in health in vulnerable children and young people.

