Health Inequalities - Early Years

Fatalities Investigation and Review Studies project (FIRST)
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My name is Alyson Leslie and I am a senior lecturer in the Fatalities Investigation and Review Studies project (FIRST) at the University of Dundee. I am a former assistant director of social work and I undertake reviews and inquiries primarily involving cases of maltreatment of children. I am currently a member of the Independent Jersey Care Inquiry Panel, reviewing abuse perpetrated in care homes over many decades.

My perspective on the Health and Sport Committee's work on health inequalities derives from my work on reviewing child fatalities. The Scottish Government has in the past week affirmed its commitment to developing a national system of reviewing all deaths of children in Scotland on a case by case basis and the Chief Medical Officer has funded work at the University of Dundee piloting one system of such reviews. We will have submitted our report on these pilot reviews, known as Ruby Reviews, by the time of the Committee's 13th May meeting for the Scottish Government's consideration and evaluation.

The Committee will be aware of research findings by the Institute of Health Metrics and Evaluation (IHME) in Seattle showing the rate of child deaths in the UK is amongst the worst in Europe. There are five excess children's deaths every day in UK compared to Sweden.

Within the UK, the rate of child deaths is Scotland is higher than in the other jurisdictions of the UK, the largest disparity being in child and adolescent trauma deaths, that is deaths from injury, assault, suicide or involving reckless behaviour, particularly amongst boys. This is despite child and adolescent injury death rates almost halving in Scotland since the early 1990s.
Around 440 children in Scotland die each year. That is over 32000 potential years of life - years where children and adolescents won't be growing, learning and contributing to our society, years of loving and being loved, years of sorrow for grieving families.

There is a well-established link between child mortality and deprivation. Most child deaths occur in infancy, within the first few days and weeks of life, the dominant causes being perinatal events or congenital anomalies. Although various streams of work seek to reduce deaths in this group, yhe highest proportion of deaths with potentially modifiable factors is in the highlighted 11-15 age group. All categories of child death are associated with material deprivation.

Previously in Scotland questions have been raised, including by the chair of this Committee, about the high level of deaths amongst vulnerable children. Over a six year period (from 2003) 144 children who died in Scotland had been referred to the Children's Reporter. What was particularly significant about that group of children was the age distribution: the majority were not, as

would have been expected in a general population, in the perinatal group, instead they were predominantly school-age children. They died from a range of causes including accidents and chronic conditions. The fact each had been referred to the Reporter was an indicator that someone, somewhere a teacher, a social worker, a police officer, a member of the public had already been concerned about some aspect of their care or vulnerability.

Epidemiological studies can only tell us so much about the characteristics of children who die, the reasons for their deaths and whether and how each death may have been preventable. Particularly where numbers are relatively small, the case by case review of all child deaths advocated by Scottish Government, is essential in order to identify and respond to preventable factors in each death. The Ruby Review approach we have been piloting, for example, brings together a range of professionals who knew the child, who cared for them or were with them at the time they died along with a group of expert determined by the nature of the child's circumstances and death.

Around two hours was spent reviewing each case, collecting up to 300 pieces of data and making findings and recommendations. Participants have included paediatricians, paramedics, social work, police, public health, pathologists, procurators fiscal, voluntary organisations such as RoSPA and Scottish Cot Death Trust and a trading standards officer. The reviews were independently chaired by legally qualified volunteers.

We know from the experience of other nations, the US, Australia, New Zealand and parts of Canada, that this approach can be effective in reducing child mortality. There is now evidence from the US, for example, of a reduction in some categories of child death (eg road traffic deaths, maltreatment deaths) where actions have been taken as a result of child death case reviews either in implementing recommendations or by using the rich data they generate to better target public health initiatives.

This approach is only part of the answer to reducing child mortality. A colleague at the University of Dundee, Professor David Collison, has shown the high correlation between income inequality and child mortality in the 24 richest Organisation for Economic Co-operation and Development (OECD) countries. Countries where the maximisation of share holder value was a primary commercial imperative, (endorsed and sanctioned by national economic and fiscal policy) had more inequalities and fewer of their children survived to adulthood, the most significant factor in those countries being income inequality.

The work of Professor Collison, of Professor Richard Wilkinson of University of Nottingham and others reminds us that health driven and case by case approaches to health inequalities only take us so far. Strategies to tackle Scotland's unacceptably high rates of child mortality must also include recognition of the socially damaging inequalities and consequences which derive from adherence to certain economic models and from traditional approaches to corporate governance.

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Global Public Health Unit, SSPS, University of Edinburgh

We welcome the Scottish Government's decision to hold an inquiry into health inequalities in Scotland, and we thank the Health & Sport Committee for the opportunity to make a submission in relation to health inequalities in the early years. We focus our contribution on drawing the Health and Sport Committee's attention to relevant initiatives and research evidence (i.e. Q5).

As researchers engaged in understanding the causes of health inequalities and the policy implications, we would like to emphasise the role of broader social determinants (i.e. the circumstances in which people live) in shaping health inequalities within the Scottish population, including inequalities in the health of children, and early lifecourse influences on health inequalities.

We regard health inequalities as a reflection of underlying social inequalities which are evident in relation to social class, socioeconomic position, and ethnicity. Such inequalities exist along a social gradient; it is therefore important for policy-makers to address the causes of these inequalities across this gradient rather than framing health inequalities as an issue that affects only the poorest groups in society. Policy efforts to reduce health inequalities should include two broad strategies:

First, efforts must be made to reduce the extent to which social inequalities give rise to health inequalities (e.g. by decreasing the vulnerability of these groups by increasing their access to health-promoting and protective resources; & ensuring such groups have appropriate access to health and other public services to ameliorate the impact of health and social disadvantages - Dahlgren & Whitehead, 2006). Second, and most fundamentally, policy measures (including at national level) must seek to reduce the social inequalities which underlie health inequalities.

With regard to health inequalities in the early years, we recommend four specific areas for policy focus:

1. **Reduce the number of children growing up in deprived or unstable financial circumstances** by ensuring that households with children have the financial resources needed to maintain a healthy standard of living. This kind of approach has long been advocated by health inequalities researchers, from the Black Report (1980) to the Marmot Review (2010) and a recent survey of 92 researchers working on health inequalities in the UK further emphasises this (Smith & Kandlik Eltanani, in press). Specific measures to help achieve this may include:

    a. **Extending and reinforcing commitments to pay a living wage in Scotland** (including to all staff employed by companies either contracted by the public sector in Scotland or in receipt of Scottish government benefits, such as tax allowances/incentives). There should also be a commitment to regularly reviewing the level at which this

wage is set, with input from public health experts, to ensure that it is sufficient for a healthy life (NB research indicates income levels needs to be substantially higher for healthy living than current levels of welfare support in the UK enable Deeming, 2011; Morris et al, 2010).

b. **Ensuring that all those outside of regular employment, including those working on flexible (e.g. 'zero hours') contracts have an adequate, stable source of income for healthy living**. Research indicates that precarious work situations impact negatively on health, as well as income, but that these impacts are, to a large extent, mitigated in countries with a Scandinavian welfare regime (Kim et al, 2012).

c. **Reintroducing universal child benefit in Scotland.** This ensures no children fall between the gaps of targeted policies. It is also non-stigmatizing. UK research consistently finds that poor mothers spend universal child benefit on promoting and protecting their children's health and wellbeing (Strelitz and Lister, 2008).

d. **If Scotland were to become independent (or otherwise gain sufficient legislative powers), implementing the 2010 Marmot Review recommendation to review the full system of benefits, taxation, pensions and tax credits with a view to enabling standards for healthy living across the population.**

2. Improve the accessibility and quality of early years education

Evidence indicates that high-quality pre-school education can reduce the adverse impacts of children growing up in disadvantaged social and economic circumstances (Geddes et al 2010). The Scottish Government has recently announced plans to expand provision of childcare for two, three and four-year olds (Scottish Government 2014). While this is a positive measure in terms of allowing more parents and carers to seek paid employment, it will not improve the educational experience of these children unless added investment and regulation is introduced to ensure children are cared for by qualified pre-school educators. Investment in high quality pre-school education (as distinct from childcare) has been shown to improve children's social and health outcomes, while also being cost-effective in terms of long-term public spending on education, welfare and criminal justice costs (Geddes et al 2010). This is an important example of the need for joined-up policy work.

3. Improve the quality of child nutrition

Improved child nutrition has benefits in terms of both health and learning outcomes, and thus offers a strategy for reducing health inequalities both directly and indirectly. Measures to improve the diet of children from less advantaged families include:

a. **Expansion of free school meals.** We applaud the Government's expansion of free school meals to all P1 to P3 children (Scottish Government 2014), and would like to emphasise the potential for this

measure to improve child health and health equity as well as reducing financial pressure on families. We therefore urge the government to take steps to ensure that school meals are nutritious and high-quality, as well as free, and to extend this commitment to older age groups.

b. **Expand regulation to reduce advertising of processed food and sugared beverages to children.** Marketing directed at children has been shown to shape food preferences and influence consumption patterns (Hastings et al, 2006). While the UK regulates advertising of specific foods during television programme intended for under-16 year olds (Ofcom, 2007), there is no statutory regulation of food advertising directed at children via non-broadcast media, including social and online media. More comprehensive regulation is needed to protect children from exposure to sophisticated marketing from processed food and beverage companies (this includes marketing within stores as well as in various media sources).

4. **Improving the safety of the environments in which children grow up.** There is a strong social gradient in child accidents, including fatal road accidents. Research demonstrates that these differences reflect spatial and socioeconomic differences in risky environments, rather than (as is sometimes assumed) parental awareness of risks (Roberts, 2012). Specific interventions to address these varying risks might include:

   a. Introducing 20mph speed limits in more urban areas.
   b. Improving the quality and provision of safe green and play spaces, particularly in less advantaged communities.
   c. Strengthening regulations to protect the quality and safety of rental accommodation.

We thank the Health & Sport Committee for the opportunity to contribute to this inquiry.

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Health Inequalities - Early Years

Growing Up in Scotland study (GUS)
Centre for Research on Families and Relationships

The Growing Up in Scotland study (GUS) is a major longitudinal research project that tracks the lives of several cohorts of Scottish children through the early years and beyond. The study is funded by the Scottish Government and carried out by ScotCen Social Research. GUS provides crucial evidence for the long-term monitoring and evaluation of policies for children, with a specific focus on the early years. It collects a wide range of information about children and their families. The main areas covered include education, childcare, parenting, health and social inclusion.

Key points in relation to health inequalities in the early years

- Young children in Scotland living in disadvantaged circumstances experience considerable inequality both in terms of their exposure to the risk factors for poor health **and** their early health outcomes. During their first 4 years, the inequality in exposure to risk is greater than that evident for actual health outcomes.

- Disadvantaged households experience a double burden in their experience of health inequalities with children and adults within them being at greater risk of negative outcomes. Reducing health inequalities amongst children therefore requires action to address the social and health inequalities experienced by their parents, wider families and communities.

- While there is much that can be achieved through the health service, evidence from GUS suggests that many of the actions required to reduce health inequalities in the early years lie outwith the remit of health services and other service providers.

- GUS findings suggest that it is difficult to counter the very powerful structural and economic influences on children's lives. However, some factors contributing to 'resilience' (the avoidance of poorer early health outcomes amongst those experiencing disadvantage) can be identified. These include factors at the individual, household and community level.

- By exploring the relationships between parenting and children's health it is clear that the health benefits of better parenting appear greatest for those families experiencing the highest levels of family adversity. This suggests that policies to support and improve parenting may contribute to a reduction in health inequalities. However, GUS also finds that families experiencing disadvantage are less likely than others to access services and to seek support and advice from professionals. While there is a range of parenting programmes being delivered across Scotland, overall programmes to support parenting are likely to provide only a partial solution to reducing inequalities in health.

1. The character of health inequalities in the early years

A key theme emerging from a range of research and policy documents from across the UK and further afield is that inequalities in health, and other outcomes, often emerge in the very earliest stages of life and persist throughout subsequent life stages. GUS seeks to add to this body of research, with the aim of providing new information to inform policy development in Scotland.

GUS is tracking the lives of two main groups of children – 5,000 born in 2004/05 and 6,000 born in 2010/11. Children and their families from all parts of Scotland are taking part in the study. Participants were selected at random from Child Benefit records, and together they are representative of all children in Scotland of these ages. Data is collected through an annual interview with families, taking place in their own homes and carried out by trained interviewers.

GUS adds to the data collected and reported by the NHS in Scotland firstly, by being able to link health outcomes with other circumstances and experiences. Secondly, the 'longitudinal' nature of the study allows researchers to examine in detail how early circumstances and experiences are associated with later outcomes.

A broad interpretation of health has been applied in GUS analysis, drawing on the World Health Organisation's founding definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"[1]. Our definition of health inequalities is based on that used in the report of the Scottish Government's Ministerial Task Force on Health Inequalities, *Equally Well* which defined health inequalities in the early years in two ways. Firstly, inequalities can relate to negative outcomes such as low birth weight or other indicators of a failure to thrive. Secondly, it can mean inequalities in exposure to risk factors that increase the likelihood of, or perpetuate, poor health outcomes. These include poor diet, lack of physical activity, parental drug or alcohol misuse, being in care, living in a poor physical environment and family poverty.

Health inequality in GUS is defined as the unequal socio-economic patterning of *outcomes* and *risk factors* which disadvantage less affluent children. *Outcome* measures include reported general health; experience of illness and long-term health problems; accidents; weight (Body Mass Index); cognitive ability; and social, emotional and behavioural development. *Risk factors* include exposure to smoking at home, maternal health (including mental health), children's physical activity levels and their diet (including breastfeeding).

[1] See: http://www.who.int/about/definition/en/print.html

GUS collects a range of measures which can be used to explore differences in health for children in different socio-economic circumstances. The main socio-economic measures used have included equivalised household income, parents' highest level of education, socio-economic classification, employment status, area deprivation, and housing tenure.

Analysis has usually compared the proportion of children in each group who experienced the particular health outcome or risk factor. However, more complex analysis has also been used to identify factors that appear to be associated with positive outcomes for children from disadvantaged backgrounds – i.e. to examine 'resilience'.

1.1 Inequalities in health outcomes

1.1.1 Physical health

In their analysis of health inequalities over the first four years of life, Bromley et al[2] found that children living in the most deprived areas, those with the lowest income households or in routine and semi-routine households had worse health outcomes on a range of physical health measures. These ranged from very early measures of health collected at a single time point – such as birth weight, or time spent in a Special Care Baby Unit or Neo-natal unit after birth – to broader, repeated measures such as parent-assessed general health, long-term health conditions and accidents.

For example, as shown in Figure 1, children in more disadvantaged circumstances – whether measured according to household income or area deprivation – were significantly more likely than their more advantaged peers to have been reported as having fair, bad or very bad health during their first four years of life.

Figure 1 Fair, bad or very bad health at least once between birth and four years by equivalised household income quintile and area deprivation quintile

[2] Bromley, C. and Cunningham-Burley, S. (2010) *Growing Up in Scotland: Health inequalities in the early years* Edinburgh: Scottish Government

1.1.2 Overweight and obesity

Direct measures of the children's height and weight were taken at ages four and six years. These were used to derive their body mass index (BMI) which was compared with standard growth charts for children of this age to assess whether they were underweight, normal weight, overweight or obese.

Analysis of variations in the proportion of children who were overweight or obese at age six[3] found that children whose mothers had a lower level of education (below NVQ level 4), were in the bottom 40% of average household incomes, and those who lived in areas in the two most deprived quintiles were at greater risk of being overweight or obese.

The factors associated with children being overweight or obese are: mother's overweight or obesity, frequent snacking on sweets or crisps as a toddler, skipping breakfast, not eating the main meal in a dining area of the home, low parental supervision, poor maternal physical health and low 'child friendliness' of the local area (as perceived by parents). This suggests that measures to reduce obesity should include 'whole family' approaches to healthy living and measures to improve social and physical environments.

1.1.3 Cognitive ability

Children were asked to complete two cognitive assessments each at ages 3 and 5. These assessments measured their ability in relation to expressive vocabulary (knowledge of names) and non-verbal reasoning (problem solving ability).

The analysis of cognitive ability[4] demonstrates that children from more advantaged circumstances significantly outperform those from disadvantaged circumstances, particularly in relation to differences in parental level of education. At the time they entered school, children whose parents had no

[3] Parkes, A., Sweeting, H. and Wight, D. (2012) *Growing Up in Scotland: Overweight, obesity and activity* Edinburgh: Scottish Government

[4] See: Bradshaw, P. (2011) *Growing Up in Scotland: Changes in child cognitive ability in the pre-school years* Edinburgh: Scottish Government; and Bromley, C. (2009) *Growing Up in Scotland: The impact of children's early activities on cognitive development* Edinburgh: Scottish Government

qualifications were found to have vocabulary ability around 18 months behind children of degree-educated parents. The longitudinal analysis shows that the ability gap between more and less advantaged children is already apparent at age 3 and largely persists during the pre-school period.

1.1.4 Social, emotional and behavioural development

GUS analysis shows[5] that around the time they enter school, around 1 in 10 Scottish children have moderate or severe social, emotional or behavioural difficulties. This rises to around 1 in 4 in relation to difficulties with conduct.

Children in lower income households and were more likely than those in higher income households to exhibit more negative social, emotional and behavioural characteristics and to show more negative change in social development during the pre-school period.

1.2 Exposure to risk factors

GUS research has not only shown that children in more disadvantaged circumstances tend to have poorer health outcomes than their more advantaged counterparts, but that they also have higher exposure to *risks* for those outcomes. Indeed, often the inequality in exposure to risk is higher than that evident for outcomes. In some cases, it is the increased exposure to these risks which fully explain the socio-economic inequalities in the outcomes themselves.

In her analysis of the period from birth to age four, Bromley found that children living in the most deprived areas were significantly more likely to have had a mother who smoked (including during pregnancy) and who had poorer physical or mental health. Those children were also less likely to have been breastfed and to eat fruit and vegetables, and more likely to eat unhealthy snacks and have lower levels of physical activity.

Similarly, in relation to overweight and obesity, Parkes *et al* found that after allowing for other confounding factors the effect of mothers' lower education level was reduced. That is, the findings suggest that greater overweight and obesity amongst children whose mothers had lower educational qualifications was largely explained by lower rates of breastfeeding, earlier introduction of solids, and greater likelihood of snacking on sweets and crisps as a toddler amongst children in this group. Furthermore, children who were exposed to these risks - irrespective of their mother's level of education - had a greater chance of being overweight or obese at age six.

Analysis by Chanfreau *et al*[6] focused on identifying key events that happen during childhood and examined whether families who experience these events are more likely to face known drivers of negative child outcomes.

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[5] Bradshaw, P. and Tipping, S. (2010) *Growing Up in Scotland: Children's social, emotional and behavioural characteristics at entry to primary school* Edinburgh: Scottish Government

[6] Chanfreau, J., Barnes, M., Tomaszewski, W., Philo, D., Hall, J. and Tipping, S. (2011) *Growing Up in Scotland: Change in early childhood and the impact of significant life events* Edinburgh: Scottish Government

The research looked at four significant events: parental separation; moving home; parental job loss and the onset of persistent maternal health problems. It explored the association between these events and factors which other research, including GUS, has shown to be related to poor child outcomes - income poverty, poor maternal mental health, chaos in the home environment and quality of parent-child relationship.

The research found that disadvantaged children were more likely to experience the events which led to the circumstances which subsequently drive negative outcomes thus giving some insight into the reasons behind the greater level of negative health outcomes amongst this group. For example, parental separation – more prevalent amongst families on relative low income – was associated with poorer maternal mental health, a factor associated with negative child health outcomes.

1.3 Resilience

In many cases, GUS analysis has gone beyond simply quantifying the extent of child health inequalities in the early years, seeking to identify factors which are associated with disadvantaged children avoiding negative outcomes, that is, resilience. On the whole, findings suggest that it is difficult to counter the very powerful structural and economic influences on children's lives. However, there are some suggestions of behaviours and experiences which appear to benefit disadvantaged children.

In relation to her broad analysis of health inequalities in the early years, Bromley found that, amongst children who were disadvantaged, those who experienced the following had a greater chance of avoiding negative health outcomes:

- Mother without long-term health problems
- Living in a household where at least one adult was in employment
- An enriching home-learning environment (child experiences a greater level of daily activities such as reading stories, singing nursery rhymes, painting/drawing)
- A mother who was older (35 or older)
- More positive attitudes to seeking support
- Satisfaction with local facilities

The significance of having an enriching home-learning environment has repeatedly been found to be an important factor in influencing children's early cognitive outcomes, including for disadvantaged children. Improved vocabulary ability between age 3 and 5, specifically amongst children from more disadvantaged groups, was also found to be associated with a greater consistency of parenting, stronger parent-child attachment, attendance at ante-natal classes and having been breastfed. Having better, earlier communication skills (e.g. at age 22 months) was also important.

One of our analysis projects[7] has explored in detail the relationship between parenting and child health outcomes. The analysis revealed that both child health and parenting skills varied considerably with levels of family adversity. In addition, the nature of the relationship suggests that some of the differences in child health outcomes observed between children who experience different levels of family adversity occur because of the related differences in parenting. The implication is, therefore, that changing parenting behaviours, particularly amongst more disadvantaged groups, may improve health outcomes for children within that group, but also that measures to support parenting provide only a partial solution to reducing health inequalities.

2. Barriers and challenges

A central theme across GUS findings has been the variation in the ways that formal support services are used by families with different characteristics. Mothers experiencing disadvantage are less likely than their more advantaged peers to attend antenatal classes, parenting classes and parent and baby/ toddler groups. Parents whom service providers and policymakers often most want to reach are those most reluctant to engage with services[8]. Younger parents, lone parents, parents with lower levels of income and education are generally less comfortable engaging with formal support services (like health visitors) and more likely to perceive a stigma attached to seeking formal support. These same parents are more likely to say that they dislike the 'group format' of some programmes and would prefer to receive information, advice and support on a one-to-one basis[9].

GUS finds that over two-thirds (70%) of parents with a 10 month old baby had not attended any parenting class or programme over the past year. The most commonly attended programme or class is baby massage, attended by 24% of all parents. Over half (54%) of parents stated that it was either not at all or not very likely that they would participate in a parenting programme in the future. This suggests that support for parents to reduce health inequalities in the early years might be best delivered by universal services known and trusted by parents. Despite reluctance from some groups to approach professionals like health visitors for advice and support, satisfaction with the services provided by health visitors in Scotland is very high. The majority of parents (83%) reported that their health visitor was either very good or fairly good at providing helpful advice and 91% said the same in relation to listening to them[10].

[7] Parkes et al (2011) Growing Up in Scotland: Parenting and children's health Edinburgh: Scottish Government

[8] Mabelis, J & Marryat, L (2011) *Growing Up in Scotland: Parental service use and informal networks in the early years*, Edinburgh: Scottish Government.

[9] Bradshaw et al (2013) *Growing Up in Scotland: Birth Cohort 2 – results from the first year*, Edinburgh: Scottish Government.

[10] Bradshaw et al (2013) *Growing Up in Scotland: Birth Cohort 2 – results from the first year*, Edinburgh: Scottish Government.

3. Recent progress

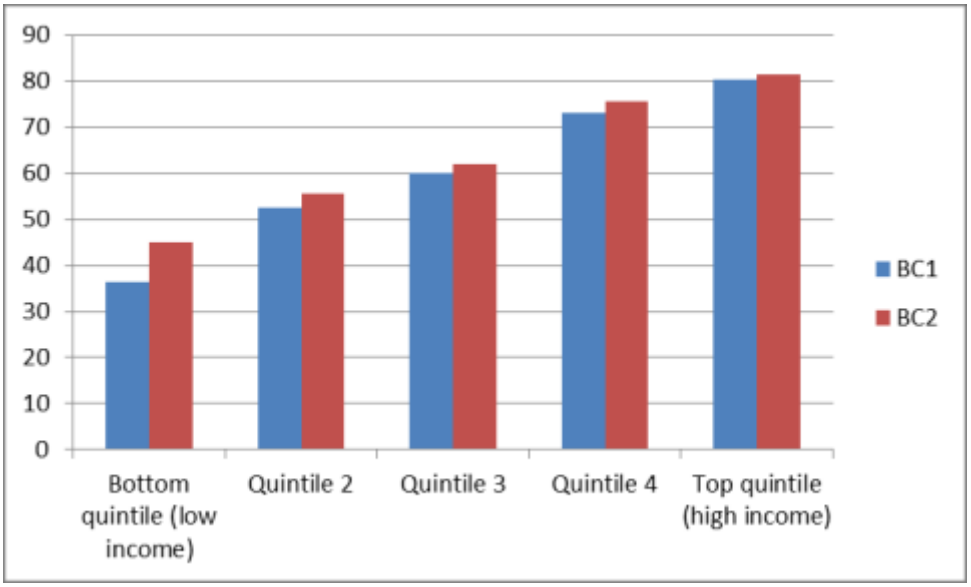
The research design of GUS enables us to monitor change between two birth cohorts. We are able to compare the circumstances, characteristics and experiences of children born in 2004/05[11] with those of children born in 2010/11[12]. There has been a significant amount of early years policy development activity during this period, including the three social policy frameworks, the *Early Years Framework*, *Equally Well* and *Achieving our Potential* and more recently, the Early Years Collaborative[13].

Comparing data collected from both cohorts when children were 10 months old shows some improvement in the rates of alcohol consumption during pregnancy. 80% of women having babies in 2010/11 reported not drinking any alcohol during their pregnancy, compared with 74% of women who had babies in 2004/05. It is notable that mothers educated to degree level and those in higher income households were more likely than mothers with lower qualifications and in lower income households to have consumed alcohol during their pregnancy. For example, 31% of mothers with a degree level qualification reported having some alcohol compared with 12% of those with no qualifications. In terms of changes between 2004/05 and 2010/11 amongst different socio-demographic groups, alcohol consumption during pregnancy declined for all groups but the reduction was most apparent amongst older mothers (over 40 at the time of the child's birth) and amongst mothers with lower incomes.

Overall rates for smoking during pregnancy and for breastfeeding have remained stubbornly static. In relation to smoking, higher rates amongst more disadvantaged parents remain and the difference between them and more advantaged parents remain. For the younger birth cohort, 73% of all mothers said they did not smoke at all during pregnancy. 87% of women educated to degree level did not smoke during pregnancy, compared with 40% of mothers with no qualifications. However in relation to breastfeeding, with caution we can conclude from GUS data that there have been some improvements amongst more disadvantaged groups, indicating a decrease in inequality on this measure. For example, Figure 2 below shows that while the stark differences in breastfeeding initiation rates amongst different groups of mothers remain, there has been a significant increase in the proportion of mothers in the lowest income group initiating breastfeeding. In addition, breastfeeding rates amongst mothers with no qualifications have increased from 30% to 40% while the rates amongst degree educated mothers remained static at around 86%. As such, the gap between advantaged and disadvantaged mothers and babies has narrowed.

Figure 2: % of mothers initiating breastfeeding by equivalised household income

[11] Birth Cohort 1 or 'BC1'
[12] Birth Cohort 2 or 'BC2'
[13] For more information about how GUS relates to the policy landscape in Scotland please see Chapter 1 – Introduction of Bradshaw, P et al (2013) Growing Up in Scotland: Birth Cohort 2 Results from the first year



Between the two GUS birth cohorts, recommendations on when to introduce solid foods to babies (weaning) changed from between 4 and 6 months to 6 months or older. The data highlights that, in line with new advice, babies born during 2010/11 were on average being weaned later than those born 6 years earlier. Fewer babies started solids as early as 4 months (40% in BC2 compared with 59% in BC1) and as early as 5 months (69% in BC2 compared with 81% in BC1). This means that more parents have waited until 6 months to introduce their baby to solid foods.

In conclusion, GUS demonstrates that inequalities of health in the early years are associated with inequality at later stages, and experiencing poorer health in early childhood is associated with poorer outcomes later. As the children in GUS grow older, we will continue to examine the relationship between early health and later health and other related outcomes, as well as exploring whether and how the shape of inequality changes between the two cohorts.

Centre for Research on Families and Relationships
March 2014

Links to GUS Research Summaries

Health inequalities in the early years
Key early years indicators on pregnancy and birth
Infant feeding: breastfeeding and weaning
Parenting and children's health
Overweight, obesity and activity
Parental service use and informal networks in the early years
Change in early childhood and the impact of significant events
Children's social, emotional and behavioural characteristics at entry to primary school
The circumstances of persistently poor children
Maternal mental health and its impact on child behaviour and development

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www.growingupinscotland.org.uk

Health Inequalities - Early Years

Prof Philip Wilson, University of Aberdeen

I am grateful for the opportunity to submit evidence on this matter to the Health and Sport Committee. I am professor of primary care and rural health at the University of Aberdeen before which I was a senior lecturer in infant mental health at the University of Glasgow with 25 years relevant clinical experience as a GP. While in Glasgow I led a population-based programme of research into the mental health of children aged 1-10 years, and I continue to act as senior academic advisor on this work. In this written response I would like to focus on the role of general practitioners and health visitors as well as on the importance of standardised assessment approaches.

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

The Scottish Collaboration for Public Health Research and Policy produced an excellent scoping document on this subject three years ago[1]. I have little to add to the findings in this document except to say that there is very strong evidence for the benefits of nurse home visiting programmes (eg the Family Nurse Partnership), for high quality preschool education (eg the HighScope Perry project) and for some targeted parenting programmes (eg Incredible Years). Each of these programmes has substantial potential for reducing social inequalities, if appropriately targeted. Nevertheless, claims for some interventions (eg the Triple P Parenting programme) have been over-inflated[2] and it is very important to examine the quality of evidence before committing substantial public funds.

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

Following the Hall 4 guidance in 2005[3] a number of important problems became apparent. This guidance assumed that vulnerability could be predicted very early in a child's life, and where problems emerged that were not predicted, that families would seek help. The end result was the abandonment of routine child health surveillance beyond the age of six weeks. The work we undertook in Glasgow made it clear that important developmental problems such as language delay can not be predicted[4-6] and parents often do not seek help when important problems emerge[4;5.] The Scottish Government wisely reintroduced a universal assessment focussed on language and social development at 27-30 months last year.

The work of the Early Years Collaborative is to be commended. The Stretch Aims relating to attainment of developmental milestones at 27-30 months and at school entry are excellent but there is a lack of clarity about how these should be achieved and, worse, there is no clear guidance on how the milestones should be defined. I would like to make the following three recommendations to deal with these deficits:

- Introduction of a universal child health assessment at 13 months, around the time of the MMR. Our research in Glasgow[7] showed that this was a highly successful and acceptable contact performed by health visitors, and the content of the visit ensured that the more vulnerable families received more care.
- Introduction of standardised instruments for assessment of achievement of milestones at 27-30 months and school entry across Scotland. I would suggest the Strengths and Difficulties Quesionnaire[8] (SDQ) and the Sure Start Language Measure, as used in Glasgow, would be most suitable and acceptable.
- To allow the concept of "small tests of change" to be developed further in order to inform tests of change of sufficient statistical power (ie trials) to establish beyond reasonable doubt that interventions have actually worked.

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

There is no doubt that early intervention with vulnerable families by nurses is highly effective, and cost-effective. For example, David Olds' landmark randomised trials of the Nurse Family Partnership in the US have demonstrated that about 30 hours of input between mid pregnancy and the age of two years can halve criminal behaviour, substance use, smoking, running away and high risk sexual behaviour by age 15[9]. Nurses are much more effective in this work than paraprofessionals[10], and continuity of care is crucial.

There have been continued attempts to replicate Olds' work in Scotland, and much resource allocated, but the model is not directly transferrable. In the US, there is no universal health visiting service and consequently no mechanism for identifying actual need in individual families in the community. Offering the Nurse Family Partnership intervention to all families is clearly impractical, expensive and unjustified. The current policy of directing attention to families on the basis of predicted vulnerability (ie to teenagers who book early enough in their pregnancy) without actual assessment appears highly inefficient: it gives resources to families who do not need them, and misses many children with substantial need who do not fall into the 'right' demographic group. We have the potential for an efficient and flexible use of resources through use of an 'active filtering' approach in which professionals and families together determine level of need with reference to standardised assessment tools[11]. Resources should be directed towards those most in need. In other words we need an intelligent system for 'case-finding' and resource allocation.

In Scotland, the only professions in routine contact with all children under the age of three years are general practitioners (GPs) and health visitors (HVs) as well as midwives in the first few days of life. In the past ten years, a number of policy developments have progressively undermined the involvement of GPs and HVs with children to the extent that most Scottish children (apart from seeing an HV at 27-30 months) do not see either profession except on

an opportunistic basis after the age of four months. Because we can learn from past mistakes it is worth enumerating these policy initiatives:

- Nursing for Health. This shifted the focus of health visiting from work with individual children towards community development and other public health responsibilities. Training in child development disappeared from the curriculum
- The Review of Nursing in the Community. This development proposed the end of health visiting as a profession in favour of the introduction of a generic community nurse role. Although now abandoned, the damage to professional morale was grave. Health visiting courses were cut and many HVs left the profession, never to return.
- The Scottish implementation of Health for All Children[12] (Hall 4). This report was interpreted erroneously by many health boards as supporting the view that families considered to be at "low risk" did not require any health visiting input after 8-16 weeks. There is now robust evidence that no more than half of vulnerable families can be reliably identified by that time, even in the context of an intensive home visiting programme[13]. Not only health visitors, but also general practitioners, now do less preventative work with children[14] than they did a few years ago.
- The Glasgow review of health visiting. In its original form, this set of policies advocated removal of health visiting from attachment to general practices (a process which has sadly already taken place in many areas), management of the profession by social work services, ending of HV involvement in immunisation, and introduction of skill-mix teams. This policy caused great damage to the profession despite never being fully implemented. Many HVs took early retirement, moved to other areas or left the profession.
- The new GP contract introduced in 2004 focussed almost entirely on chronic disease management (many of these diseases, incidentally, are more likely after adverse early childhood experiences). The Quality and Outcomes Framework has produced substantial improvements in chronic disease outcomes and has effectively reduced social inequality in health. It was a missed opportunity rather than an actively damaging policy development, but a substantial component of GPs' pay is now determined by quality indicators, none of which, apart from immunisation rates, are anything to do with children

The development of HV skill mix teams, while appearing to offer a rational approach to cost containment, appears not been handled well in Scotland and has tended to pay insufficient regard to the importance of continuity of relationships, both between HVs and families and between HVs and primary care teams including GPs. These relationships are crucial, not only in the process of assessment of family needs[15] but also in the process of inter-professional communication about the needs of children[16].

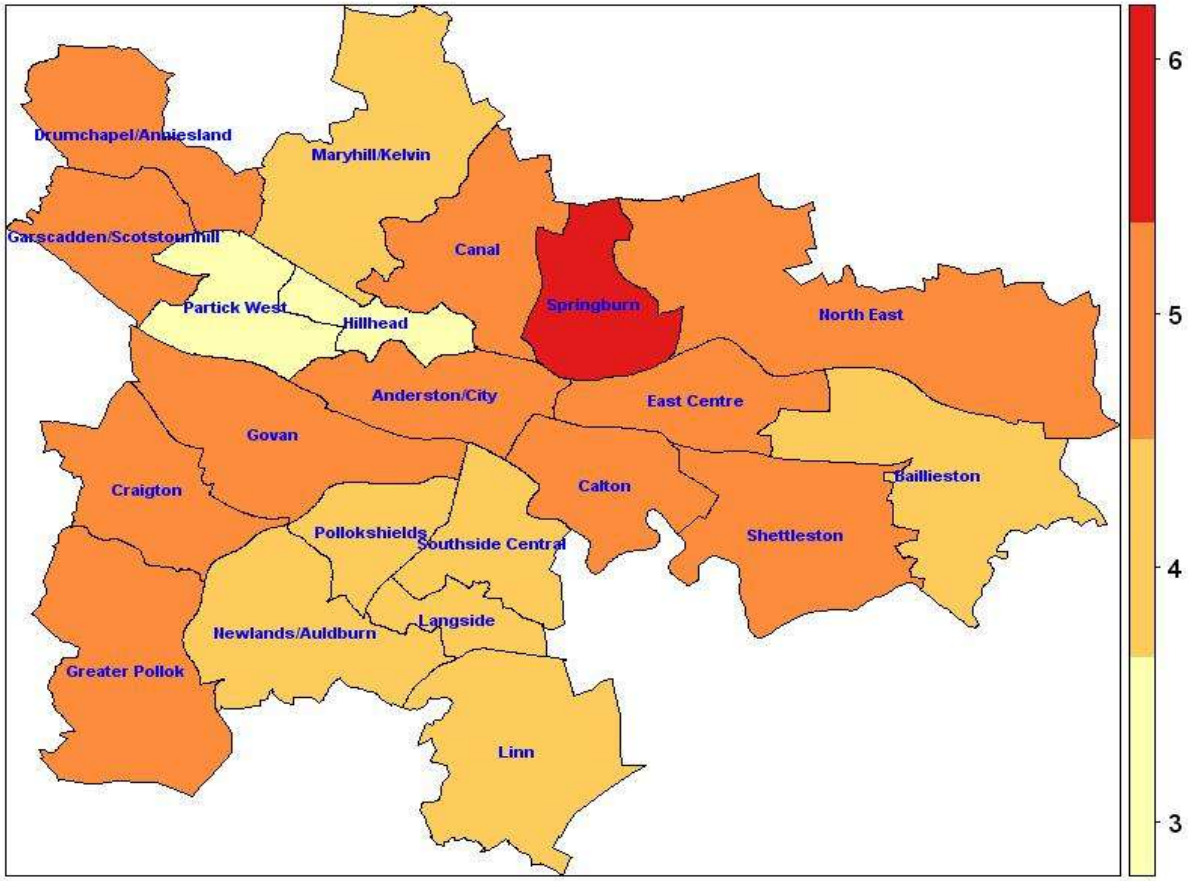
4. *What barriers and challenges do early years services face when working to reduce health inequalities?*

We have a very demoralised and understaffed health visiting workforce and a GP workforce that has forgotten the importance of preventive child health work. Scottish Government has, to its great credit, begun to turn the tide by recognising the status of health visiting and in general allocating the health visitor to the role of named person. Nevertheless, a whole generation of health visitors has been trained without any in-depth knowledge of child development and this is a serious deficit. In my view health visitors should be universally acknowledged as the experts in normal child development, at least for preschool children.

Although it could be seen as a specific personal plea from an academic, I would like to make the point that it is very difficult to get research funding for work in the field of child development compared with say, cardiovascular disease. Given that social development in early childhood is one of the most powerful determinants of mortality and morbidity[17], this situation appears to me at least to be perverse.

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

My research group in Glasgow has been measuring the social and emotional wellbeing of all children in the city at the ages of 30 months and 5, 7 and 10 years. We have uncovered clear evidence of social differentials in mental wellbeing, and these differentials widen when children start primary school. The map below illustrates the differences in SDQ scores for the most affluent parts of Glasgow compared to the most deprived: scores in Springburn are twice as high as those in Hillhead.



I believe that these social differentials in childhood mental health underlie the differences in adult morbidity and mortality attributable to deprivation.

Philip Wilson DPhil MRCPCH FRCGP,
Professor of Primary Care and Rural Health, University of Aberdeen (and general practitioner).
March 2014

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Health Inequalities - Early Years

WAVE Trust

As the twig is bent, the tree's inclined
(Alexander Pope)

All happy families are alike; each unhappy family is unhappy in its own way.
(Leo Tolstoy, Anna Karenina)

Introduction

Not long after a child starts pre-school or primary school, experienced staff can predict -- with depressing accuracy -- which children are most likely and least likely to succeed . . . in school, in society and in life. We will know that health inequalities have largely disappeared when it becomes impossible to predict young children's futures correctly.

It is never too late to help children in meaningful ways. For example, there is abundant evidence (from EPPE and Sure Start in the UK to Abecedarian and High/Scope in the States) that high quality early childhood education makes a difference, especially for those children who are furthest behind. The evidence is clear that *high quality* early learning and childcare reduces inequalities.

However, as do the Growing up in Scotland research findings, this evidence also underlines the point that even *very young children are already exhibiting major – and growing -- discrepancies* in their wellbeing and readiness for school. Therefore, WAVE recommends that the Committee's 'early years' inquiry and its eventual recommendations **focus on the period from pre-birth to pre-school***.* This should include **preconception** health/care.

For more than a decade, WAVE Trust has reviewed and analysed the best available research -- and evidence from practice -- from Scotland, the UK, Europe and internationally from a variety of disciplines. The latest major WAVE report (2013) – *Conception to age 2; the age of opportunity* – consolidates the findings and translates the science into practical recommendations for policy and practice. Although produced in collaboration with the UK Departments of Education and Health, the extensive international evidence base cited within that report – and undergirding this brief submission -- is relevant to the Scottish Parliament Health and Sport Committee's inquiry. See:
http://www.wavetrust.org/sites/default/files/reports/conception_to_age_2_-_the_age_of_opportunity_-_web_optimised.pdf

Given the space limits for submissions to this inquiry, WAVE has not specifically highlighted and cited the excellent work undertaken by other Scottish organisations – from the Scottish Collaboration for Public Health Research and Policy (SCPHRP) to the Glasgow Centre for Population Health – as it is anticipated that these researchers will provide their own evidence to this Inquiry.

Underlying principles and recommended directions of travel

1. **Primary prevention of health inequalities – that is, keeping them from happening in the first place – must become a far higher priority in terms of the allocation of Scotland's public resources**. From the Christie Commission to numerous research studies, the evidence is compelling about the imbalance in favour of intervening after the fact, while too little is done in the earliest years to prevent health inequalities from beginning. Remedial intervention will always be necessary, but it is not a sufficient or wise national strategy for reducing health inequalities. This point has been widely accepted and agreed, but not yet acted upon robustly.

2. **Reducing health inequalities means according as much priority to social, emotional and intellectual development, as to physical milestones**. Health encompasses far more than not being ill, injured or incapacitated. Advances in neuroscience, genetics/epigenetics and other relevant fields have confirmed the lifelong importance of relationships and communications during the earliest weeks, months and years in shaping brains, predispositions and behaviours for life. Promoting positive/secure attachment between babies and their parents/carers – and preventing negative/insecure (especially 'disorganised' attachment) -- is as crucial to their long-term mental/emotional health as breastfeeding and good nutrition is to their physical wellbeing.

3. ***What matters most is what children actually experience during the first 1,001 days of life***. While understandable, there has been an over-reliance on using poverty and postcodes as proxies for health inequalities. And yet, there are children in higher socioeconomic families/communities who are suffering lives of pain and adversity, just as there are poorer children who are thriving in loving, competent, stable families. Universal, robust and frequent early years screening and services (with extra help for those children and parents who need it) are the best way of discovering, and dealing with, what is actually true -- rather than making decisions based upon assumptions, instead of individual realities. Making significant health improvements (and reducing health inequalities) becomes more difficult and more costly to achieve over time.

4. **Child maltreatment – that is, abuse, neglect and living with domestic and community violence – is a root cause of enduring health inequalities**. The long-term (often life-long) negative consequences of multiple adverse childhood experiences (ACEs) on mental and physical health can be profound. By contrast, positive/secure attachment, the absence of maltreatment and the consistent nurturing (emotional and physical) are the foundations upon which good health is built. Dramatically reducing health inequalities cannot occur unless and until child maltreatment is dramatically reduced, too. Preventing child maltreatment – and thereby, reducing health inequalities -- requires a serious, sustained governmental and societal commitment to a Scotland in which: *Every baby is nurtured; Every child is thriving;* and, *Every parent is prepared and supported*.

5. **Eliminating health inequalities during the early years also requires consistent, positive, two-way relationships of trust between professionals/practitioners and mothers/fathers/carers**. There is evidence that some good public health advice and assistance initiatives have unintentionally exacerbated health inequalities because they did not operate within the context of a respectful relationship. The parents whose behaviours were influenced most have too often been the ones least in need of assistance. And yet, research indicates that many parents/carers previously (and erroneously) regarded as 'hard to reach' are much more likely to hear and heed the exact same information and advice when help is offered in the context of a positive relationship with the providers. Thus, the real need is for better, relationship-based support, rather than simply increasing the size of the early years workforce.

6. **Preconception health/care is crucial to preventing health inequalities because: a) birth outcomes are the first indicator of health inequalities; and, b) the health of the mother at *conception* remains the best predictor of birth outcomes.** Expecting a baby can provide a wonderful motivation to become healthier, but pregnancy is not the best time to *begin* dealing with the conditions, behaviours and concerns that can negatively affect birth outcomes – and sow the seeds of lasting health inequalities. If at the time when pregnancy is confirmed, the expectant mother: is obese; has major mental health problems (e.g. stress or depression); has been binge drinking, smoking or taking a variety of either illegal drugs or inappropriate medications; not had adequate folic acid or good nutrition; and/or has underlying serious problems (from domestic violence or homelessness to undiagnosed medical conditions (e.g. diabetes), then there are greatly increased risks of poor birth outcomes -- and of health inequalities being present from a baby's first breath. Valiant efforts to compensate for such difficulties during pregnancy are underway and need to increase, but none of them are as good as being healthy and well prepared at conception.

Responding to the Health Committee's five specific questions

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

Health inequalities reflect, and contribute to, larger social, economic, gender, educational and geographic inequalities across Scotland. A fairer society – starting with a stronger safety net, and a higher 'floor' (below which no individual or family is allowed to remain) – is the national goal toward which we all should be working. Early years interventions – especially those operating effectively from pre-birth to pre-school -- have the potential to make an enormous difference in diminishing health inequalities. One of the characteristics of more equal societies (e.g. in the Netherlands and the Nordic countries) is that they have made, and *sustained*, robust investments in primary prevention and early intervention during at least the first 1,001 days of life. Not coincidentally, these are also the societies rated highest on international child wellbeing measures.

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

If Scotland's early years policies are judged by: their good intentions; high aspirations; intended direction of travel; cross-party support; coherent analysis; persuasive rhetoric; the responsiveness to the needs of children born with immediately obvious birth defects; and, shining examples of good practice, then they are excellent.

By contrast, if they are judged by: the consistency of their implementation; their relative priority within public budgets (especially within the NHS); the balance between primary prevention and reactive interventions; the proportion of children affected by significant/multiple adverse childhood experiences and toxic stress; the robustness of parental preparation and support; the identification and response to developmental problems arising in the two years between the end of universal health visiting and the new 27-30 month health checks; the effective promotion of breastfeeding and positive/secure attachment; the investment in upgrading the early years workforce; and, the affordability, accessibility and average quality of childcare during the first three years of life, then Scotland's early years policies do not compare favourably with the rest of Europe.

Health inequalities from pre-birth to pre-school remain far too great, despite a genuine desire to reduce them among Scottish policymakers and practitioners. The most accurate answer may be to state that early years policy in Scotland has a strong foundation upon which to build, is off to a good start and has great potential not only to improve overall child health and wellbeing, but also to diminish longstanding health inequalities.

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

WAVE Trust's general answers have already been provided – especially the need for the health service to emphasise *primary prevention* (not just 'interventions' as the question asks). The following are the specific steps for addressing health inequalities:

a) Act strongly in favour of the five recommendations in *Putting the Baby IN the Bath Water** (as the new Children and Young People Act only takes some initial steps toward them);

b) Create a preconception health/care commission, then convene a preconception health summit to launch this field (including holistic family planning) as a national priority;

c) Provide the resources, time and powers needed for the Early Years Collaborative to achieve its 'stretch aims' and fulfill its potential;

d) Remove the barrier within the Additional Support for Learning Act that limits assessments of, and robust support for, all children under school age having additional support needs (and their parents/carers) – most of which are health-related;

e) Robustly promote good infant (and parental) mental health, the best possible infant nutrition (especially breastfeeding) and positive/secure attachment, especially within families that are already dealing with inequalities and vulnerable to being left behind;

f) Assess and assist patients/clients/users in adult services (e.g. mental health and substance abuse) as *parents/carers*, not just as individuals;
g) Increase the focus and resources devoted to preventing, identifying and responding effectively to fetal alcohol harm
h) Raise awareness, and significantly enhance the diagnosis and treatment, of co-morbidities and multiple morbidities in young children (instead of stopping assessment at the first one identified);
i) Devote greater priority and resources to preventing, stopping and reversing the harm done through child abuse, child neglect, toxic stress, disorganized attachment and living with domestic violence; &
j) Combine relationship-based support, social marketing and co-production with parents/carers to conduct effective public health campaigns resulting in better child outcomes and less inequality.

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

There are three key barriers to overcoming health inequalities during the early years.
The first is the misperception that the early years are already receiving a disproportionately high level of public resources; whereas, in reality, the government spends less on the first 1,001 days of life than on any other age cohort across the entire life span. An abundance of wonderful proclamations about the importance and virtues of the early years is no substitute for actually investing in them.
The second is the myth that good parents "comes naturally' to most people; and therefore, parenting education is only needed by a hopelessly deficient minority (usually defined socioeconomically). This creates a disincentive to focus on properly preparing the next generation of parents/carers.
The third is a lack of confidence about, and commitment to, *transformational* change in the early years by most of the relevant groups. This can seen in the sense of fatalism that the majority of pregnancies will continue to be unintended (instead of an empowered, informed choice) to thinking that 'more of the same' people and practices is the only way forward.

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

A wealth of the relevant research evidence can be found in WAVE Trust's 2013 publication, **Conception to age 2: the age of opportunity***.* Hard copies were sent to the Health Committee.

Other major publications and sources of information WAVE recommends are listed below. These eleven recent documents are not only important in their own right, but also include references to the major research, meta-analyses and other evidence that the Health Committee might find helpful.
a) **WHO European Review of Social Determinants and the Health Divide**, 2013
b) **What can NHS Scotland do to prevent and reduce health inequalities?** GPs at the Deep End, 2013
c) **Fair society, healthy lives: strategic review of health inequalities in**

England post-2010. Marmot Review Team, 2010
d) **Doing better for children**, OECD, 2009
e) **The earliest intervention: Improving birth outcomes and lowering costs through preconception health and health,** Children in Scotland, 2010
f) *The lifelong effects of adverse childhood experiences*. V Feliitti and R Anda in **Chadwick's Child Maltreatment**, 2014
g) *The international charter on prevention of fetal alcohol spectrum disorder,* **The Lancet Global Health,** 2014
h) **Leveraging the biology of adversity to address the roots of disparity in health and development***.* J Shonkoff, 2014 (Harvard University Center for the Developing Child)
i) **WHO European Report on Preventing Child Maltreatment**, 2013
j) **Early Life Adversity and Children's Competence Development: Evidence from the Mannheim Study of Children at Risk.** D Blomeyer, *et al.,* Institute for the Study of Labor (IZA), 2013
k) **Findings, Practice and Policy Implications from LONGSCAN: The 20-Year Longitudinal Studies of Child Abuse and Neglect.** J Kotch, *et al., University of North Carolina, 2012*
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***** Copies have already been provided to all MSPs on the Health and Sport Committee

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March 2014

Health Inequalities - Early Years

Institute of Health and Wellbeing, University of Glasgow

Overview:

While most of the major drivers of the distribution in health lie outside of the NHS, it does still have an important role to play. Interventions delivered early in life (even prenatally) do, indeed, have great potential for reducing health inequalities.

The problem is that interventions which are effective in improving health and life chances overall will not necessarily reduce *inequalities* in health unless careful steps are taken. This is because more advantaged groups find it easier to access programmes and make changes themselves without support, and because they are easier for health and other professionals to reach [1].This means that a reduction in health inequalities is likely to require intensive, targeted intervention directed at those who are most vulnerable, and to take account of possible barriers such as lack of time, finance and coping skills, delivered within the context of proportionate universalism which may mitigate the risk of highly targeted work normalising the multiple risks, hazards and problems which the intervention is likely to be trying to allay [1-2]. It should also be born in mind that higher level interventions, most of which will not be administrable under the NHS, for example improved nursery school provision, may be particularly effective in improving the health of the most disadvantaged children. Key guidance and review papers published in recent years include: Macintyre's review of inequalities in health in Scotland which identifies which kind of policies are most likely to reduce them [1], the Marmot review which does the same for England [2], and NICE guidance on social and emotional wellbeing of vulnerable children aged under 5 years, which outlines the role of the NHS in supporting home visiting, childcare and early education interventions [3].

Research currently being undertaken within the Institute of Health and Wellbeing at the University of Glasgow will certainly help answer the questions posed by the consultations: we provide a summary below; we would be happy to engage with the committee further should more detail be helpful.

How effective are early years interventions in addressing health inequalities?

Parenting programmes are one of the key ways of intervening in early life [4]; there is an extensive body of high quality research evidence which demonstrates the effectiveness of particular parenting programmes in improving health and other outcomes for both parents and children [5-8].

However, four important, and related, gaps remain in this evidence. First, few studies pay attention to the issue of reach - the proportion of a target group which actually gets the programme. Second, few studies have considered whether programmes actually recruit and retain the parents and children in the most disadvantaged positions who are likely to need them most [9]. Third, we do not fully understand how and why some early intervention programmes

which work on average for disadvantaged families do not work for the most disadvantaged. Finally, few studies have long term follow-up. We just don't know how long the effects of a programme persist. The next generation of studies needs to focus on unpacking how, precisely, the evidence based interventions work, and for whom, and to build on the existing, but relatively small, evidence base around long-term outcomes, cost effectiveness and the challenges of reaching the most vulnerable.

Two randomised controlled trials, at the Institute of Health and Wellbeing, University of Glasgow, are evaluating early interventions targeting the most vulnerable groups in our society. The first evaluates two evidence based parenting programmes; the second focuses on an assessment and treatment programme for families in which child maltreatment has occurred.

(i) The Children, Young People, Families and Health Programme of the Medical Research Council/Chief Scientist's Office Social and Public Health Sciences Unit , Institute of Health and Wellbeing, is rigorously evaluating two early years parenting interventions through the THRIVE trial. Led by Dr Marion Henderson, THRIVE is a three arm randomised controlled trial funded by the National Institute for Health Research from 2013-2017; recruitment of mothers has just started. Preliminary findings will be made available throughout the trial, with the main outcomes likely to be published in 2017 [10].

The theoretical basis of the interventions is that women vulnerable in pregnancy are more likely to be anxious and depressed and to produce a higher level of stress related hormones that have been shown to be damaging to their foetus[11]. Thus, intervening ante-natally may be optimal [12-15]. The trial will compare the cost effectiveness of Enhanced Triple P for Babies, Mellow Bumps, and Care As Usual, as delivered within the NHS in Greater Glasgow and Clyde and Ayrshire and Arran, in improving both mother-child interaction and maternal mental health.

The primary research questions that will be addressed by THRIVE are:

1) Do participants receiving Enhanced Triple P for Babies or Mellow Bumps show significantly lower anxiety, depression and outwardly directed irritability compared to those receiving Care As Usual when their babies are 6 months old?
2) Do women who receive Enhanced Triple P for Babies or Mellow Bumps show more sensitive interactions with their babies compared to those receiving Care As Usual when their babies are 6 months old?

THRIVE and ancillary projects will also allow us to better understand a number of areas on which evidence is currently sketchy including:

- Whether, and how, such group based parenting programmes work for mothers with particular vulnerabilities;

- Whether, and how, more skills based or more therapeutic intervention is most effective for particular parents;
- The role of fathers in parenting interventions and in understanding child and mother outcomes;
- Whether parenting interventions designed for vulnerable populations delivered within the NHS can successfully recruit and retain the women they are designed to reach during the antenatal period.

ii) The Mental Health and Wellbeing Group, Institute of Health and Wellbeing, is rigorously evaluating the New Orleans Intervention Model through the Best Services Trial, funded by the Chief Scientist's Office and NSPCC. The New Orleans Intervention Model was developed in the United States and is an infant mental health service targeting families whose children have just come into foster care because of maltreatment. The New Orleans Intervention Model is being compared with enhanced services as usual – a social work based assessment service. Since the trail started, all children aged 0-5 coming into an episode of foster care because of maltreatment in Glasgow are offered a specialist assessment.

The theoretical basis of the New Orleans Intervention Model is that if families who have maltreated their child are to be able to change enough to safely have their children home, they need to own the fact that they have maltreated their child and work to build more positive attachment relationships. For maltreated children, the most important intervention may be the provision of a safer and more nurturing home environment: research on sensitive periods in neural development suggests that addressing inadequate care in the early months and years of life may improve neural circuits underpinning emotional regulation and allow maltreated children to reach their full developmental potential [16].

We are currently planning a multi-centre version of the Best Services Trial that will ask the questions:

1. Does the New Orleans Intervention Model improve the mental health of young children coming into an episode of foster care?
2. Is the New Orleans Intervention Model cost-effective compared to usual services?

In addition to these Randomised Controlled Trials, a systematic review of interventions that encourage parents to reflect on their own experiences of being parented is also being conducted as part of the work of the Children Young People Families and Health programme. The review aims to elucidate issues around context, mechanism and outcomes and how these three factors are related in understanding the effectiveness (or not), and for whom, of interventions which use such reflection as a way of bringing about behaviour change in participants' own parenting behaviour.

Further, the Measuring Health programme of the Medical Research Council/Chief Scientist's Office Social and Public Health Sciences Unit is evaluating the effectiveness and cost effectiveness of the Health in Pregnancy Grant. This was a universal payment of £190 made to women who had reached the 25th week of pregnancy and had received health advice from a midwife or doctor. The grant was designed to provide additional financial support in the last months of pregnancy towards a healthy lifestyle including diet, and it was suggested that the link to the requirement for pregnant women to seek health advice from a health professional may provide a greater incentive for expectant mothers to seek the recommended health advice at the appropriate time. The grant was introduced for women with a due date on or after 6th April 2009 but was subsequently withdrawn, the last payments being made to women who had reached the 25th week of pregnancy by 1st January 2011.

The evaluation is focusing on differences in birth-weight for babies born to those mothers who were eligible for the Health in Pregnancy Grant with babies born before the Health in Pregnancy Grant was introduced or after it was withdrawn. Specific questions the research project will address are:

1) Were there differential impacts of the intervention for particular subgroups defined by socioeconomic (both area deprivation and individual occupational social class), demographic (marital status, age, maternal height), or obstetric (parity, previous Caesarean section) factors, or for selected combinations of these groups?
2) Was the Health in Pregnancy Grant cost effective? How did cost - effectiveness vary across important subgroups identified as having differential outcomes?

The evaluation of the Health in Pregnancy Grant will result in recommendations regarding the appropriateness of reintroducing the Health in Pregnancy Grant. If shown to be effective and cost-effective, recommendations on whether the payment should be made to all women, as before, or targeted at certain groups with the intention of reducing inequalities in birth-weight and other outcomes will be made. The main results are likely to be available in autumn 2015.

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

The health service continues to play an important role. The THRIVE trial will identify many of the barriers and challenges in delivering antenatal parenting programmes for vulnerable mothers, and Best Services Trial is already helping us understand much about the delays and barriers that prevent young maltreated children getting the nurturing care they need in order to reach their full developmental potential.

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

The Children Young People Families and Health programme has explored possible mechanisms for child health inequalities using observational data from the Growing Up in Scotland study. Some inequalities in five year olds' health and health related behaviours are associated with differences in parenting behaviours, controlling for household adversity [5]. Further research is investigating whether parenting practices help to explain the emergence of a social class gradient in Body Mass Index status between 4 and 6 years.

The Institute of Health and Wellbeing has also been exploring inequalities in mental health in all preschool children in Glasgow City for the past five years, using Strengths and Difficulties Scale. Since 2013, all children in P3 and P6 in Local Authority schools in Glasgow City have also been assessed using the same scale. The evidence has demonstrated significant inequalities in the areas of social, emotional and behavioural difficulties. By P3, children were significantly more likely to have difficulties in social, emotional, and behavioural development if they were male, had been 'Looked After' at some point in the first four years of life, were in a school with a higher level of children eligible for Free School Meals, and if they had experienced difficulties in development at preschool. Furthermore, the evidence suggests that inequalities in such problems widened in the first three years of school , with the proportion of children from the most deprived quintile of area deprivation in Glasgow increasing from 7.1% to 12.1%, whilst children in the least deprived areas started with much lower levels of difficulties (2.9%) and remained at this level [17]. In 2016 (funding dependent) the research will be able to explore what happens to this cohort of children when they reach P6. It is hoped that eventually this will be able to be linked to school exam data and leaver destinations, in order to assess the impact of such difficulties for Glaswegian children.

Research by the Measuring Health programme using the Aberdeen Children of the 1950s study has identified both socio-economic context (primary school & neighbourhood) and composition (individual and family) in early life as important indicators for adult health, even after accounting for current social position [ref]. This means that the way individuals are grouped within schools and neighbourhoods is important over and above individual characteristics alone. This research showed the family was also influential on adult health and mental wellbeing.

Concluding remarks

Research clearly shows that early intervention is important in addressing health inequalities but now we need to focus on the mechanisms through which effective interventions appear to work in vulnerable populations [18]. A stronger evidence base in this area is needed, requiring rigorous evaluative work with regard to implemented interventions. These should elucidate which intervention components are critical to effective programmes and the contextual factors necessary for them to work, thus clarifying requirements for scaling up while addressing inequalities. The current focus on the early years as a policy priority in Scotland has a strong rationale on which laudable policy, measures and practice have been based, but its success in addressing health inequalities needs to be closely monitored and explored. Early years

interventions should not be regarded as a panacea; investment in higher level alternatives, probably *not* administered through the NHS, is crucial in improving the health of the most disadvantaged children.

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Appendix

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Health Inequalities – Early Years

Centre for Excellence for Looked After Children in Scotland

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

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

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

Context

As of July 2012[1], there were 16,248 looked after children in Scotland. A total of 2,706 children were on the child protection register, of whom 730 were also looked after. The total number of looked after children in Scotland has increased by 49% since 2001, but growth has largely been restricted to community-based placements such as foster care and kinship care (friends and relatives), which now constitute 59% of the total population. A further 31%

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

are ‘looked after at home’ by birth parents, and 9% are accommodated in residential establishments.

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

- 45% of children and young people aged 5-17 looked after by a local authority had a

diagnostic mental health disorder;

- Amongst children aged 5-10, 52% of accommodated children had a mental health

disorder compared to 8% of children living in private households;

- 44% of children placed with birth parents, half of children placed in foster care and
- Two-fifths of children in residential care have a mental health disorder;
- Over 22% of looked after children surveyed had tried to hurt, harm or kill
- themselves; this rate was higher for children living in residential units (39%)
- compared to those with birth parents (18%) or foster carers (13%)

Key messages

- Looked after children share many of the same health risks and difficulties as their peers, but often to a greater degree. Their long-term health outcomes are considerably worse;

- Article 24 of the United Nations Convention on the Rights of the Child recognises the right of the child to the enjoyment of the highest attainable standard of health;

- Preventing health inequalities for looked after children requires investment in population-based programmes as well as in more targeted services ;

- Exposure to early adverse life events can affect the developing brain, exerting powerful effects on neural structure and function which can affect a child's life course. The brain develops rapidly in the first two years, but the majority of neurons are formed pre-birth ;

- There is often a mismatch between child development timeframes in the early years and timeframes or decision-making in children's services;

- Interventions which focus on building attachment and developing nurturing and supportive environments are important, particularly in the early years;

- Young people tell us that that stable placements and consistent, supportive relationships with carers had a huge influence on their emotional wellbeing, their achievements at school and their motivation to lead healthy lifestyles;

- Appropriate support provided to caregivers in the early years is important, particularly for those caring for disabled children; disabled children are more likely to be looked after, remain in care for longer and have a higher risk of being placed inappropriately compared to non-disabled children, which will affect their health and wellbeing;

- The health service has a key role in addressing health inequalities and ameliorating the health damage caused by disadvantage. Where looked after children have access to specialist health practitioners, their health outcomes improve;

- Barriers faced by early years services working to reduce health inequalities include: limited quantitative information on looked after children's health; short-term funding and support for initiatives; limited understanding about the role of the corporate parent and lack of understanding of children's rights and what this means in practice.

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

There is often an assumption that policies tackling the determinants of health automatically tackle those of health inequalities; however, addressing the determinants of health inequalities requires consideration of the unequal distribution of health determinants (Graham & Kelly, 2007). Policies that have achieved overall improvements in key determinants of health have not always reduced inequalities and can have the opposite effect. Understanding this helps to determine the interventions and policies pursued. Objectives for health are likely to focus on reducing overall exposure to health damaging factors, whereas those tackling health inequality will focus on levelling up the distribution of health determinants. The drive for health improvement can result in an 'inverse care law' effect whereby the benefits of policies accrue to more advantaged groups and overall improvements in health mask continuing inequalities. Some policies may do both, but clarity of purpose is important. Preventing or reducing health inequalities for our most vulnerable members of

society, including looked after children, requires investment in both population-based programmes as well as more targeted services. Marmot (2010) suggests that to reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity proportionate to the level of disadvantage: 'proportionate universalism'. His report concluded that reducing health inequalities would require action on six policy objectives, the first being to *'*give every child the best start in life,*'* crucial to reducing health inequalities across the life course. The rationale is clear:

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

Understanding the impact of adverse conditions

There is strong evidence to show that exposure to early adverse life events can affect the developing brain and exert powerful and potentially long-term effects on neural structure and function, which can affect a child's life course. The impact on the brain is not constant throughout life with early experiences exerting a particularly strong influence in shaping the functional properties of the immature brain[3]. Many looked after children are exposed to adverse experiences, including pre-natal exposure to alcohol and/or other harmful drugs, neglect, sexual abuse, exposure to violence and parental instability (e.g. criminal behaviour, substance abuse etc.). The adverse childhood events study in California looked at the impact of nine types of adverse events and subsequent outcomes. It found that a young person who has experienced four or more adverse events in early life is eight times more likely to become an alcoholic and four times more likely to misuse drugs. A boy who experiences physical violence in early life is eight times more likely to use violence on his partner and four times more likely to be arrested for carrying weapons, a cycle of persistent harm which Scotland's Chief Medical Officer refers to as 'intergenerational mayhem'[4]. This needs to be understood in the context of environmental factors and parenting that undermine healthy development and their impact on outcomes for children as well as the mitigating impact of protective factors. Effective intervention in the early years can help to break this intergenerational cycle.

Decision-making timeframes

One of the most challenging issues in intervening effectively and promoting better outcomes for abused and neglected children is a mismatch between

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

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

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

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

Building attachment/ relationships

Young people tell us that stable placements and consistent, supportive relationships with carers had a huge influence on their emotional wellbeing, their achievements at school and their motivation to lead healthy lifestyles. Conversely, they note how detrimental unstable or changing placements can be upon their health and wellbeing[5]. Interventions which focus on developing nurturing environments are crucial, particularly in the early years. The bond between a child and primary caregiver in the first year of life is usually seen as the template for future relationship experiences, and children with secure attachments have developmental advantages.[6] If children have not developed emotional competence, they will struggle to manage the learning environment at school and into later life. There are various evidence-based attachment-promoting interventions in pregnancy and the early years e.g. *Mellow Bumps* aims to reduce maternal stress and increase pregnant women's awareness of the emotional needs of babies and *Circle of Security* works with high-risk pre-school children and their caregivers, using an attachment based intervention to help adults understand the concepts of a secure base (Furnival: 2011).

Young people with care experiences are also more likely to have children at a younger age (Chase et al., 2009). This can pose challenges for young parents, due to limited finances, a reluctance to engage with professional services, little help from the wider family and a lack of residential provision to support these mothers (and sometimes fathers).[7] Supporting pregnant teenage girls through pregnancy and the first couple of years of the baby's life can transform the lives of baby and mother. A mother who receives high-quality maternity care in pregnancy is in a good position to provide a good start for her child. Regular contact with health professionals and early antenatal booking is important as many vulnerable women may delay seeking maternity care until well into the pregnancy. Whilst universal services provide support for all pregnant women, some mothers may not take up these

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

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

[7] CELCIS (2013) Written Evidence submitted to the Scottish Parliament Health and Sport Committee: Teenage Pregnancy Inquiry
http://www.celcis.org/media/resources/publications/Response_Inquiry_into_teenage_pregnancy.pdf

services. Targeted interventions such as the *Family Nurse Partnership* can be particularly effective: the aim is to improve pregnancy outcomes through better health-related behaviours and improved parenting. Nurses develop trusting relationships with mothers and family members and review their own experiences of being parented whilst promoting sensitive, empathetic care of their children. Evaluations have shown improvements in women's pre- and postnatal health; reductions in smoking during pregnancy, higher levels of breastfeeding and increased self-esteem. Breastfeeding provides optimal nutrition and is good for the health of the child and the mother. It also helps to build attachment. Whether the child is breastfed or other arrangements are made, it is essential that safe and sufficient food is provided. This can be an issue if a decision has been taken to take the baby into care, due to the risks being considered too great for the baby to be cared for by the parent. 'The ultimate priority is to ensure the baby receives adequate nutrition from the person responsible for providing the nutrition and ensuring sterilisation of feeding equipment. Alternatively if the priority is breast feeding, baby and breast should be together and social work needs to manage the risk'.[8]

Support to caregivers

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

Types of interventions

If we wish to address inequalities in health for looked after children, we need to consider which interventions work. McIntyre (2007) notes that these can be directed at one or more of three levels: the structural or regulatory level; the local level and at individual or family level. More advantaged groups with better access to resources find it easier to access health promotion advice and preventative services (e.g. immunisation, dental check-ups). Disadvantaged groups tend to be harder to reach and can find it harder to change behaviour, e.g. a mass media campaign intended to reduce socio-economic differences in women's use of folic acid to prevent neural defects in

[8] Interview with LAAC nurse 28th March 2013

babies resulted in more marked social class differences in use than before the campaign (McIntyre: 2007). McIntyre suggests that interventions with more disadvantaged groups will need to be more intensive and targeted: information-based approaches such as pamphlets in GPs surgeries, media campaigns or those requiring individuals to 'opt in', may be less effective amongst these groups. An interesting intervention is *Mellow Parenting*, a programme aimed at parents of children under five. It has a theoretical basis in attachment theory, behavioural theories, cognitive behavioural therapy and social and experiential learning, and was originally developed to meet the specific needs of vulnerable, hard-to-reach families, many of whom have experienced abuse and disruption in their own childhoods. Evaluations have shown improvements in mother-child interaction, mothers' effectiveness in parenting and children's language and non verbal abilities.

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

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

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

Children and Young People (Scotland) Bill 2014
In the Stage 3 debate of this Bill, the Minister for Education and Young People stated that the Bill took a universal approach, noting that 'if we begin to recognise some groups of children, this undermines universality'. Notwithstanding this, key provisions were made to the looked after sections of the Bill, a recognition that these children face the greatest challenges and need extra support. The continuing care provisions, whilst not addressing early years directly, will enable young people to remain in their current care placement beyond 16 and up to 21. Young care leavers are particularly vulnerable, their health and wellbeing much poorer than those who have never been in care. These provisions recognise that the pressures associated with independent living can have a detrimental impact on the health of young care leavers and potentially place them at risk. These are the parents of the future, more likely to be parents than their peers, so considering this within the context of the early years is relevant, notwithstanding the fact that they have a right to good quality health care. Their stability at 18 and upwards in both placement and in relationships is an acknowledgement of the corporate parent role - that we have a responsibility to look after our young people in the way that any good parent would do and ensure that these young people are not placed at a disadvantage compared to their peers. The Bill also defines Corporate Parenting in statute and clarifies the public bodies to whom this applies. It is essential that this role is understood in practice and we hope that a statutory provision will help to move this on.

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

3. What role can the health service play in addressing health inequalities through interventions in the early years?
The health service has a key role in addressing health inequalities and ameliorating the health damage caused by disadvantage. Universal health services have a preventative and inclusive effect: antenatal care, health visiting, free obstetric care, vaccination programmes and school health services are important for preventing inequalities (Macintyre, 2007). Many looked after children will have missed vaccinations because of frequent

moves or failing to turn up for appointments and flexible approaches and consistent record keeping will be needed to improve and monitor take up. The need for a specific focus on looked after children's health has been recognised by the Scottish Government. In 2010, the Ministerial Task Force called for a shared sense of responsibility for the outcomes of looked after children, stressing the role of NHS Boards in health and health improvement. Two important pieces of guidance have also been produced: *We Can and Must Do Better* (2007) stressed that 'the health of our looked after children and young people remains poor when compared to other children and young people: this has the potential to have a serious and negative impact upon educational outcomes and future lives'. Action 15 of the guidance called on Health Boards to assess the physical, mental and emotional needs of all looked after children and young people and put in place appropriate measures to take account of these assessments. The National Residential Child Care Initiative (NRCCI) (2009) saw this as a matter of urgency and it became a requirement in CEL16 (2009). The recognition that Health Board Directors have a responsibility for looked after children and young people and care leavers in their area, including those looked after at home is an important recognition of their essential role as corporate parent. *These Are Our Bairns* (2008) called on local authorities, health services and other agencies to focus on their corporate parenting duty 'to promote health, to protect health, to assess and identify health-related risks and to treat health problems'. Despite this requirement, provision is patchy.

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

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

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

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

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

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

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

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

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

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

Kerrane (1997) argue that no child is too impaired to be informed about what is going to happen in a way she can understand.

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

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

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

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

General Comments from the United Nations Convention on the Rights of the Child: General Comments are official statements, adopted by the Committee on the Rights of the Child, which clarify aspects of the Convention that require further interpretation. They are particularly helpful for practitioners who wish to ensure that a rights-based approach informs their work. General

Comment 7 (2005) *Implementing child rights in early childhood* is particularly relevant.

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

Centre for Excellence for Looked After Children in Scotland
March 2014

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Health Inequalities - Early Years

University of Dundee: Education, Social Work and Community Education

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

    - Early years interventions adopt many approaches, are delivered in a variety of settings and utilise a range of models so it is difficult to address the above in an holistic manner.

    - Health inequalities equally are dependent on a wide range of variables such as class, gender, access to services, poverty, lifestyle etc. Poverty, disadvantage, marginalisation and exclusion from society are key factors which impact on children and families in many communities which result in poor health.

    - Integrated approaches to early intervention and targeting services to the most vulnerable communities is a step in the right direction in relation to addressing health inequalities

    - Positive in that it encourages partnerships between setting and home.

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

    GIRFEC/Poverty agenda/Curriculum for Excellence/Pre Birth to Three – viewed very positively and making a difference to addressing some of the health inequalities.

    Scotland's Future: Your Guide to an Independent Scotland – sets out a commitment, in an independent Scotland, to developing a universal system of early learning and childcare for children from the age of one until they start school – positive step, but details required.

    Children and Young People Bill (2014)

    - The extension to the number of 2 year olds who will be eligible to receive 600 hrs of funded places – the commitment to provide for Looked After Children is welcomed, however, there is a need for those practitioners who have the responsibility for the care and education to be highly trained to meet the holistic needs of young children and encourage development and learning. If the needs of vulnerable children are to be met staff need to be highly motivated and in possession of higher level qualifications with sound knowledge of attachment theory and specialism in early years. (Too often the under-threes are very often looked after by the least experienced and least qualified staff in day-care.)

Wider issues:

- The importance of GTCS working more closely with SSSC to avoid unnecessary duplication, role confusion and to improve outcomes.

- There must be a raising of awareness of the need for skilled practitioners throughout Scotland. However, this must also address the pay and conditions for those employed in day-care. Graduate status is not currently reflected in pay.

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

- An integrated approach where all relevant services work collaboratively together is a strong driver to addressing health inequalities

- For example, this would include community based health service professionals such as GPs and other health professionals including dentists, health visitors and drug and alcohol workers, as well as hospital based professionals working collaboratively with early years workers, teachers, social workers, play workers, parents, carers and others who have a stake in the positive development of children and families.

- Understanding the role and contribution of other disciplines and how they can collectively work together to address inequalities is crucial to effective practice.

- Drawing on community knowledge, strength and building this capacity is crucial.

- Promote play especially outdoor play as a means of getting it right for health and well-being – in early years settings, out of school care and involving families.

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

- The scale of the issues and the complexity is vast. There are many 'wicked' problems which require a collaborative focus of many minds to begin to effect change. These 'minds' should absolutely include children and their families as key stakeholders and 'experts' in a process of change.

- Additionally the questions have to be asked, do people want to change and if not, should they be 'forced' to change? Changing opinion and behaviour is difficult to achieve, trying to do so without gaining individual 'buy in' is practically impossible.

- Listening to communities and working from a relationship based perspective where, in relation to early years, children and families/carers and the wider community help set the agenda and pace would be advisable.

- Funding is an issue – in the current austere climate where resources are stretched, funding should be ring-fenced and targeted to specific disadvantaged communities. Services such as 'Sure Start' have had their funding cut as have other early years services. Directing funding, not only to early years services but to those communities that are most vulnerable, is essential.

- Targeting particular families within communities e.g. health visitors moving away from a universal service, however, could foster greater stigmatisation and reduce effective engagement.

- A lack of 'joined up' working across services can lead to duplication, reduced effectiveness and less effective outcomes.

- Health inequalities is 'everyone's business' and a recognition of this is important for all services, many of which may not seem initially obvious, for example, police, fire service, housing, town planning

- All work to reduce health inequalities should be collaborative, adopting a community based approach where people have a real voice in setting the agenda. Within early years this would not only include families and carers but also enlist opportunities to hear the child's voice as well as wider community interests.

- Effectively engaging children and families on any health inequality projects is less likely to be successful if it emanates from for example, an education or health settings or adopts a formal approach. Using informal learning methods within the community, within settings that people feel safe and comfortable, is far more likely to reap rewards.

- Challenges of working with drug and alcohol dependent parents without support. Lynn

- Access to outdoors and staff ratios – risky play.

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

Scandinavia
Outdoor play settings in Scotland e.g. Secret Garden, Fife and many early years settings using woodlands etc. for outdoor play and learning and benefits to holistic development including health and well-being.

Family Learning
Family learning is a powerful tool which can challenge educational disadvantage, promote socio-economic resilience and foster positive attitudes towards life-long learning. The family is indeed a community within a community so when they learn together it shows community capacity building at its best.

In a 2008 evaluation, HMIE defined the aim of family learning programmes as: 'to encourage family members to learn together. They are learning as or within a family. They should include opportunities for intergenerational learning and, wherever possible, lead both adults and children to pursue further learning.'

In this evaluation, HMIE acknowledged that the role of community learning and development in supporting family learning is not well understood.

Subsequently, the Scottish Government funded a study Scoping of Sustainable Models of Family Learning (2008) and, in the following year, two case studies were developed to provide examples of Effective and Inclusive Practices in Family Learning (2009).

Project examples:
Learning Together in Castlemilk (2013);
Family early literacy and numeracy, Dundee (2013);
Joint nursery to primary transition project, Edinburgh (2012)
http://www.educationscotland.gov.uk/search/?strSearchText=family+learning&strSubmit=true&form_submitted.x=0&form_submitted.y=0

Nurture groups are suitable for different age groups and a variety of ages can benefit, although early intervention is best and the primary focus is on the early stages.
http://www.educationscotland.gov.uk/supportinglearners/positivelearningenvironments/positivebehaviour/approaches/nurture/index.asp
Dundee City Council – School Community Support Project
https://www.dundeecity.gov.uk/dundeecity/uploaded_publications/publication_1056.pdf
DJCAD – toolkit being developed to support mechanisms for understanding different perspectives
CLD – ladder of engagement

Education Scotland publishes a new quality improvement framework for culture and sport provision
http://www.educationscotland.gov.uk/newsandevents/educationnews/2012/pressreleases/october/howgoodisourcultureandsport.asp

University of Dundee: Education, Social Work & Community Education

Health Inequalities - Early Years

Alan Sinclair CBE,
Associate of the Centre for Confidence and Wellbeing

Question 1
How effective are early years interventions in addressing health inequalities?

The most reliable way to produce a physically and mentally healthy, independent adult is to ensure that when he or she is a baby his or her neurological and biological development takes place normally. The effects of this are magical but it does not take much to achieve it. What it requires is providing secure, stimulating and nurturing relationships with one, or if possible, with both parents. It also requires preventing the baby from experiencing trauma and stress (commonly resulting from alcohol, drugs and violence).

No doubt you will receive all sorts of evidence to support the above thesis. The evidence does exist and I use medical and time-series evidence in talks and written work. But I have come to realise that evidence in this area is at best of secondary importance.

In the countries that fare best in child well being (The Netherlands, Denmark, Finland, Sweden) the reason that they have such strong preventative approaches to health and young babies and their parents, is because they consider it to be the right thing to do. And it has been ingrained in public health for a hundred years or more.

For some reason the Scottish health system looks at young children in the way we look at a leaking roof. It is a technical problem and it needs an intervention to be fixed - as is implicitly illustrated in question 1.

All parents struggle in bringing up children and some parents struggle more than others. At the centrepiece of what works well is the relationship between the parent or parents and the baby.

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

We have no shortage of policy. Our issue is Implementation Deficit Syndrome.

In recent years there has been more talk about early years. But if you are a health board chief executive or chairman, you get your collar felt if you fall down on budgets, capital spend, waiting lists, hospital induced infections and now care for the elderly. Early years and parenting does not feature as a priority.

GPs are busy dealing with whoever comes through their doors.

Health Visitors are the profession that has the most contact with babies and parents. It varies across the country but the trend seems to be one of an ageing profession with those that retire not being replaced. The pressure is on those remaining to cover more babies and mothers.

Politicians do not find this easy. The public do agitate about waiting lists and the like. Young babies do not form a vocal lobby or vote.

Yet the paradox is, if you want a physically and mentally healthy adult, you need to support the baby and the parent from conception to about age two or three.

I have a growing fear that by framing early years as a health inequality issue we are marginalising the middle class and the problems they have with their children (anxiety, depression, self harm, eating disorders, abuse of drugs and alcohol and suicide) and the role of the middle class in expressing and agitating for change.

I fear that the concentration of government policy (across governments) on child-care intensifies the policy idea that early years is about parents going back to work. It takes us further away from the key notions about attachment, relationships, care and love. Local authority day care usually starts at 3 years of age. The big issues and opportunities are in the period before day care starts.

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

A useful way of answering this question is by contrasting practice in The Netherlands which is very good and undergoing a major drive for further improvement, with Scotland where performance is “middling”.

In The Netherlands there are Family Centres in every neighbourhood that aim to support parents and babies and answer all questions about growing and raising a child – without tipping over into picking up needless issues.

Mother and Baby Wellbeing Clinics is the centrepiece of Family Centres providing a relationship and support from birth to school age.

One home visit is made shortly after birth. The parent(s) and child then visit the clinic in weeks 4 and 8, then in months 3, 4, 6, 7, 9, 11, 14 and 18, then at 2 years, 3 years, 3 years and 9 months and then at 5 years or 6 years as the child learns to read and write.

In contrast, in Scotland, Health Visitors sign off the overwhelming majority of their parents and children at 8 weeks. The next single port of call is around two years later.

Clinics are staffed by doctors who attend to health, social and emotional development, motor skills, language and general health and by nurses who concentrate on baby care, parenting, feeding, toileting and sleeping. Back-up for health and development is provided by walk-in surgeries and a telephone helpline.

Several features are worth stressing. The support starts early and is truly comprehensive across the country for all babies and their parents. It has continuity of care built in – it is about relationships formed with doctors, nurses and development staff. It is comprehensive and welcomed by parents across all socio-economic groups.

The health system in Scotland looks at technical health. In The Netherlands, this service looks at the child in the round: their development, language, emotional life and how the parent(s) cope or do not. From this regular and personal contact, relationships grow and where necessary specialist services like speech therapy or a family counsellor are identified.

Question 4
What barriers and challenges do early years services face when working to reduce health inequalities?

Before addressing barriers it is worth bringing to mind the obvious: health services start by having the most contact with parents and babies, they are trusted and are universal.

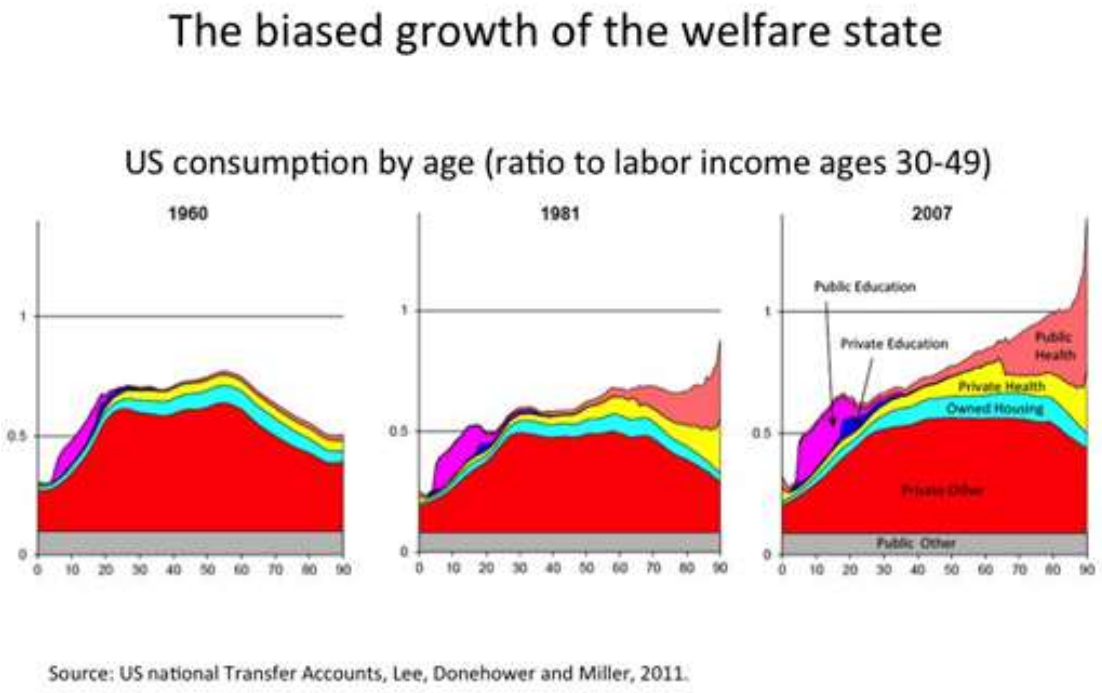
The first barrier is one of framing and history. Our health services are dedicated to helping ill people get better or manage their conditions. Only a smaller sliver of attention and resources goes into prevention. When health services intervene it is to provide a technical fix. As we see from The Netherlands and other countries, their focus is on the whole mother and father relationship with the child and is concerned as much about the child's development as with the child's physical health.

The second barrier is low priority and status accorded to early years and parenting support. Senior health board management, as illustrated earlier do not have early years and parenting as a big-ticket item. It is not what real men do. Health Visitors as an endangered species, comes as a consequence of this low priority. A number of local authorities have also found children services a comparatively easy place to look when reducing budgets.

The third barrier is the crisis of care. Estimates vary, but it seems safe to conclude that 40-50% of lifetime health spend goes on the last few months of life. Given the age profile of the population the clamour is on to meet the health and care needs of older people. Our health services are stretched to meet this demand, a demand that comes with a trump card. The more important question of intergenerational success and failure is in this context the loser.

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

a) Below you will find three graphs of spend/consumption for people aged 0 to 90 years of age for 1960, 1991 and 2007. The data is from America and I have been unable to find a similar exercise conducted on Scottish or UK data. But given that major qualification, I feel that it does give us some insight to the creeping and thus almost imperceptible increase in inequality between generations as well as within generations.



b) In The Netherlands a group of local authorities got behind a report that identified that the 'youth chain' was not working: no one owned the problem; the needs of children and parents needed to be seen as pivotal; local cooperation between different services was too loose; and help was insufficient. A list of barriers, I am sure, which will have been identified in different submissions. In short, support needed to be timely and tailored.

Central government shared the concerns and was prepared to act.
In 2005, Professor Schrijvers of the medical faculty in Utrecht lead the three wise people called in to advise the government in the face of rising levels of dyslexia, Attention Deficit Disorder and Hyperactivity Disorder (ADHD), autism and stresses in children. For teenagers and young adults, the government was concerned about violence at home and on the streets, suicide and depression. Schrijvers' argument is that parents are psycho-pathologising their children's behaviour and that the root cause is that, "parents do not know how to handle their children".

It was out of this work by local and central government that the national government adopted the plan to set up Family Centres in every neighbourhood, in all 418 municipalities. These would complement and supplement the Mother and Baby Wellbeing clinics by providing a means for spotting and anticipating problems; giving guidance and counselling; and creating a means for coordinating local care.

The Netherlands already has the highest rating for child wellbeing in the OECD and among the countries of the EU. I strongly commend their approach to the Committee.

Alan Sinclair CBE,
Associate of the Centre for Confidence and Wellbeing
March 2014

Health Inequalities – Early Years

Scottish Collaboration for Public Health Research and Policy
University of Edinburgh

Background: Early Years policies and programmes in Scotland have recently emphasized improving the levels of, and reducing inequalities in, child development before school entry. This is entirely in keeping with current scientific evidence internationally (Hertzman et al. 2009; 2010) which shows that high-quality, universal, early childhood education and care (ECEC) is the most cost-effective investment for improving lifelong health and economic productivity. This is especially the case for children from socio-economically deprived backgrounds, in that ECEC can substantially "level the playing field of life."

Indeed, some experts (Nores & Barnett 2010; Temple & Reynolds 2007) have convincingly argued that universal ECEC is *an essential investment* if any society is to successfully reduce lifelong health and functional inequalities by social class – of which Scotland has some of the steepest in Western Europe (Popham & Boyle 2010). The key reason this is so is that the first few years of life are the time when the human brain is most malleable, as its sophisticated circuitry is recurrently sculpted by daily experience. Thus stimulating, loving and healthy environments in infancy and toddler-hood lead to much more brain capacity than deprived, neglected and unhealthy environments (both social and physical). Accordingly, the Scottish Early Years Collaborative explicitly sets out as one of its core "stretch goals" the achievement of optimal developmental attainment in all Scottish children by school entry.

Unfortunately, it does not provide specific guidance to Local Authorities (LAs) or preschool education professionals on how to achieve that goal. In particular, the Collaborative's documentation is silent on precisely *how* Scotland could go about *measuring* early child development, especially at school entry, when the cumulative effects of local neighbourhood and family/home "learning environments" can be most easily assessed (Frank & Haw 2011; 2013). Such measurement would ideally allow each neighbourhood to assess how well a given cohort of school-enterers has developed in their first half-decade of life.Based on this evidence, improvements to local pre-school programming and facilities can then be put in place, and the effects seen in the improved developmental scores of future waves of children entering school. However, at this time there is no standardized Scottish measurement tool.

Project Summary: In response to the challenge of how to accurately and efficiently measure child development over the first half-decade of life, the Scottish Collaboration for Public Health Research and Policy, funded by the MRC and CSO, have been working with developmental psychologists from University of Strathclyde in Glasgow. The group recently designed and conducted a pilot of a Scottish version of an internationally validated P1-teacher questionnaire for systematically assessing the developmental status

of all school-enterers, when their P1 teacher has got to know them, after a few months in class. The results of that 2011-12 pilot study[1] in East Lothian show that this questionnaire – the Scottish Early Development Instrument (SEDI) – was easy for East Lothian P1 teachers to use, requiring only minimal language adaptation from the original Canadian version. More importantly, it was capable of readily distinguishing major differences (a 2.4-fold variation) in the proportion of children with SEDI scores low enough to be considered "developmentally vulnerable," across East Lothian quintiles of deprivation. Similar differences in SEDI scores were observed across the six primary school clusters in East Lothian, which have widely varying levels of deprivation (measured here by the Scottish Index of Multiple Deprivation.)

Both this "social gradient" in SEDI scores, as well as the overall average score for East Lothian students (27% "vulnerable") were very similar to the gradient and average scores found in both Australia and Canada, where the EDI has been used extensively for many years (Lloyd et al. 2009). Furthermore, the overall cost of data collection was only about £20 per student assessed, comprised almost entirely of the cost of buy-out time, to allow the teachers to complete the SEDI forms for their classes. This comes to about 7p per capita of total LA population, if the SEDI is used every three years, as in other countries. East Lothian parents/teachers/LA officials have been delighted to receive the project's detailed SEDI reports on each of their school clusters, for use in planning local improvements in pre-school programming. [This routine practice with EDI results internationally is entirely ethical because all individual students' scores are anonymized – thus also achieving a 98% acceptance rate for the SEDI among parents of P1 students in East Lothian.]

Current Status: Despite the very promising performance, acceptability and cost of the SEDI in East Lothian, SCPHRP and its collaborators have found little interest, among key Scottish stakeholders in the Early Years Collaborative (EYC), in further roll-out of the SEDI across Scotland. However, a number of LAs are interested in pursuing this approach, which actually measures what the EYC explicitly calls for: optimization of the global developmental status of P1 children. The reluctance on the part of some to further test the SEDI's practicability in Scotland appears to be related to the currently delicate relationship between the SG and LAs. The current devolution of decision-making to Scottish LAs in many sectors, as well as recent major budget cuts, appear to make it awkward for the SG to actively promote specific actions (including the use of specific measurement tools, such as the SEDI) by LAs across Scotland. The SCPHRP and its collaborators would suggest to the Parliamentary Health and Sport Committee that this unfortunate impasse may lead to unnecessary delay in achieving the laudable goals of the EYC, and certainly impair the evaluation of whether or

[1] Publication: Lisa Marks Woolfson[1], Rosemary Geddes[2], Stephanie McNicol[1], Josephine Booth[1], John Frank[2] . A cross-sectional pilot study of the Scottish Early Development Instrument: A tool for addressing inequality. *BMC Public Health* 2013, 13:1187. DOI: 10.1186/1471-2458-13-1187.
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not these goals are being met, according to a standardized, validated yardstick, across Scotland.

The Bottom Line: SCPHRP and its collaborators therefore call on the Committee to specifically recommend that further work be done in Scotland, jointly by willing LAs and the SG, to evaluate the suitability of rolling out the SEDI across Scotland. We stand ready and willing to provide, at no cost, scientific advice on how best to do that.

Scottish Collaboration for Public Health Research and Policy
University of Edinburgh