



**scottish universities  
insight institute**

mobilising knowledge for a better Scotland

## **Poverty and children's health and well-being**



Mark Willis, Child Poverty Action Group (CPAG) in Scotland  
Dr Daniela Sime, Social Work & Social Policy, University of Strathclyde  
Dr Jennifer Lerpiniere, CELCIS, University of Strathclyde

## **POLICY BRIEFING**

### **2015**

# Poverty and Children's Health and Well-being

Mark Willis, Daniela Sime and Jennifer Lerpiniere

This briefing provides an overview of the research evidence on the impact of poverty on children and young people's health and well-being. It focuses on the impact of poverty on children's physical and mental health, their behaviours in relation to healthy lifestyles, the social determinants that influence children's health outcomes and, issues in their access to, and use of, health care services. The briefing identifies key recommendations for the promotion of health and wellbeing, to build on the resilience of families affected by poverty.

## Key points

- In Scotland, the risk of a wide range of negative health, social, emotional and cognitive outcomes and circumstances is greater for children from less advantaged backgrounds, measured in terms of their family's income, social class and multiple deprivation.
- Poverty increases the risk of premature birth, lower birth weight, complications in pregnancy and childbirth, as well as infant mortality.
- Poverty is linked to increased risk of childhood illnesses and accidents.
- Increased risk of suffering from ill health can affect children's ability to do well at school. This, in turn, is one of the factors contributing to greater numbers of children from less advantaged backgrounds leaving school with low or no qualifications.
- Poverty can affect speech and language development.
- Poverty in early childhood is linked with increased risks of mental ill-health in adulthood.
- Families in poverty encounter a range of barriers in accessing provision of services, such as high quality leisure facilities – barriers include cost, transport, limited access to information, stigma, safety and poor quality provision in deprived areas.
- Certain groups, such as looked after children, certain ethnic minorities, children from migrant and asylum seeking families are also at increased risk of ill health.

## Key recommendations

- Governments and local authorities should increase support for mothers in the pre-birth stage.
- Support families with young children through increased provision of childcare and opportunities for parents to engage in children's learning.
- Ensure income maximisation as part of health provision.
- Local authorities should focus on poverty proof services, by identifying 'invisible' barriers to families' access to services.
- Increase mental health support and promote healthier lifestyles among looked after children and young people.
- Ensure local and national budgeting reflects the projected increase in child poverty and its immediate and long-term effects on wellbeing.

## 1. Introduction

Some children growing up in poverty go on to achieve amazing things. However, in societies with high levels of inequality like the UK, the odds are stacked heavily against them even before they are born. The risk of a wide range of negative health, social, emotional and cognitive outcomes and circumstances is greater for children from less advantaged backgrounds, measured in terms of their family's income, social class and experience of multiple deprivation (Bromley and Cunningham-Burley, 2010). Families and individuals can show remarkable resilience in overcoming these disadvantages, and the effects of a loving and nurturing home and a supportive community go some way in counteracting the negative impact of poverty on children's health and wellbeing. However, even with these protective factors, the majority of children in low income families will need a combination of luck and effort to avoid the risks to their health and wellbeing that are associated with poverty. When this support is absent or under pressure, children and young people's chances of achieving their full potential are reduced. This briefing paper aims to provide an overview of the well-established links between poverty and child health and wellbeing, and conclude with some recommendations on what can be done to level the playing field and give every child the best start in life.

## 2. What do we mean by child poverty?

Peter Townsend, the sociologist who did so much to advance our understanding of poverty and its relationship to the wider society, and one of Child Poverty Action Group founders, defined poverty as follows:

*"Individuals, families and groups in the population can be said to be in poverty when they lack resources to obtain the type of diet, participate in the activities and have the living conditions and amenities which are customary, or at least widely encouraged and approved, in the societies in which they belong." (1971: 31)*

As this definition makes clear, poverty can only properly be understood in relation to the typical living standards in society.

Children are considered to be living in poverty if they live in households with less than 60% of median household income. This is the key measure used by the UK and Scottish governments, and by the EU. Another way of measuring the effects of poverty in relation to health is by using the Scottish Index of Multiple Deprivation (SIMD), which identifies small area concentrations of multiple deprivation across all of Scotland in a consistent way, combining 38 indicators across 7 domains, namely: income, employment, health, education, skills and training, housing, geographic access and crime.

**Currently around 1 in 5 (220,000) children in Scotland live in poverty, according to Government data** (Scottish Government, 2014). Institute for Fiscal Studies (IFS) modelling has forecast that, by 2020, up to 100,000 **more** children will be pushed into poverty in Scotland compared to 2011, primarily as a result of tax and welfare reforms resulting in a [further] decrease in income for families. This has major implications for the health and wellbeing of children in Scotland, and for the organisations which provide them with services.

### 3. What do we mean by health and wellbeing?

The World Health Organisation (WHO) defined 'health' in its Constitution (1948) as:

*"a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity."*

Since then, the distinction between a positive concept of healthy wellbeing and the negative one of the absence of illness or impairment has become widely accepted. In 1986, the WHO reinforced this distinction with the statement that health:

*"is a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities."*

While every individual has a general understanding of 'health', the concept covers a wide range of factors including:

- antenatal care
- nutrition and healthy weight
- oral health
- speech, language and communication
- violence and gender-based abuse
- substance misuse and addictions
- mental health
- illnesses and accidents
- life expectancy

The Scottish Government places the wellbeing of children and young people at the heart of its *Getting It Right for Every Child (GIRFEC)* approach. This uses eight areas of wellbeing for all children and young people to grow and develop and reach their full potential:

- *Safe*
- *Healthy*
- *Achieving*
- *Nurtured*
- *Active*
- *Respected*
- *Responsible*
- *Included*

These basic requirements are rooted in the *United Nations Convention on the Rights of the Child* (1989), which in turn is now enshrined in the *Children and Young People (Scotland) Act 2014*.

## 4. How does poverty impact on children's health and wellbeing?

Specialists in health promotion and public health have become increasingly aware that family income and other resources, including education, wider social networks and support in communities, impact on children's health and wellbeing even before birth. While health behaviours and practices may superficially appear as a private matter for the individual, health practices are shaped by individuals' ability to adopt health-promoting behaviours and are constrained by everyday contexts, such as family and neighbourhood.

In this section, we summarise the evidence on how poverty impacts on children's opportunities for good health and wellbeing by identifying some of the factors which impact on their families' ability to provide children with the best health outcomes.

### Pregnancy

Lack of adequate income during pregnancy is an obvious risk to the health and safety of both mother and child. The physical impact on development is well established (as discussed below), but harder to measure may be the impact of stress due to financial worries. Deprivation is also associated with greater exposure to risks for poor outcomes such as smoking in pregnancy (43% of mothers in most deprived areas smoked as compared to 9% in the least deprived), unplanned pregnancy (39% in most deprived, as compared to 8% in least deprived) and planned bottle-feeding (46% in most deprived, as compared to 15% in least deprived) (Bromley and Cunningham-Burley, 2010). Being poor also affects mothers' ability to have a healthy diet, and is associated with difficulties in getting practical and emotional support during the pregnancy.

### Infant mortality

Children from low income families are more likely to die at birth or in infancy than children born into better off families. Children born to parents with manual backgrounds are around twice as likely to die in their first year of life as those born to parents from non-manual backgrounds (General Registrar Office for Scotland, 2010). Ethnicity and deprivation remain important associates of stillbirth and neonatal death; reducing stillbirths and neonatal deaths in these groups remains a difficult but vital public health challenge (Centre for Maternal and Child Enquiries, 2011).

### Birth outcomes

A woman in a low income household is more likely to be poorly nourished during pregnancy and deliver a baby prematurely or with low birth weight (Dowler *et al.*, 2001). Children born in the poorest areas of the UK are more likely to spend time in neo-natal units, with the relative risk of low birth weight being 7.1% in the most deprived areas, compared with 3.6% in the least deprived areas (Scottish Government, 2013 a). Low birth weight has been associated with increased risks of poor health later on in life.

### Breastfeeding

There is also clear association between deprivation and breastfeeding, with lower levels of exclusive breastfeeding among mothers in the most deprived areas (22.8% of babies were exclusively breastfed in the most deprived areas, compared with 52.4% in the least deprived areas). Younger mothers (24 and under) were also three times less likely to exclusively breastfeed their children (NHS, 2014). Levels of

breastfeeding are often linked to mothers' understanding of the benefits of breastfeeding for mother's and child's health, as well as a range of cultural factors and support networks available to mothers to adopt breastfeeding.

### **Early childhood illnesses**

Physical ill-health is much more prevalent in low-income, compared to high-income households, but in children, gender differences are also notable. The Scottish Health Survey 2012 found that 31% of boys in the lowest income quintile had a longstanding illness, compared to 15% in highest income households, whereas for girls it was 11% and 10% respectively. Three year olds in households with incomes below £10,000 are 2.5 times more likely to suffer chronic illness than three year olds in households with incomes above £52,000 (McKendrick, 2014). Children who have experienced poverty in early childhood have also been shown to be at greater risk of developing diabetes, heart disease, strokes and lower life expectancy as adults (End Child Poverty, 2008).

### **Risk of accidents in early childhood**

Children living in deprived areas were more likely than those living in more affluent areas to experience 2 or more accidents requiring treatment before the age of four. 26% of those living in the most deprived areas of Scotland experienced an accident, compared with 17% in the least deprived areas. 'Family adversity' (an index combining 8 measures of disadvantage including poverty and maternal depression) is significantly associated with children experiencing 3 or more accidents requiring medical attention before the age of 5 (Growing Up in Scotland, 2013). Although rare, death rates in Scotland for unintentional injury are twice as high for the most deprived children compared to the most affluent.

### **Healthy diet and weight**

Poverty also impacts on families' ability to give children a healthy diet, through increased cost of healthy foods, physical access to shops, other costs associated with preparing healthy meals, lack of knowledge on healthy diets and cultural values. While the public discourse tends to focus on 'blaming the poor' for poor choice diets, more focus needs to be put on the structural barriers that make it difficult for families to engage in health-promoting behaviours. Dietary difficulties are reflected in discrepant rates of obesity among children, with boys from low income households more likely (43%) to be overweight or obese than boys from the highest income households (24%). Similarly, 36% of the girls in low income households are overweight, as compared to 25% in the highest incomes households (McKendrick, 2014).

### **Access to leisure spaces and community participation**

Poor health and low income are associated with living in areas with less adequate services, limited transport and poorly resourced local leisure spaces. This offers less opportunity to participate in education or leisure, or to get involved politically. People are instead more likely to fear for their safety as their local areas are affected by vandalism, gangs and damage to property (Scottish Government, 2013 b). Substantially lower levels of feeling safe and a higher level of concern of being bullied or being harmed by adults in play areas are reported by children living in deprived areas.

### **Developmental difficulties and readiness for school**

Poor children disproportionately had development and language problems (21 per cent, compared to 12 per cent among non-poor children), as well being three times

more likely than their non-poor peers to experience social, emotional and behavioural difficulties (Barnes *et al.*, 2010). This has an impact on children's readiness for school, as at the age of 3, children whose parents have low or no qualifications, are already behind their more advantaged peers in terms of social and emotional development (Bradshaw, 2011). At age 5, compared with children whose parents have no qualifications, those with a degree educated parent are around 18 months ahead on vocabulary and 13 months ahead on problem-solving ability. This gap between children in the top and bottom social classes continues to widen as children grow older.

## Wellbeing

The Strengths and Difficulties Questionnaire (SDQ) is comprised of 25 questions answered by parents on behalf of children aged 4–12, covering factors such as consideration, hyperactivity, mood, sociability, obedience, anxiety and unhappiness. A total SDQ score of 14 or more reflects borderline or a higher than average proportion of total difficulties. The Scottish Health Survey (2012) found that 31% of boys in the lowest income households had a score of 14 or more in the SDQ, compared to 9% in the highest income households, and for girls, it was 16% of lowest income households, compared to 2% of highest income household households.

## Stress in early childhood and increased risk of mental health

Family stress and adverse living conditions impact on parents' health and ability to parent, with direct consequences for children's level of stress. Research with children growing up in impoverished environments has highlighted the increased levels of the stress hormone cortisol in children's brains. These stress hormones can inhibit the development of skills such as planning, impulse and emotional control, and attention, with direct consequences for children's ability to engage in learning and to react appropriately to stressors in the environment (Jensen, 2007). Other research has also shown how poverty impacts on children's self-esteem, as they are more likely to feel they are 'useless' or a 'failure', suffer from stigma and become socially isolated (Griggs and Walker, 2008). Growing up in stressful households has been associated with increased risks to mental health later on, with children living in low-income households being nearly three times more likely to suffer mental health problems than their more affluent peers (Scottish Government, 2013 a).

## 5. Looked After Children and Young People

Many children and young people looked after by local authorities come from backgrounds which are associated with poorer health outcomes, including low-income status and abusive (mental, physical or emotional) or neglectful environments (Scott and Hill, 2006). Ward *et al.* (2002) have highlighted concerns about the poor mental and physical health of LACs, whilst others have noted that, as a group, they have generally good levels of physical health (Scott and Hill, 2006).

The high levels of mental health problems and psychiatric disorder, including behavioural disorders, are greater for looked after children compared to all other children, but also compared to children from disadvantaged backgrounds (Ford *et al.*, 2007; Lachlan *et al.*, 2011). Self-harm, suicidal ideation and completed suicide



have also been recorded as higher in looked after children (Fuller *et al.*, 2014; Furnivall, 2013). Living away from parents has been identified as a risk factor for suicide, and therefore is a factor which is particularly relevant for children living in care placements away from home (Evans, 2004). Despite this high level of mental health need and risk, there is still a dearth of mental health support for looked after children.

Although children and young people may have better physical health compared to mental health, inequity exists in the accessibility of health services for this group. Dental health, for example, has been highlighted as a problematic area, with as many as 50% of looked after children (the majority boys) not having attended the dentist over the course of a year (reported in Scott and Hill, 2006). In an innovative move however, the University of Glasgow Dental School has reported positive outcomes of a community dental service aimed at ensuring children receive a consistent dental service regardless of care placement moves (Welbury, 2014). Similarly, looked after children may miss out on immunisations (Ward *et al.*, 2002) and have less access to information on sexual health and safer sex, particularly if they miss out on education. Additional concerns about long-term health exists because this group of children are more likely than the general population to engage in risk taking behaviours, reflecting a similar concern for those from low income backgrounds. For example, in 2004 smoking rates of looked after children aged 11–15 years in the UK were four times higher compared to non–looked after peers (ASH Scotland, 2014). Looked after young people are also more likely to drink alcohol or take drugs than non–looked after children (Scott and Hill, 2006).

In a welcomed move, the Scottish Directors of Public Health Group has identified the health needs of looked after children as a strategic priority setting the following aims to improve health outcomes for this group of children (Scott *et al.*, 2013; Lachlan *et al.*, 2011):

- Develop a database within the NHS to collect quantitative data about health needs and outcomes of LACs. This will be used to identify need and inform service provision,
- Strengthening the role of Looked After Children’s nurses,
- Improved services for looked after children from Child and Adolescent Mental Health Services,
- Increased interagency working to improve health outcomes,
- Increased use of Getting it Right for Every Child (GIRFEC) framework.

## 6. Welfare reform and its impact on children’s health and well-being

Findings from Child Poverty Action Group’s (2014) Early Warning System (EWS) highlight that the impact of welfare reform on children’s health and wellbeing in Scotland, as follows:

- Reduced income undermines families’ ability to maintain their health as nutritious food, a warm home and trips to the doctor or dentist become increasingly unaffordable,
- These factors are likely to increase pressure on health and social care services. Worryingly, however, research has shown that families on low

income are actually *less* likely to access healthcare services (Griggs and Walker, 2008),

- Recurring themes identifiable through EWS cases include increased levels of stress and anxiety amongst parents, with direct impact on children,
- EWS case studies show that stress and anxiety is often worsened by ongoing uncertainty about income, including regular assessments and the threat of benefit withdrawal. The stress of living in poverty brings added risk of relationship problems and increased risk of relationship breakdown.

## 7. Recommendations for policy and practice

The impact of poverty on individuals and society as a whole is significant, not only in terms of emotional scars and stigma poor people suffer, but also in terms of long-term effects on individuals' health, well-being and lifelong opportunities. Children growing up poor are more likely to leave school with no or low qualifications, suffer from poor physical and mental health in later life, and are likely to require increased support mechanisms from public services in later life. For societies, there are considerable fiscal costs associated with providing formal family support services for those who need them, particularly when residential care is required (Griggs and Walker, 2008). With current UK-Government plans to increase cuts to family support through welfare reform, and to reduce funds for support services, rates of child poverty are likely to increase dramatically by 2020—potentially to 300,000 children in Scotland. In addition to the need for action to increase parental earnings in the labour market and restore the value of family benefits within the social security system, findings from the evidence analysed in this briefing suggest the following recommendations:

- **Governments and local authorities should increase support for mothers in the pre-birth stage**

The Healthy Start scheme provides vouchers for milk, fruit and vegetables and free vitamins for pregnant women under 18 and others on a low income, up to the child's 4<sup>th</sup> birthday. It is a UK-wide scheme administered by the NHS. There is scope to increase the availability of the scheme, and some health boards in Scotland have made the vitamins freely available to all pregnant women, regardless of income. An example of a concerted effort in increasing take-up can be seen in the Early Years Collaborative project in Leith (<https://vimeo.com/102126052>). Similar efforts can be made, involving health professionals, with the Sure Start Maternity Grant, which is due to be devolved to the Scottish Government, providing an opportunity to increase its effectiveness.

- **Support families with young children through increased provision of childcare and opportunities for parents to engage in children's learning**

Current plans to increase childcare provision for 3–5 year olds and vulnerable 2 year olds should remain a priority for the Scottish Government, to ensure that children and parents have access to high quality childcare. With support from education staff, parents can become more informed about the best ways to support their children's cognitive, social and emotional skills development, for example, through increased time spent on reading activities at home, constructive play and

positive parenting. Provision of childcare should be flexible, to fit in with parents' employment decisions, and help increase family income.

- **Ensure income maximisation as part of health provision**

Frontline staff across all services working with families at risk of poverty should have awareness of sources of help and assistance for families facing financial difficulties, such as the Scottish welfare fund, income maximisation, debt and housing advice services. Services should consider whether it might be possible to put referral pathways in place for families as a means of boosting uptake, such as the *Healthier, Wealthier Children* project in Greater Glasgow and Clyde.

- **Poverty proof services by identifying 'invisible' barriers**

Families encounter barriers to keeping healthy that might not be immediately apparent. These include access to and affordability of good food, access to cooking facilities, access to leisure services, lack of transport to and from services, stigma and negative staff attitudes. It is important that services engaged in supporting families are aware of the potential impact of indirect costs and invisible barriers on families' ability to engage in health promoting behaviours and maintain their wellbeing. More research is needed around stigma and the cultural attitudes to health and wellbeing, such as values around breastfeeding, diet, smoking and alcohol use, exercise and stress management.

- **Increase mental health support for, and promote healthier lifestyles among, looked after children and young people**

The poor mental health of looked after children is of significant concern to services and carers. It is critical that CAMHS and social care services look for effective ways to support children and young people in order that they may come to terms with trauma that they have faced. To promote healthier lifestyles, another area of major concern amongst looked after children, prevention and health promotion strategies should be developed to highlight to service providers, carers and children and young people the benefits of improved diets, reduced risk taking behaviours, self-care, and increased uptake of immunisations and health checks, including dental care.

- **Ensure local and national budgeting reflects the projected increase in child poverty and its effects on wellbeing**

New procedures for local children's services planning will come into force from 2016. Under the Children and Young People (Scotland) Act 2014, children's services plans must be put in place locally, highlighting how the wellbeing of children and young people in different demographic areas will be safeguarded and promoted. Local authorities should use these plans as an opportunity to outline how their services will protect the most vulnerable families.

## References

- ASH Scotland (2014) *Report on the mapping of existing tobacco control policies within looked after and accommodated children and young people (LAACYP) services in Scotland*, Edinburgh: Action on Smoking and Health (ASH).
- Barnes, M.; Chanfreau, J.; Tomaszewski, W. (2010) *Growing up in Scotland: The Circumstances of Persistently Poor Children*, Edinburgh: Scottish Government.
- Bradshaw, P. (2011) *Growing up in Scotland: Changes in child cognitive ability in the pre-school years*, Edinburgh: Scottish Government.
- Bromley, C. and Cunningham-Burley, S. (2010) *Growing up in Scotland: Health inequalities in the Early Years*, Edinburgh: Scottish Government, Available at: <http://www.gov.scot/Resource/Doc/310476/0097973.pdf>
- Centre for Maternal and Child Enquiries (2011) *Perinatal Mortality 2009*, Available at: <http://www.hqip.org.uk/assets/NCAPOP-Library/CMACE-Reports/35.-March-2011-Perinatal-Mortality-2009.pdf>
- Child Poverty Action Group (2014) *Welfare Reform and Children's Services Planning: CPAG Discussion Paper*, Available at: [http://www.cpag.org.uk/sites/default/files/EWS-Childrens-Services-Planning-\(Oct14\).pdf](http://www.cpag.org.uk/sites/default/files/EWS-Childrens-Services-Planning-(Oct14).pdf)
- Dowler, E.; Turner, S. and Dobson, B. (2001) *Poverty Bites: Food, health and poor families*, London: Child Poverty Action Group.
- End Child Poverty (2008) *Unhealthy Lives: Intergenerational links between child poverty and poor health in the UK*, Available at: <http://www.endchildpoverty.org.uk/files/ECP%20Health%20Summary.pdf>
- End Child Poverty (2014) *Child Poverty map of the UK*, Available at: [http://www.endchildpoverty.org.uk/images/ecp/Report\\_on\\_child\\_poverty\\_map\\_2014.pdf](http://www.endchildpoverty.org.uk/images/ecp/Report_on_child_poverty_map_2014.pdf)
- Evans, E., Hawton, K., Rodham, K. (2004) Factors associated with suicidal phenomena in adolescents: A systematic review of population-based studies, *Clinical Psychology Review*, 24(8), 957-9.
- Ford, T.; Vostanis, P.; Meltzer, H. & Goodman, R. (2007) Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households. *British Journal of Psychiatry*, 119, 319-325.
- Fuller, J.; Hennessy, C. & Rigby, P. (2014) *A Retrospective Review of Risk Factors for Suicide in Looked After Children and Accommodated Children in Glasgow*. Edinburgh: G Child Protection Committee.
- Furnivall, J (2013) *Understanding suicide and self-harm amongst children in care and care leavers*. Edinburgh: IRISS Insight.
- General Registrar Office for Scotland (2010) *Births, Marriages and Deaths*, see summary analysis at: <http://www.poverty.org.uk/s21/index.shtml>
- Griggs, J. and Walker, R. (2008) *The costs of child poverty for individuals and society: A literature review*, York: Joseph Rowntree Foundation, Available at: <http://www.jrf.org.uk/system/files/2301-child-poverty-costs.pdf>
- Growing Up in Scotland (2013) *Accidents and Injuries Briefing*, Available at: <http://growingupinscotland.org.uk/wp-content/uploads/2013/10/GUS-Accidents2013.pdf>
- Jensen, E. (2007) *The effects of poverty on the brain*, Available at: [http://thesciencenetwork.org/docs/BrainsRUs/Effetcs%20of%20Poverty\\_Jensen.pdf](http://thesciencenetwork.org/docs/BrainsRUs/Effetcs%20of%20Poverty_Jensen.pdf)
- Lachlan M, Millard A, Putnam N, Wallace AM, Mackie P & Conacher A (2011) *Mental Health Care Needs Assessment of Looked After Children in Residential Special Schools, Care Homes and Secure Care*. Edinburgh: ScotPHN.
- McKendrick, J.H. (2014 b) What is life like for people experiencing poverty? In McKendrick, J.H.; Mooney, G.; Dickie, J.; Scott, G. and Kelly, P. (2014) *Poverty*

- in Scotland: The independence referendum and beyond*, London: CPAG, 136–157.
- NHS (2014) *Breastfeeding Statistics*, Information Services Division. Available at: <http://www.isdscotland.org/Health-Topics/Child-Health/Infant-Feeding/>
- NHS Greater Glasgow and Clyde (ND) *Healthier, Wealthier Children*, Available at: <http://www.nhsggc.org.uk/your-health/campaigns/healthier-wealthier-children/>
- Scottish Government (2013a). *Long-Term Monitoring of Health Inequalities: Headline indicators – October 2013*. Edinburgh, Scottish Government. Available from: <http://www.gov.scot/Publications/2013/10/7316#>
- Scottish Government (2013b) *Scotland's People Annual Report: Results from 2012 Scottish Household Survey*, Edinburgh, UK.
- Scottish Government (2014) *Poverty and income inequality in Scotland 2012/2013*, Available at: <http://www.gov.scot/Publications/2014/07/9247/0>
- Scott, S.; Hattie, R. & Tannahill, C. (2013) *Looked After Children in Glasgow and Scotland: A Health Needs Assessment*. Edinburgh: ScotPHN.
- Scott, J. & Hill, M. (2006) *The Health of Looked After and Accommodated Children and Young People in Scotland*, Edinburgh: SWIA.
- Townsend, P. (1979) *Poverty in the United Kingdom*, Allen Lane.
- Ward, H.; Jones, H. Lynch, M. & Skuse, T. (2002) Issues concerning the health of Looked After Children. *Adoption and Fostering*, 26, 8–18.
- Welbury, R. (2014) The development of a designated dental pathway for looked after children *British Dental Journal* 216, 136 – 137.
- World Health Organisation (1948) *Preamble to the Constitution of the World Health Organisation*, International Health Conference, New York, 19–22 June 1946, into force on 7 April, 1948.
- World Health Organisation (1986) *Ottawa Charter for Health Promotion*, presented at the first International Conference on Health Promotion, Ottawa, 21 November.
-

## About the authors

*Mark Willis* is Welfare Rights Officer at Child Poverty Action Group, Scotland. Mark has been with CPAG for 7 years, focusing on benefits for children, delivering training and contributing to CPAG's Welfare Benefits & Tax Credits Handbook.

*Daniela Sime* is a Senior Lecturer in the School of Social Work & Social Policy, University of Strathclyde. Her research interests are in social justice and inequalities, with a focus on children's education, participation in society and equal opportunities. She has worked on a range of projects, funded by the Big Lottery Fund, Save the Children and British Academy, on the impact of poverty on children's access to services, well-being and education.

*Jennifer Lerpiniere* is Research Associate at the Centre for Excellence for Looked After Children in Scotland (CELCIS). She has carried out research with vulnerable people from a range of backgrounds, including looked after children and young people, adults and children with disabilities and young people and adults experiencing homelessness.

## Contact details

Dr Daniela Sime  
School of Social Work & Social Policy  
Lord Hope Building  
141 St James Road  
Glasgow G4 0LT  
e: [daniela.sime@strath.ac.uk](mailto:daniela.sime@strath.ac.uk)

## About the Programme

This policy briefing has been produced through a programme funded by the Scottish Universities Insight Institute (SUII), entitled '*Children and young people's experiences and views of poverty: Implications for Policy and Practice*'.

All programme activities and other outputs are available at:

<http://www.scottishinsight.ac.uk/Programmes/Equality2015/ChildrensViewsofInequalityPoverty.aspx>

**The Scottish Universities Insight Institute** promotes collaboration and engagement between researchers and wider society. Its objective is to help members of wider communities– in the public sector, business and the third sector –gain new insights into issues with which they deal and to be better informed in the decisions they take. In doing so, SUII provides universities with pathways to impact for their research. To find out more about the SUII activities and see past programmes and outputs, please visit: [www.scottishinsight.ac.uk](http://www.scottishinsight.ac.uk)



**scottish universities  
insight institute**

mobilising knowledge for a better Scotland