

Policy bulletin

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EUROPEAN CITIES
AGAINST CHILD POVERTY



Improving life chances for children and breaking life cycles of deprivation – focus on health and social care

European Cities Against Child

Poverty is a network whose members exchange mutual learning among local and regional authorities, to form initiatives and policies which will successfully reduce child poverty. London is the lead partner in the network, which is comprised of five core partners (London, Milan, Helsinki, Amsterdam and Budapest) and five associate partners (Copenhagen, Uppsala, Sollentuna, Solna and Vasteras).



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Health issues and child poverty

Health problems are a source of poverty in several of our partner cities which is why it has been chosen as a key theme for our research.

Children in poverty are at a greater risk of health problems, with poor nutrition, inadequate housing conditions and insufficient medical care increasing the likelihood of illness and disability. The cost of medical treatment can be a barrier to healthcare, while lack of information and poor accessibility can also impact negatively on the health of poor children. The Network has considered which policies and strategies in this area, operating at regional or local level, are working most successfully to improve the life chances of children. Particular attention was devoted to strategies targeting children from disadvantaged groups such as children with disabilities, ethnic minorities and children in care.

The following findings were identified by our partner cities. Although the research from each city is not comparable, it does provide a good idea of the challenges they each face.

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Mutual Learning on Social Protection and Social Inclusion



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Life expectancy

In **London**, life expectancy varies greatly by electoral ward but averages at 77.4 years for men and for women at 82.

In **Amsterdam**, life expectancy varies according to ethnic origin, with the inhabitants of Amsterdam of Mediterranean origin having the best expectancy. Inhabitants of Turkish and Moroccan origins, however, suffer the highest rates of mortality in the first year of life. On average, life expectancy for Amsterdam men is 75.8 years, and for women it is 80.4 years.

Life expectancy at birth in **Hungary** still remains among the lowest in Europe. Mortality is almost three times higher than the EU average and, amongst the Roma, the mortality rate is double the average and life expectancy is 20 years less. In 2002, Hungarian men had a life expectancy of 68.4 years and women of 76.6 years.

Research in **Helsinki** shows that life expectancy is linked to education, with a difference of 7.8 years between those who had received basic education and those who had received higher education. The life expectancy of Helsinki women is nearly 82 years whereas the expectancy for men is 75 years.

2007 data on life expectancy at birth in the **Lombardy Region** gave 78.8 years for men and 84.3 for women.

Obesity rates and poor diet

In **London**, where the rate of childhood obesity is one of the highest in England, 7% of all deaths can be directly attributed to obesity. Obesity has proven to be directly related to social class and occurs mainly in the most deprived members of society.

In **Amsterdam**, 15% of young people are seriously overweight and 60% do insufficient exercise. Obesity is a particular problem amongst Turkish and Moroccan girls.

Over the last 25 years the incidence of children with diabetes has tripled in **Hungary**, probably due to the decrease in breastfeeding. Low income levels are also seen to cause problems of undernourishment amongst children.

In **Helsinki**, levels of obesity are on the increase, especially in socio-economically

disadvantaged areas because healthy food is more expensive.

According to a survey conducted in primary schools in **Milan** in the school year 2005 to 2006, 9.2% of the pupils were overweight and 7% were considered obese. While the nutritional value of food served in school canteens is subject to rigorous inspections by the Primary Health Care Units, eating habits at home were found to be strongly influenced by the household's income. Once again, the high cost of healthy foodstuffs can lead to less healthy diets in lower income families.

Smoking rates

In **London**, smoking causes 10,000 premature deaths a year, which is the equivalent to one death per hour. The London Health Observatory has also noted that social inequalities mark smoking rates – the less affluent sectors of society are more likely to smoke.

In **Amsterdam**, teenagers are starting to smoke at an ever younger age, some before the age of 10. In the Netherlands, children whose parents smoke are 13% more likely to smoke themselves. Peer pressure is also noted as an important factor.

Lower educational attainment and poor health is perceived to correlate with poverty and disadvantage in **Hungary**. For example, 79% of boys in care smoke daily, compared to 26% of grammar school pupils.

There are clear differences between various socio-economic groups with regards to smoking habits in **Helsinki**: people in high-level professional, educational and income groups on average smoke the least.

At age 16, 24% of girls and 21% of boys smoke in **Solna**.

A nationwide survey in **Italy** recorded smoking as a problem affecting approximately 1.5m young people between the ages of 15 and 24. Around 140,000 15 to 17 year-olds smoke an average of 10 cigarettes a day. 34% of these young smokers had their first cigarette by the age of 15.

Alcohol consumption and drug use

In **London**, people on high incomes *and* those in lower socio-economic groups tend to consume more than the advised amount of alcohol and to “binge drink”.

Drinking too much is a more widespread problem amongst native Dutch people than ethnic minorities in **Amsterdam**, while cannabis consumption is more frequent amongst the latter group.

Nine out of ten 12-year-olds throughout **Finland** do not consume alcohol but four out of five 16-year-olds do consume alcohol. In **Helsinki**, it is estimated that there are 50,000 to 80,000 excessive consumers of alcohol and approximately 6% of all pregnant women have a substance abuse problem.

In **Uppsala**, 3,800 children aged 0 to 15 are living in families with alcohol problems. Drug or alcohol addiction in the family is the most common reason for children being taken into care.

In **Solna**, 74% of the girls and 59% of the boys age 16 drank alcohol, as shown by a survey in 2008.

Data from a 2007 survey on the consumption of mood-enhancing substances in the city of **Milan** indicates that there are substantial differences according to age groups and gender: 37% of males and 22% of females aged between 15 and 24 declared that they had got drunk at least once in the month before the survey. Percentages dropped as ages increased.

Teenage pregnancy

In 2006, on average, 45.6 out of 1,000 females aged 15-17 gave birth in **London**. Between 1998 and 2005, the average number of teenage pregnancies had been decreasing in 28 London Boroughs, but greatly increasing in the other five.

The number of teenage births has demonstrated a decreasing trend in **Amsterdam**: a 30% decrease occurred between 2001 and 2005. This drop has, in part, occurred due to the fact that Turkish and Moroccan teenage girls are opting for an abortion more often. Nevertheless, girls from ethnic minorities are still more likely to become teenage mothers than Dutch girls.

In **Hungary**, traditional practices and customs may influence the levels of teenage pregnancies amongst the Roma community – one Roma belief, for example, states that a girl should have a baby at the age of 18 otherwise she is regarded as infertile.

In **Helsinki**, where the abortion rate is higher than in the rest of Finland, more effective contraceptive counselling has helped to curb the problem.

Teenage pregnancies are not a big problem in **Sweden** or **Solna** but on the other hand there are about 30,000 abortions in Sweden amongst teenagers each year.

In **Milan**, 187 young women (19 and under) gave birth in 2006. In the same year, 162 young women had abortions.

Behavioural problems

More than 6% of children in the **Netherlands** suffer from a type of behavioural disorder. This is higher than the national average, which is due to the large number of parents with psychiatric disorders including addiction, one-parent families, migration, and lower socio-economic circumstances.

In **Hungary** one in five children has emotional, behavioural or psycho-somatic problems and 18 to 28% show aggressive behaviour.

Mental illness

In **London**, 14.8% of people are believed to suffer from a psychiatric disorder (2005). Mental health problems are more prevalent in deprived neighbourhoods and one out of five young people experience a mental health problem every year (Mental Health Foundation, 2009).

Mental health problems are most common in disadvantaged areas in **Helsinki**. 11,600 Helsinki residents receive a disability pension because of mental and behavioural disorders, whereas in 2006 approximately 50,000 Helsinki residents received reimbursement for anti-depressants.

In 2006, in the city of **Milan**, 7,064 patients with mental health problems were released from hospital, 659 of whom were minors (9.3%). The most frequent syndromes

observed were schizophrenia and mood, neurotic and personality disorders.

In **Hungary**, where the prevalence of depression is on the increase, research shows that rates of depression correlate to perceived socio-economic status.

Common reasons for children being taken into protection

In **London**, children are taken into protection to safeguard and promote the welfare of the child in question.

The most common reasons for taking a child into protection in **Amsterdam** is neglect and parenting incapacity.

The most common reasons in **Helsinki** are: parents' substance abuse or mental health problems, difficulties relating to family's interaction and life control and difficulties in parenting.

In **Solna** it is very common for children in care to have parents suffering from drug or alcohol addiction. Mental health, drug and alcohol problems are also common traits in the young people themselves.

In **Milan** children may require social assistance for the following reasons: difficult family situations, absence of parents, assistance for children involved in penal proceedings, children in situations of serious psychological distress and severe disabilities.

Financing of health services in our cities

Health care in the **UK** is funded by taxes. Primary Health services (e.g. doctor, pharmacists, walk-in health centres etc.) are delivered locally and are managed by Primary Care Trusts. Patients do not have to pay for

healthcare in the UK, delivered by the National Health Service (NHS), although there is a charge levied to cover medications.

Basic health care is available for all **Dutch** citizens. Basic health insurance of some form is obligatory for everyone. The health insurance market has been opened up and is becoming more competitive. It is possible to upgrade health insurance to receive extra services (cosmetic surgery, dentist, orthodontist, private room in hospital). However GP's, medication, hospital care etc. are mostly paid for by the health insurance companies.

Health services in **Hungary** are funded primarily by social health insurance from the Health Insurance Fund (HIF) for recurrent costs, administered by the National Health Insurance Fund Administration (NHIFA). It is the most important source of financing of the recurrent costs of health services, and provides cash benefits such as sickness allowances. The HIF is separate from the government budget. Capital costs are mainly financed from taxation. Services are delivered predominantly by local government-owned public providers, who contract with the NHIFA.

Basic health care in **Finland** is primarily financed through taxes. Adults are charged a visit fee and/or a day-care fee. Customers pay for their medicine themselves, for which they will be partially reimbursed by the Finnish Social Insurance Institution. In addition, a portion of financing comes from state aid.

In **Italy** the National Health Service (SSN) is financed by the taxpayer. In addition, the Primary Health Care Units can make use of revenues from prescription charges and fee-earning services.

In **Sweden**, all health services and care are financed primarily by taxes. A small individual fee is charged.

Focus on common themes and challenges faced by our cities

- life expectancies tend to vary according to ethnic origin
- higher expense of healthy foodstuffs has a detrimental effect on the diets of lower-income families
- social inequalities mark smoking rates – the less affluent sectors of society are more likely to smoke
- rates of alcohol and substance abuse seem to depend on gender and ethnic origin, although these change from country to country
- mental health problems are more prevalent in deprived neighbourhoods
- mental health issues, substance abuse and the incapacity of parents are common reasons for children to be taken into care.

Fourth policy workshop: Helsinki, 23 April 2009

Practical ways to improve children's health and social care

On 23 and 24 April 2009, delegates from the five partner cities and representatives from over a dozen regions across Europe came together to discuss effective practical ways to improve life chances for children and breaking cycles of deprivation with a focus on health and social care.

This practical workshop featured presentations of successful projects:

- Starting Together – Amsterdam
- Parental Steps – Solna
- Working for Wellness – London
- Utsikten – Uppsala
- Music Therapy for Early Interaction in High Risk Families – Helsinki
- From Consumed to Consumers – Milan
- Health School by Blueprint – Budapest

Study visit to Vesala Comprehensive School, Helsinki

Delegates at the Helsinki event took part in a visit to Vesala Comprehensive School, a secondary school with a high concentration of pupils with learning, social and behavioural difficulties (50 out of 365) and students of 23 different nationalities (27% of the student population are immigrants).

Visitors were welcomed by the School Principal Juha Juvonen and special education teacher Niina Halonen-Malliarakis who, with two pupils, led a tour of the school premises. The visitors had a chance to see the facilities dedicated to health and social care support, some classrooms and workshops and the greenhouse.

Although most pupils are motivated and well behaved, there are some problems with truancy and a lack of parental support in some cases can make supporting the children more challenging. Nevertheless, the school has devised innovative methods to improve learning incentives. There is a strong focus on non-academic education alongside more traditional forms of schooling. For example, at the centre of the school building is a large greenhouse with plants and animals where pupils are encouraged to spend time.

In order to ensure pupil welfare, meetings involving teachers, a public health nurse, a psychiatric nurse, a social worker and a study counsellor are held on a weekly basis in order to resolve students' learning and behavioural problems. Delegates heard from members of this welfare team who spoke briefly about their roles as support staff for the pupils.

Students with learning difficulties and social or behavioural problems are sometimes fully integrated into class but there are special classes for those pupils who need extra support. Furthermore, there are employment-focused "Own Career" classes involving youth workers, action-based forms of work and on-the-job learning. Smaller classes of around 16 pupils allow a higher rate of one-to-one teacher-pupil engagement.

The school is also involved in several national and European projects that address issues as diverse as bullying, safety and special education.

How can projects run in European cities promote better health among children and families?

O Empower parents to help themselves and their children

Most of the projects described here recognise that in order to improve children's health and well-being, interventions need to be holistic and directed towards helping their parents. Particularly successful are those programmes which aim to empower parents through a holistic package of support to help themselves. Such projects often bring parents together to share ideas about better parenting and encourage "self-help" approaches. Other approaches help to remove the stigma associated with mental health issues or dependence on social welfare benefits.

Case study: Starting Together – Amsterdam

Since 2007, the City of Amsterdam has run an early childhood intervention programme: Starting Together. Its aim is to prevent the development of psycho-social problems, anti-social behaviour and criminality in young people by identifying risks at a very young age.

The programme operates through the Parent Child Health Centres (PCHCs) which deliver public health services to children and young people aged between 0 and 19 and also act as the locations for parenting sessions. The centres employ nurses who are now being trained in a new method (DMO-protocol) to enable them to detect potential problems at an early stage in a child's life.

The nurses focus on learning how to empower parents to speak more openly about their own and their child's health and well being. The first meeting between the parents and the nurse takes place when the child is eight weeks old. Meetings focus on five main areas, each of which is addressed from a number of angles with particular emphasis placed on the emotional and social aspects of parenting:

1. the child's well-being
2. parenting skills
3. partners' roles
4. social support
5. challenges in family life e.g. housing, finances

Nurses are also trained to identify appropriate sources of further support to which they can refer parents and their children. In other Dutch cities, the same programme has resulted in an increase in successful referrals from 19% to 30% and an increase in positive parenting. It is hoped that the Amsterdam programme will have a similar impact, and also encourage healthcare professionals to take a more positive view towards discussing difficult but important topics with parents, such as their financial situation or relationship with their partners.

In the longer-term the programme aims to build a lasting network of delivery partners which will maintain the holistic support package offered by this programme. From 2007 to 2010 the programme will receive €500,000 per year from national and city government sources and health insurance, with a view to running it as part of mainstream youth healthcare from 2011.

Further information is available at www.samenstarten.nl.

Case study: Parental Steps – Solna

The Solna Parental Steps programme was developed in 2004 and is based on the Iowa Strengthening Families Programme, U.S.A. The programme was developed for parents whose teenage children have been in contact with either social services or the police due to alcohol or drug-abuse and anti-social behaviour. Run by the city's social services department, this is a skills-building programme which aims to help parents to prevent alcohol and drug abuse by their children. This is achieved by providing them with tools for early detection and more knowledge of the health risks involved. This support should also strengthen links between all family members during teenage years and result in lower consumption of alcohol and drugs.

Most parents who attend the programme are mothers and most refer themselves to the programme through the City of Solna website. Others hear about the programme through schools and the local newspaper, as well as through police who have been in contact with young offenders.

Parents attend six two-hour sessions, each involving a DVD which presents a family scenario (e.g. conflicts, differing views, stressed situation) for discussion by the group of parents. They are encouraged to draw lessons about how to deal with such situations in their own lives and take steps to implement them at home.

○ Encourage children and young people to take control of their own health and lifestyles

These projects work directly with children and young people to address health issues. The aim is to identify ways of improving their health by encouraging children and young people to consider how poor health impacts negatively on other areas of their lives. They run workshops and engage young people in activities which encourage them to address health issues, such as alcohol and drug abuse, in a wider social context.

Case study: Health School – Budapest

Run by the not-for-profit Blue Point Drug Prevention Centre, the Health School is a “road-show” style one-day workshop which aims to combat and address the causes of substance abuse among young people. Peer pressure, family neglect and poor examples set by other people in their lives commonly lead young people to abuse drugs and alcohol.

The programme mainly works with 14 to 18 year old pupils at vocational training schools, although it is available to all schools. The programme has run on 15 occasions and works with roughly 100 young people each time. It is funded by government resources for health.

Open and democratic dialogue is central to the programme's impact on the young people it works with. The workshop makes use of multi-media technology and informal group discussions to invite young people to consider the impact of substance abuse on their wider context e.g. their community or the environment. By covering these wider issues, rather than focussing only on the problem and its causes, the workshop encourages students to participate in group discussion. It takes the view that complex structures are more interesting to teenagers than facts about nutrition and health.

Case study: From Consumed to Consumers – Milan

This project is run by Offertasociale, a consortium enterprise of 29 municipalities in north-east Milan which manages social services. It aims to increase the involvement of local community and voluntary organisations in the delivery of services and also promotes better integration of social, educational and health policies.

From Consumed to Consumers evolved through joint planning between the local public health agency, social services and schools. It focuses on the relationship between children's eating habits and public advertising for food and aims to increase children's awareness of the influence of advertising and develop their skills to "decrypt" its messages.

The project aims to build children's capacity to choose to eat healthy food and encourages them to recognise the negative effects of publicity for unhealthy food. It teaches them how to identify the methods of communication which publicity uses to influence them and, in turn, supports them to be critical of such advertisements and develop "defence strategies."

Young people between 11 and 14 years of age were involved in the programme and were given the opportunity to develop and film their own food advertisement. This helped them to put into practice some of the communicative methods they had learnt. Roughly 60 pupils were involved in the project which also worked indirectly with about 40 parents.

O Improve health and reduce poverty through improving access to employment for parents

By supporting and guiding parents into training and employment, these projects help to address a range of problems faced by families, including poor health and poverty-related issues. Importantly this support takes a holistic view of the barriers which parents must overcome to improve their health and their chances of finding work – many of these problems are interlinked and need to be addressed together. Strong links with specialist services and other referral organisations are vital in ensuring that parents are supported effectively.

Case study: Working for Wellness – London

This is a major national initiative to implement evidence-based interventions for anxiety disorders and depression that will see London receive around £49m for three years until 2011. The initiative will be working across half the capital by autumn 2009.

The services under the Working for Wellness (WfW) initiative are integrated with employment advisers, who provide additional input to ensure effective employer engagement. The programme will also train 500 therapists in order to meet its target of treating 140,000 Londoners during its lifetime, half of whom should recover following support. Overall 4,000 programme beneficiaries are expected to stay in or move into employment through the programme's linked employer scheme and its partnership with Jobcentre Plus and local NGOs.

WfW places outreach workers in local venues such as GP surgeries, libraries and children's centres where there is no stigma associated with mental health. Many clients also often refer themselves. The programme often works with parents or lone parents who are suffering from mental health problems which prevent them from working. Advisers address a range of problems - it is never solely a health problem - in order to support parents back into work. Services include offering advice with debt, housing and relationships. Parents are referred to specialist support services as necessary. The support is successful; the pilot project worked specifically with lone parents, 65% of which have improved their mental health as a result of the programme.

Case study: Utsikten – Uppsala

The Social Welfare Office in Uppsala runs a programme called 'Utsikten', meaning 'The View.' Its aim is to support parents in receipt of welfare benefits to find alternative and sustainable income through employment. This will break the cycle of social exclusion and improve their children's life chances.

The key target group for the programme are adults aged between 30 and 50, people with foreign origin and the long-term unemployed who are dependent on welfare benefits. Most of the clients come from large families.

The programme attempts to increase access to employment for its clients through networking with employees and employers, conducting study-visits, delivering training and offering seminars on language training, religion, social sciences and health. It cooperates closely with the local labour office, health organisations, the social welfare department and charities to deliver this kind of support.

The programme started on 1 March 2009 and it is joining forces with Uppsala University to conduct related social research into the target group.

Summary points

The following policy recommendations for improving are based on the findings and discussions of representatives from our cities:

- Empower parents to help themselves and their children through a holistic package of support.
- Bring parents together to share ideas about better parenting and encourage "self-help" approaches. This helps to remove the stigmas associated with mental health issues or dependence on social welfare benefits.

- Encourage children and young people to take control of their own health. Support them to address health issues such as alcohol and drug abuse, in a wider social context.

- Improve health and reduce poverty through improving access to employment for parents. Strong links with specialist services and other referral organisations are vital in ensuring that parents are supported effectively and holistically.

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