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Inequalities in child welfare: towards a new policy, research and action agenda

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Inequalities in child welfare: towards a new policy, research and action agenda.

Abstract

Over many years, large differences have been observed between local authorities (LAs) in England in the proportion of children who are 'looked after' out-of-home, or the subjects of child protection plans, with deprivation being identified as the major explanatory factor. This article proposes that such differences be re-conceptualised as 'child welfare inequalities' and suggests that drawing parallels with health inequalities would have value in a number of respects. Four aspects of child welfare inequalities are suggested. An analysis of officially published data provides new evidence of inequalities between LAs in two key markers of child welfare, and the relationship with deprivation, measured by Index of Multiple Deprivation scores. Although this correlation is unsurprising there has been a lack of recent research into the extent and the underlying causes of child welfare inequalities, a reluctance to describe differences as inequalities or to propose action on the underlying social determinants. Reading across from the field of health inequalities opens up new directions for child welfare policy, practice, theory and research internationally as well as creating the potential for alliances with others taking action to reduce health inequalities.

Keywords

Child protection, child welfare, deprivation, health, inequalities, looked after children.

Inequalities in child welfare: towards a new policy, research and action agenda.

Introduction

On March 31st 2012, a child living in Blackpool, England, was eight times more likely to be ‘looked after’ out of home – to be in the care system – than a child in Richmond upon Thames, an outer London borough (Department for Education (DfE), 2012a). This inequality in childhood chances exemplifies a pattern of difference across all English local authority areas which is systematically related to deprivation. Neither the inequity nor the link to deprivation will be of great surprise to followers of the English child welfare system. For years, authors have reported that deprivation is the largest factor explaining major differences between local authorities in key aspects of child welfare, such as the proportion of children entering the care system (becoming ‘looked after children’ (LAC)) or being subject to a child protection plan (CPP) (Bebbington and Miles, 1989; Oliver et al., 2001; Dickens et al, 2007).

However, unlike the longstanding, extensive analyses of the social determinants of inequalities in health (WHO, 2008; Marmot, 2010), the exploration of *inequality* as a key concept in child welfare in England – or internationally – has scarcely developed. Despite Frost and Stein’s (1989) call that understanding should be located in the concepts of inequality and power, inequality remains a largely untheorised and unexplored dimension of child welfare research, practice and policy making in England and worldwide.

Recently, Featherstone et al. (2012) have argued that the widening social inequalities central to neo-liberal economic policies are the critical context for thinking strategically about developments in child welfare in England. I agree and my purpose here is to begin to map out this territory, to ask what current evidence tells us about child welfare as a site of social inequalities, what is known

about the causes of such inequalities and what might be the consequences of seeing child welfare through an inequalities lens. Throughout, my approach involves reading across from the field of health inequalities.

The rates at which children are the subject of child protection plans or looked after out of home, are key markers of disrupted or threatened childhoods. The underlying factors explaining differences in these rates are the focus here, what Munro (2010, p. 13) called ‘the long chains of causality’ and Marmot (2005, p.1099), for health, ‘the causes of the causes’. This is a central issue for current English child welfare policy. The lines of argument are drawn, in part, between those who, like Forrester et al. (2009), propose that out of home care should be the experience of *more* children – reflected in the current government’s view that permanent alternative families should be found for more children and more quickly (DfE, 2011) – and those who make the case for greater family support (for example, Featherstone et al., forthcoming). A focus on *inequalities* may raise the possibility of new policy objectives and approaches to practice, and make the case for updated and new lines of research, transcending the traditional terms of this debate: the dichotomy of ‘child rescue’ vs ‘prevention’.

Health inequalities and child welfare inequalities

Health inequalities are defined as ‘disparities in health (and in its key determinants) that are systematically associated with social advantage/disadvantage’ (Braveman and Gruskin, 2003, p. 256) and internationally recognised as unethical. Health inequalities are most commonly expressed and measured in terms of patterns of mortality and morbidity. For example, average male life expectancy in Blackpool in 2008-10 was 7.7 years less than in Richmond upon Thames (Office for National Statistics, 2011). Inequalities in health refer both to unfair *chances* of getting ill or of dying prematurely and to unequal *experiences* of health and illness. Unequal experiences, including unequal access to health *services* and other resources which enable people to secure or maintain good health or to manage illness, are sometimes measured by subjective perceptions of health

(McLeod and Bywaters, 2000). Over forty years of research can be summarised as showing (Bywaters et al., 2009) that:

- large inequalities in health exist between and within countries
- social position powerfully affects health chances and health experience
- health inequalities are primarily a product of social determinants which act on people's health across their lifecourse;
- health inequalities act across the whole of society; there is a gradient of health inequalities not a gap
- action on the causes of health inequalities is a pre-requisite for maximising population health.

However the mechanisms which link the social determinants to health outcomes for individuals and populations remain contested, not only between individual lifestyle versus structural explanations but also concerning the ways in which structures act to produce differential health outcomes (see, for example, Scambler, 2011).

While this established understanding of health inequalities may be helpful in examining inequalities in child welfare, mapping across conceptually from health inequalities to inequalities in child welfare is not straightforward. The term 'child welfare' as used here describes a set of policies and services provided to (or interventions in the lives of) children and/or parents, aimed at ensuring children's protection and good development. In this sense 'child welfare' equates more closely to health services than to health. However, child welfare interventions are sometimes experienced not as wanted and chosen services but unwelcome, involuntary intrusions while this is relatively rarely the case for health services (with obvious exceptions).

An alternative term which arguably mirrors the concept of health more closely is that of (child) wellbeing. As Bradshaw et al (2006) and Rees et al (2010) suggest, however, wellbeing is itself a

complex and contested concept internationally. Extensive work has been undertaken in recent years to develop ways of understanding and measuring child wellbeing. Central to this has been the development of indices of child welfare to enable comparisons to be made at the population level between and within nations (for example, Bradshaw et al., 2009; Bradshaw and Richardson, 2009). Such indices are based on multiple domains, each measured by a number of indicators.

A key issue is that neither indices based on child defined nor other defined well-being seem well equipped to measure the experience of children who are the focus of child welfare interventions. As the Good Childhood Report (Children's Society, 2012, p.61) put it,

(T)he well-being of specific sub-groups of children ... may not be well represented in general population surveys. ... children not living with their family are a key minority group who may be particularly vulnerable to low well-being. More work is required to identify particular sub-groups of children who are at high risk of low well-being and to understand the factors involved in this.

There are two main reasons. First, because the indices are operating at whole population levels, the relatively extreme childhood experiences of LAC and CPP are largely invisible. Some attempts have been made to include relevant data, such as non-accidental deaths (Bradshaw et al., 2006) or 'children in need' (Bradshaw et al., 2009), but these are largely subsumed in the plethora of other indicators. Indeed, many of the questions used in surveys on which the indices are based betray the assumption that children are living at home with their parents. Second, where researchers have sought measures based on child welfare services they have found the data unavailable either at the local level (Bradshaw et al., 2009), or internationally (Bradshaw et al., 2006). International definitions in child welfare are not well established (Thoburn, 2007).

Thus, while child wellbeing may provide a good conceptual parallel to health, its practical value in mapping child welfare inequalities requires development. That being the case, I propose the

following definition of child welfare inequalities: unequal chances, experiences and outcomes of child welfare that are systematically associated with social advantage/disadvantage.

At least four aspects of child welfare inequalities can be identified:

- inequalities in a parent's or child's chances of engagement with or intervention by child welfare services, reflecting diverse aspects of social position
- inequalities in child welfare interventions or provision for parents and/or children from different social groups or with different identities
- inequalities in childhood experiences and outcomes between children resulting from welfare interventions and their counterparts in the wider population
- inequalities in outcomes as adults between children who were the focus of welfare interventions and those who were not.

This characterisation of child welfare inequalities makes no prior assumptions about whether children's lives are better or worse as a result of interventions, whether more or less children 'should' be in care, for example. That must be judged by the outcomes. Similarly it does not mean that action should not be taken to protect individual children's wellbeing. The fact that the fundamental causes of unequal health are social does not mean that medical treatment is irrelevant, only that upstream as well as downstream measures should be taken. Governments may invest too little both in family support and protecting children.

To exemplify these four aspects with reference to LAC:

First, children who become looked after 'originate from the most disadvantaged social groups' (Berridge, 2007, p. 8). The NICE and SCIE Guidance on the quality of life for LAC emphasises that a 'disproportionate number' come 'from black and minority ethnic backgrounds' ((NICE/SCIE 2010, p. 9). Differences according to gender and age are also apparent (DfE, 2012a).

Second, the NICE/SCIE guidance (op cit.) urges services to meet the special needs of particular groups of LAC: children from Black and minority ethnic groups, unaccompanied asylum seekers, children who are gay or lesbian or disabled. This reflects a long history of practice in which children from different backgrounds or with different identities have not been equally well served (for example, Barn, 2007; Fish 2012).

Third, numerous policy initiatives in recent years focusing on the health and educational attainment (Department for Children, Schools and Families, 2009; 2010) of LAC have been based on evidence that they do not achieve as well as their contemporaries who are not in public care. While Forrester et al. (2009) argue – with the valid intention of rebutting the simplistic position that ‘care fails children’ (p.440) - that LAC may do as well as or better than children with equivalent backgrounds left at home, an equalities perspective requires higher aspirations. Is the requirement of the state only to ensure LAC experience the equivalent quality of care and outcomes of the most disadvantaged children in its population?

Finally, as a result of the disadvantaged circumstances from which children enter the care system in England, the sometimes less than good experience in care, the better health and educational attainment of the child population not experiencing care and difficult transitions to adult life, outcomes for LAC in adulthood remain poor compared to the population of children as a whole (Stein and Munro, 2008).

The remainder of this article examines the first of these dimensions: the relationship between child welfare intervention and social position using two key markers of inequality, a child’s chance of being looked after and a child’s chance of being the subject of a child protection plan. In part, this is because the main focus of child welfare research in recent years has been on the *experience* of out-of-home care or child protection investigation and on interventions and outcomes, while the factors *leading to* LAC or CPP have been relatively neglected (Thoburn and Courtney, 2011). The argument is structured in three main parts. First, I outline illustrative evidence of current child welfare

inequalities. Second, I ask why these inequalities are known but have not been acted on. Third, I suggest some implications for social work policy, practice, theory and research of drawing parallels with health inequalities.

Child welfare inequalities: illustrative evidence

Annually, official statistics allow comparisons between local authorities (LAs) on a number of aspects of child welfare services in England. Data are returned for approximately 150 LAs, although sometimes data are missing and boundary changes make comparisons between years invalid. Published data include the numbers of CPP and LAC at March 31st of any given year in each LA and the rates per 10,000 children (DfE, 2012a; 2012b). Tables 1 and 2 show the extent of inequalities between LAs with the highest and lowest rates.

Table 1: Children looked after at 31.3.12: Rates per 10,000 children under 18 by Local Authority, England

| Five LAs with lowest rates | | Five LAs with highest rates | |
|----------------------------|----|-------------------------------|-----|
| Richmond Upon Thames | 18 | Blackpool | 151 |
| Wokingham | 20 | Manchester | 121 |
| Leicestershire | 28 | Kingston Upon Hull | 112 |
| Harrow | 28 | Middlesbrough | 110 |
| Windsor and Maidenhead | 29 | Salford | 109 |
| England average | 59 | Ratio Highest LA to Lowest LA | 8:1 |

Source: DfE, 2012a. N = 146.

Table 2: Children Subject to a Children Protection Plan at 31.3.12: Rates per 10,000 children under 18 by Local Authority, England

| Five LAs with lowest rates | | Five LAs with highest rates | |
|----------------------------|------|-------------------------------|-------|
| Milton Keynes | 8.9 | Torbay | 114.8 |
| Richmond Upon Thames | 11.3 | Blackpool | 104.2 |
| Wiltshire | 16.3 | Middlesbrough | 80.0 |
| Lincolnshire | 17.1 | Rotherham | 73.3 |
| Rutland | 17.4 | Newcastle Upon Tyne | 69.3 |
| England average | 38 | Ratio Highest LA to Lowest LA | 13:1 |

Source: DfE, 2012b. N = 146

The Tables show large differences between LAs. As already stated, a child in Blackpool had an eight times greater chance of being looked after than in a child in Richmond Upon Thames. A similar ratio (6:1) is also found for the rates at which children started to be looked after. Inequalities in the rates for CPPs were even greater. A child in Torbay was thirteen times more likely to be subject to a CPP than a child in Milton Keynes.

This is, of course, only one way – and a crude way, albeit one employed in health inequalities’ reports (WHO, 2008) - to represent differences between LAs in children’s chances of being involved with child welfare services. These relatively few LAs could simply represent ‘outliers’, LAs operating exceptionally or under exceptional circumstances with the vast majority of LAs clustered towards the middle of the range. However, while there are a small number of individual anomalies, particularly at the extremes, as Figures 1 and 2 below demonstrate, the inequity in rates runs across all LAs, it reflects a gradient rather than gaps at either the ‘top’ and/or ‘bottom’ ends. A restatement of the evidence in terms of quintiles of LAs (Table 3) reinforces this point. A child in the highest twenty per cent of LAs was 2.8 times more likely to be in out of home care than a child living in the bottom quintile and 2.7 times more likely to be CPP.

Table 3: LAC and CPP at 31.3.12: Rates per 10,000 children under 18 by Local Authority, England:

Quintiles

| | Rates of LAC | Rates of CPP |
|------------------|--------------|--------------|
| Lowest Quintile | 35 | 23.0 |
| Quintile 2 | 48 | 31.3 |
| Quintile 3 | 59 | 39.2 |
| Quintile 4 | 75 | 47.7 |
| Highest Quintile | 98 | 62.3 |

Source: DfE, 2012a; 2012b.

To test whether these differences in children’s chances were systematically related to deprivation, the rates for individual LAs were correlated with 2010 Index of Multiple Deprivation (IMD) scores, the most comprehensive index of deprivation available (although there are arguments for alternative measures). Thirty eight indicators produce measures in 7 domains which are weighted to produce a single score for each LA: ‘the experience of the people in an area gives the area its

deprivation characteristics' (Department for Communities and Local Government (DCLG), 2011a, p.11). The domains are:

- Income deprivation
- Employment deprivation
- Health deprivation and disability
- Education, skills and training deprivation
- Barriers to housing and services
- Crime
- Living environment deprivation.

Most of the data used to produce the 2010 IMD scores (DCLG, 2011b) are taken from 2008, no updating is yet available.

Figures 1 and 2 show the clear relationship between a child's chances of being looked after or subject to a child protection plan and the overall level of deprivation in the LA in which they live. Standard parametric correlation analysis (Pearson's r) showed strong, statistically significant correlations between IMD scores and children's chances of being LAC ($r = 0.725$; $p < 0.001$) or CPP ($r = 0.526$; $p < 0.001$). Linear regression analysis was then used to quantify the association between each set of child welfare outcomes (dependent variables) and IMD scores (independent variable). IMD scores were found to explain 53 per cent of the variance between LAs for LAC, and 28 per cent of the variance for children on a CPP.

Insert Figures 1 and 2 here.

Child welfare inequalities: seen but unrecognised

Most readers will find this illustrative evidence of child welfare inequalities entirely unsurprising. Most would anticipate that families in contact with child welfare services are likely to be living in poverty and would expect rates to reflect geographical patterns of affluence and disadvantage. As

Schorr (1992, p. 8) wrote, 'everyone in the business knows it.' However, this general awareness serves to mask the significance of the issue, substantial gaps in systematic knowledge and a dearth of empirical or theoretical investigation.

The data are important, first, because of the scale of the inequalities and their significance for children's lives. These are very large differences in a child's chances of being looked after or on a child protection plan. And these experiences, particularly of LAC, are known markers of poor life chances: comparatively low rates of educational attainment, difficulties in making the transition to adulthood and high rates of young pregnancy, mental and physical ill-health, offending, homelessness and unemployment (Stein and Munro, 2008), *whether or not* similarly damaging outcomes would have been the consequence of non-intervention (Forrester et al., 2009). These inequalities affect the whole of children's subsequent lives with powerful implications for their parents and other family members (Hayes and Spratt, 2009).

Second, although 'everyone ... knows it', there is a remarkable paucity of current data about the circumstances of the families of LAC or CPP in England, or the characteristics of the areas in which they live. There are several elements to this shortfall. It is partly because there are very few epidemiological studies of English social care user populations (Keene and Xuefang Li, 2005; Maxwell et al., 2012). It is also because analyses of English child welfare populations that have been carried out have usually utilised national statistical returns and these are limited (Berridge, 2007; Sinclair et al., 2007). Data are collected on the age, gender, ethnic identity and category of abuse (for CPPs) of *children* in the system but not about their own or their *parents'* social class, housing conditions, income or employment, still less their lifetime experience of disadvantage (Brophy, 2006). Reports of important ethnic inequalities in child welfare (for example, Owen and Statham, 2009) are not controlled for social class or material circumstances because the official statistics do not gather the relevant data.

National data are reported on categories of 'need' for each referral. But social workers are required to choose only one of eight overlapping categories and tend to routinely put 'abuse or neglect' as the primary reason for initial contact. In 79 of 152 LAs' returns in 2011 the 'low income' category was either not completed or given a score of 0. It is a category which has effectively fallen into disuse. CAFCASS (2012) only reported the age, gender and previous involvement with child welfare services of children subject to applications for court orders concerning their care. Their examination of parental *characteristics* focused on substance misuse, mental ill health, domestic abuse and involvement with children's services as minors, but not their material *circumstances*. Official statistical returns and their secondary analysis do not report family circumstances, let alone the effects on their behaviour or experiences as parents and children (Ridge, 2011).

Although Spratt and colleagues have reported data for Northern Ireland (for example, Spratt and Callan, 2004), it is 25 years since a national (over 2500 children in 13 LAs) study was conducted into the circumstances of families whose children enter care in England. In 1989, Bebbington and Miles reported that more than three quarters of all children taken into care through a court order and 71 per cent of children entering care 'voluntarily' in 1987 were living in families on the lowest level of welfare benefit compared with 26 per cent of all families, and only 15 per cent were in owner occupied households compared with 72 per cent of the general population. Even this seminal study did not offer any data about social class or about the income levels of that minority not on income support.

A variety of studies (for example, Becker, 1997; Gordon and Gibbons, 1998; Thoburn et al., 2000; Winter and Connolly, 2005; Hayes and Spratt, 2009), tend to confirm the strong link between disadvantage and involvement with child welfare services but none through detailed evidence of a representative population at a national level in England. This is perhaps in part because social work practitioners and managers, researchers and policy makers have focused more attention on dimensions of inequalities other than social and material circumstances, such as ethnicity (Owen and

Statham, 2009), and on attempting to reduce inequalities in the experience of children once in care or on leaving care. While these aspects of inequality in the child welfare system are also vitally important to social justice, focusing on them may have distracted attention from the reasons why children become looked after or subject to a CPP in the first place. Moreover, while published statistics show inequalities related to deprivation *between* LAs, there are no data which enable comparisons between sub-areas *within* LAs, as there is for health. There has been a great deal of demographic, social, economic and political change since the Bebbington and Miles' work in the mid-1980s and there is a major updating task to be undertaken. Despite the very considerable human, social and economic costs of child welfare, we do not have basic evidence about the social and geographical spread of families engaged with child welfare services. As Featherstone et al. (forthcoming) put it, 'this analysis needs to be re-stated and updated. Who is being taken away from their families?... Where do they come from? What kinds of backgrounds?'

Third, when researchers *have* investigated inequalities between LAs in the rates of LAC or children subject to a CPP, on the whole they have played down the significance of what health inequalities' researchers call 'social determinants' (Marmot, 2005), in favour of a focus on either the management of services or the behaviours of families. For example, Oliver et al. (2001) examined the performance of English LAs measured by rates of LAC or CPP, noting differences ranging from 10 to 71 per 10,000 for CPP, and from 7 to 115 for LAC, based on 1999. Using the York Index of deprivation (Carr Hill et al., 1997), they found that social deprivation accounted for about 45 per cent of the differences, by far the largest single factor. The remainder of their report, however, focused on 'residuals': factors affecting inequalities *other than* deprivation. They looked in detail at 8 LAs which had high or low child welfare rates *having controlled for deprivation*, identifying what they described as technical, situational, interpretive and operational factors in the approach and organisation of the LAs' services and the characteristics of families. While focusing on important policy and practice differences, they ignored the major factor producing unequal outcomes.

Similarly, Dickens et al. (2007) investigated 'variations' between 24 LAs, focusing particularly on the proportion of children starting to be looked after between 2000 and 2001. They, too, found large differences: variations from 9 to 78 per 10,000 children. To assess the extent to which 'underlying need' could explain this difference they used the Standard Spending Assessment, a measure reflecting deprivation derived, in part, from the York Index. This measure explained 40 per cent of the variation between LAs in the rates of children entering care (52 per cent of the variation for LAC). The authors concluded that 'need' was an important factor, 'possibly the largest single one' (p.605), but focused their attention not on multiple other factors, including rates of staff turnover and management issues. Their conclusion makes no reference to deprivation or need as a cause of variation.

In part, this disjunction between evidence and analysis may reflect the limited attention that social care practice and research in England has paid to social deprivation in the past twenty years. As Garrett (2002, 193) writes, 'poverty has been sequestered from the profession's dominant discourses.' Bebbington and Miles (1989) were an exception. They reported (p. 363) that 'striking differences' in the rates of children in care 'can be mainly attributed to the circumstances of children locally': poverty, single parenthood or 'broken' relationships, housing quality and ethnicity. They largely discounted differences in LAs' policies or practices as a factor. Perhaps it is because such differences were 'well known' (p. 360) and 'it is well established that the need for children's personal social services is directly related to social disadvantage' (Department of Health, 2000, p. 90) that relatively few subsequent studies have developed the evidence, theories or action plans to reduce these child welfare inequalities by addressing disadvantage directly. The contrast with empirical and theoretical development in the study of health inequalities is stark. As Spratt and Callan (2004, p.203) expressed it, 'when it comes to operational issues within local authorities, structural analysis takes second place to procedural adjustment in addressing the needs of children and their families.' Local practices are important, as Spratt and Callan's evidence that local policies

can radically affect the numbers of cases processed as 'child protection' demonstrates, but this should not obscure the central role played by relative deprivation.

Fourth, the language in which child welfare inequalities is discussed is striking. Although the Black Report (DHSS, 1980) had explicitly talked about *inequalities* in health in 1980, that has never been the language used to describe differential outcomes of children's social care. Inequalities have been described as 'variability', 'variation', 'differences', 'disproportionalities' or 'disparities' (Bebbington and Miles, 1989; Adams, 2001; Winter and Connolly, 2005; Sinclair et al., 2007; CAFCASS, 2012).

While discussing the over-representation of Black children and children of mixed ethnicity in the child welfare system, Owen and Statham (2009, p. 8) proposed a distinction drawn from US research literature:

... disproportionality is defined as 'differences in the percentage of children of a certain racial or ethnic group in the country as compared to the percentage of the children of the same group in the child welfare system'. Disparity is defined as 'unequal treatment when comparing a racial or ethnic minority to a non-minority'...

Yet, even when equity enters the argument, as it does here, there is no further mention of equity or equality, inequity or inequality in the report.

Re-focusing on inequalities: some implications

The basic case that deprivation is the major factor explaining large inequalities between LAs has been evidenced repeatedly over twenty five years. It is hard to understand this triple reluctance to research the structural causes of child welfare inequalities, to name inequalities as such or to focus action on social inequalities even when they are identified as the central factor at work. There are at

least four major implications of reframing these differences as inequalities, by drawing parallels with health.

First, reducing social inequalities and their impact on child welfare outcomes could become central aims of policy and practice. For health, national targets have been written in terms of *reducing inequalities* in infant mortality or life expectancy; child welfare policies and practices could focus on reducing inequalities within and between LAs and between groups of children. Such an aim could be addressed through two complementary approaches:

- reducing inequalities in levels of deprivation
- modifying the influence of levels of deprivation on child welfare outcomes.

The former – more fundamental – objective is primarily an issue of national and global economic and social policy, although LAs can also act on the local economy and as advocates. The second is arguably more within the grasp of local policy makers and practitioners. This would mean no longer benchmarking LAs' outcomes against their existing level of deprivation – the predominant current approach – but challenging LAs to break the link between deprivation and welfare outcomes by tackling deprivation and its impact on children's lives at the local level. Aked et al. (2010, p.12) have argued that, 'A population-level focus on wellbeing has the potential to improve outcomes for all and reduce inequality significantly.' This would have implications for the allocation of resources between LAs and within LAs, geographically and in terms of priorities.

If significant levelling up could be achieved, it could have a transformative effect on child welfare. For example, if the 50 per cent of LAs with highest deprivation scores had average LAC rates matching those of the lowest 50 per cent, there would have been almost 14,000 fewer LAC at 31st March 2011, a reduction of 23 per cent, and almost 5000 fewer children would have started a period in care during the previous year, a reduction of nearly 18%. Given that the annual total allocated budget for LAC services alone is £2.7b in 2012-13, there is some potential for reinvesting funds in measures to reduce inequalities for communities and families.

Of course, others have argued for a greater focus on the social circumstances of families in contact with child welfare services. For example, the multiple adverse child experiences research based in Northern Ireland (see Spratt, 2011) has suggested the value of reconceptualising ‘harms to children as less associated with atypical events and more to do with cumulative adversities’ (p.15).

Featherstone et al. (forthcoming, 5) similarly are concerned to challenge policy based on ‘an unforgiving approach to time and to parents – improve quickly or within set time limits’ and argue on both moral and practical grounds for re-invigorated *family support* to replace narrow *child protection* as the central motif of policy and practice. However, there is a danger that a policy focus on increasing support to families leaves the issue of inequality unchallenged: in health inequalities’ terms, narrowing the supposed *gap* between those in poverty and the rest of society rather than reducing the *gradient* of disadvantage by reducing inequality. As Hayes and Spratt (2009) also show, in the absence of a clear commitment to understand and reduce *inequalities*, an emphasis on support can mean that families with fewer needs receive more services – a child welfare version of health’s inverse care law (Tudor Hart, 1971).

Second, cross fertilisation with health inequalities may open up new possibilities for understanding the relationship between social circumstances and social welfare inequalities. Despite the countervailing efforts of the Munro Inquiry, English government policy for children’s services remains dominated by two key ideas: early intervention, such as identifying and targeting ‘Troubled Families’ (DCLG, 2012), and managerial approaches to child protection (Chard and Ayre, 2010). By contrast the Marmot Report (2010) on tackling health inequalities in England focused attention on primary prevention across six priority areas:

- Give every child the best start in life
- Enable all children young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all

- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention.

Such priorities would, if enacted, have considerable impact on the lives of child welfare service users.

Theoretical arguments about the relationship between social determinants of health and poor outcomes are by no means settled (Graham, 2000; Scambler, 2011) but the weight of evidence linking social determinants to structural causes rather than lifestyle choices has considerable implications for the government's agenda. Although the government emphasises that Troubled Families '*cause serious problems*', the evidence suggests that they *face* multiple disadvantages and that targeting those families' behaviours does not offer an effective or socially just solution. The four key parental characteristics identified in the recent CAFCASS (2012) report - mental ill-health, substance abuse, domestic violence and a childhood history of involvement with children's services – should be viewed as proximal factors, in health terms similar to smoking, diet and exercise, factors which *reflect* underlying social determinants rather than being primary causes of family troubles. This does not mean ignoring parents' private troubles but contextualising policy and practice responses.

Third, the link to health inequalities would also open up new lines of research. As already identified, there is remarkably little up to date, systematic information in England about the social, economic, environmental and political conditions or places from which children enter care or become subject to child protection procedures. We do not have a substantial body of contemporary information, let alone routine data collection, which identifies - at the population level, either nationally or locally - the circumstances of the parents of such children, their histories and current characteristics linked to their social position. In turn, this hampers explanations of differences between local areas or nations. We do not know the extent to which there is a social gradient in child welfare outcomes, as

there is for health outcomes. We do not know whether critical period or accumulation of risk models have greater explanatory power for child welfare outcomes (Bywaters, 2007).

Fourth, in arguing for more socially just welfare policies, refocusing on inequalities could create the basis for an alliance with others nationally (Marmot, 2010) and internationally (WHO, 2011) who are making the case for action on social determinants, professionals, popular and service user movements. The Global Agenda for Social Work and Social Development <http://cdn.ifsw.org/assets/globalagenda2012.pdf> may provide part of the platform for this development, but needs to be underpinned by greater evidence and strategic alliances beyond social work.

Conclusion

In this paper, I have started to map out what it would mean to reframe child welfare theory, research and action in terms of social inequalities to parallel the discourse on health inequalities. The argument has been that this would shift attention towards the social, economic, environmental and political causes of a well-known but relatively unaddressed feature of child welfare: large inequalities in children's chances and experiences with damaging long term consequences. I have suggested that the theoretical arguments, evidence and policy proposals for health inequalities have direct relevance for child welfare policy and practice because the social determinants of inequalities in health are also the determinants of child welfare inequalities. This is supported by the strong correlation between average male life expectancy 2008-10 and the rate of children looked after per 10,000 children at 31.3.2011 in the 107 LAs for which there is comparable data ($r=0.695$). As Aked et al. (2010, p.12) put it, '(T)he conclusion from all this is clear: local government cannot improve the wellbeing of its local population without directly addressing inequalities.'

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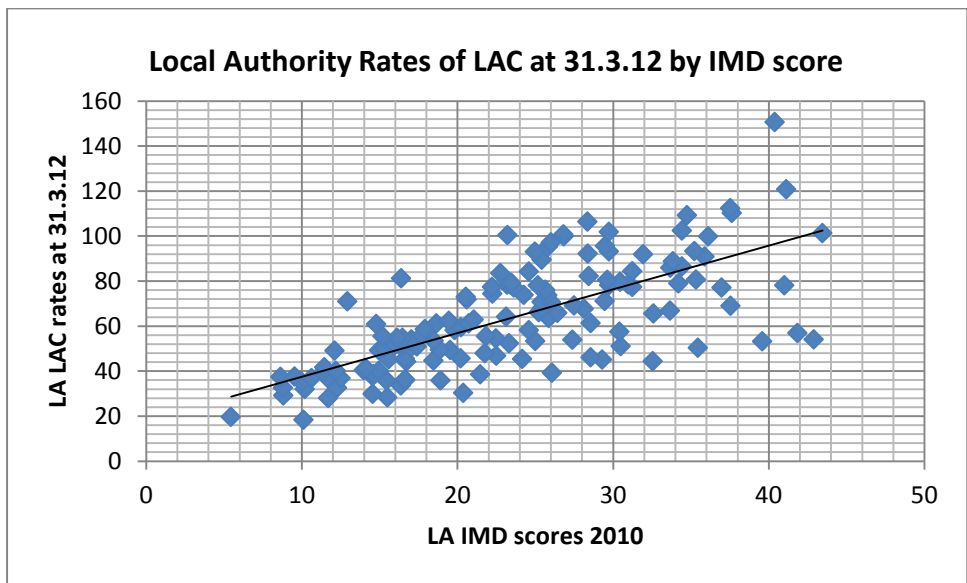
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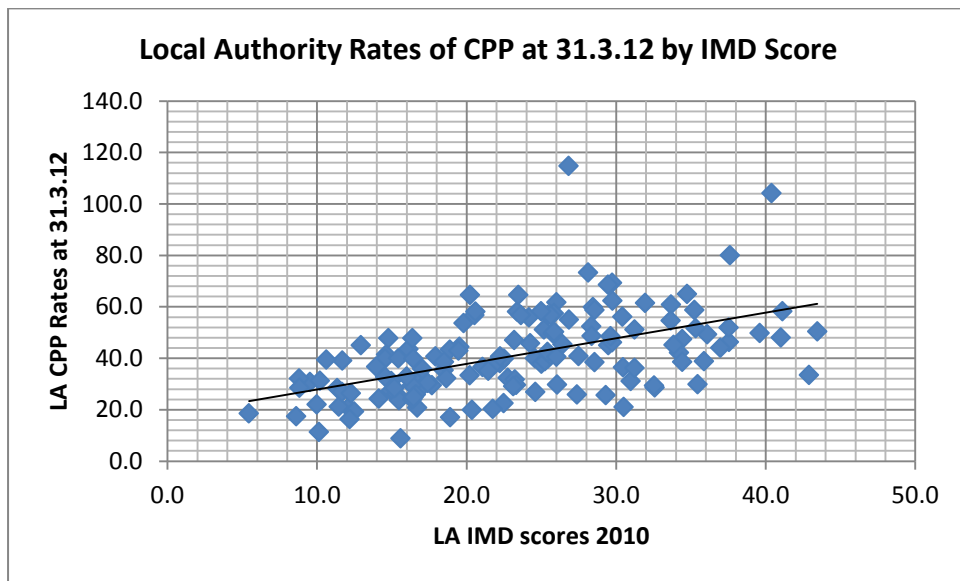
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Figure 1



Sources: DfE, 2012a; DCLG, 2011.

Figure 2



Sources: DfE,

2012b; DCLG, 2011.