



Centre for Disability Research

## Intellectual and Physical Disability, Social Mobility, Social Inclusion & Health

Eric Emerson, Ros Madden, Janet Robertson, Hilary  
Graham, Chris Hatton & Gwynnyth Llewellyn

CeDR Research Report 2009:2  
May 2009

## The Authors

**Eric Emerson** is Professor of Health and Disability Research at Lancaster University and Visiting Professor at the University of Sydney. He has been a member of several advisory groups to government and non-government organizations and has written several books and over 140 articles in academic and professional journals on issues related to the health and social inequalities faced by disabled children and adults with intellectual or developmental disabilities.

**Ros Madden** is coordinating the establishment of an ICF-related research program at the University of Sydney. Until 2006 she previously played a leading role in the development of national disability definitions and data, and in the analysis and reporting of functioning and disability statistics in Australia at the Australian Institute of Health and Welfare. Ros has worked internationally in the development and implementation of the International Classification of Functioning, Disability and Health and is on the Editorial Committee of the World Report on Disability and Rehabilitation.

**Janet Robertson** is a Lecturer in Health Research at Lancaster University. She has a background in Psychology and has been involved in research in intellectual disabilities since 1992. She has written numerous articles and reports on a wide variety of topics within the field of intellectual disabilities and is committed to research which aims to improve the quality of life and health of people with intellectual disabilities.

**Hilary Graham** is Professor of Health Sciences at the University of York, UK. She has a background in sociology and social policy, and a track-record of research and publications on health inequalities. She was a member of the Independent Inquiry into Inequalities in Health (Acheson Report) set up by the UK Government in 1997 to inform its public health strategy, and sits on a range of national and international committees seeking to develop and monitor policies to address health inequalities.

**Chris Hatton** is Professor of Psychology, Health and Social Care at Lancaster University. His research interests include identifying the inequalities experienced by people with intellectual disabilities and their families and evaluating policy innovations designed to reduce these inequalities. He has written or edited several books and over 100 articles in academic and professional journals.

**Gwynnyth Llewellyn** is Dean and Professor, Faculty of Health Sciences, University of Sydney and Director, Australian Family and Disability Studies Research Collaboration. She is a foundation member of the NSW Department of Community Services Research Advisory Council and the Expert Advisory Committee of the NSW Commission for Children and Young People. She has lead research in the field of parents and parenting with intellectual disability for over 20 years to address the social and health inequalities experienced by these parents and their children. With colleagues from the Parenting Research Centre (Victoria) she is leading an Australia wide and world first initiative to build national capacity to support parents with learning difficulties and to give their children a healthy start to life.

## Acknowledgements

We would like to acknowledge the helpful advice and suggestions given by a number of our colleagues.

Dr Bryony Beresford (Social Policy Research Unit, University of York)  
Neil Crowther (Disability Programme Director, Equality and Human Rights Commission)  
Professor David Gordon (Townsend Centre for International Poverty Research, University of Bristol)  
Rob Greig (Chief Executive, National Development Team for Inclusion)  
Dr Pauline Heslop (Norah Fry Research Centre, University of Bristol)  
Heather Honour (Learning Disability Coalition)  
Fiona Ritchie (Lead Learning Disabilities, Healthcare Commission)  
Philippa Russell (Chair, Standing Commission on Carers)  
Professor Carol Thomas (Centre for Disability Research, Lancaster University)

This paper was commissioned by and is evidence submitted to the Strategic Review of Health Inequalities in England Post 2010 (Marmot Review) <http://www.ucl.ac.uk/gheg/marmotreview> . However, the views expressed are those of the authors and do not necessarily represent the position of the Review.

## Summary of the Review

### The Problem (pages 5-10)

- Disabled people experience significantly poorer health outcomes than their non-disabled peers, including in aspects of health that are unrelated to the *specific* health conditions associated with their disability. Poorer health outcomes are also experienced by the carers of disabled children and adults.
- There are strong social gradients, across the lifecourse, in the prevalence of disability.
- These gradients are likely to result from a combination of factors including:
  - The impact of adversity and disadvantage on the onset of health conditions associated with disability
  - Intergenerational transmission of socially patterned health conditions associated with disability
  - The impact of disability on social mobility
- As a result, disabled children and adults are more likely than their peers to be exposed to general socio-economic conditions that are detrimental to health. A significant proportion of the risk of poor health of the disabled person themselves and carers appears to be attributable to their increased risk of exposure to socio-economic disadvantage.
- Some health conditions associated with disability or impairments may specifically impede the attainment of positive health.
- In addition, disabled children and adults are at risk of experiencing social exclusion and discrimination associated with their disability (disablism). The direct effects of such discrimination on health include reduced access to appropriate healthcare. Indirect effects of such discrimination on health operate through increased social exclusion, restricted social mobility and the psychological impact of direct personal experience of disablist actions.

### Recommended Action (pages 11-14)

There already exist a plethora of health, educational and social care policies and guidance in England that seek to reduce health inequalities and social exclusion and improve social mobility. All too often, however, these policies pay scant regard to the specific situations faced by disabled people, the apparent assumption being that the benefits of interventions targeted at deprived areas or families will accrue equally across all social groups. There is considerable evidence, however, that behaviour change interventions (whether 'upstream' or 'downstream') aimed at reducing health inequalities are likely to be more effective if they are tailored to the specific social and cultural contexts experienced by 'high risk' groups. Without such attention to the specific contexts faced by disabled people there is a real risk that they may fail to benefit from existing 'generic' policies. It is also worth noting that the NHS and its constituent parts are under a legal duty to pay due regard to eliminating discrimination and promoting equality of opportunity for disabled people. Therefore the *Commission* will fail to provide them with practical information if it fails to have regard to disabled people in its work.

We therefore recommend that:

- 1) In coming to its recommendations, the *Commission on Health Inequalities in England post-2010* should pay due regard to
  - a) The likely impact of recommendations on disabled people
  - b) What specific modifications or adjustments need to be made to ensure that disabled people experience equal benefits from the proposed initiatives.
- 2) Monitoring of progress toward reducing health inequalities at local (PCT), regional (SHA) and national (DH) levels should be undertaken in such a manner that data can be disaggregated by disability status and sub-categories of disability. PCTs should be required to include in their annual reports a summary of local progress in tackling the health inequalities faced by disabled people.
- 3) All changes to policy and practice should be developed and rolled out in ways that ensure evaluation and therefore maximise the potential for health gain and for policy learning. All evaluation studies should specifically address the impact of policy/practice initiatives on the health of disabled people.
- 4) A proportion of area based initiatives (e.g., Spearhead Trusts, Local Area Agreements, Sure Start, Improving Access to Psychological Therapies) should be encouraged to emphasise/prioritise issues specific to the situation of disabled people.
- 5) In order to promote disability relevant practice and information within public health and to contribute to the collection, aggregation and dissemination of information on the health of disabled people, a Public Health Observatory (PHO) on Disability should be established linked to one of the existing regional public health observatories.

There also already exists a plethora of English health, educational and social care policies and guidance that seek to improve the life chances of disabled children and reduce the disadvantage faced by disabled adults. We support the general thrust of these developments in health, education and social care, in particular their emphasis on:

- Prevention and early intervention
- The personalisation of support
- The co-ordination of support
- The devolution of resources and power to disabled people themselves (and, for children, their families)
- The move towards socially inclusive patterns of provision and support

We make a number of recommendations to strengthen these existing developments. Our recommendations - focusing on addressing disability and the disadvantages faced by disabled people from childhood and across their lives – outline a programme of policy review and development to inform and drive forward strategies to tackle the stark health inequalities between disabled and non-disabled people.

### [Recommendations for Future Research/Evaluation \(page 14\)](#)

There exists a dearth of evidence on the effectiveness of strategies to reduce the health inequalities experienced by disabled people. As such we reiterate the importance of three key recommendations made in the previous section.

- All changes to policy and practice be developed and rolled out in ways that ensure evaluation and therefore maximise the potential for health gain and for policy learning. All evaluation studies should specifically address the impact of policy/practice initiatives on the health of disabled people.
- In order to promote disability relevant practice and information within public health and to contribute to the collection, aggregation and dissemination of information on the health of disabled people, a Public Health Observatory (PHO) on Disability be established linked to one of the existing regional public health observatories.
- The Department of Health to fund a programme of work examining the nature and impact of disablism on health, well-being, social inclusion and social mobility.

# What is the ‘Problem’

## Preamble: Understanding Disability

Disability is a multi-dimensional concept and experience, arising from the interaction of health conditions and the environment. That disability is a multidimensional concept potentially affecting all areas of life is reflected in the 2007 UN Convention on the Rights of Persons with Disabilities and explicitly represented in the International Classification of Functioning, Disability and Health.<sup>1,2</sup> It may be experienced as any or all of: an impairment of body function or structure, an activity limitation or a participation restriction (see *Appendix 1*). Just as environmental risk factors affect the onset and severity of health conditions, so there are environmental risk factors for disability. These environmental factors include the built environment, personal and community attitudes, products and technology, and systems, services and policies (see *Appendix 1*). For example, the absence of appropriate health and rehabilitation services may affect the severity of an impairment following injury or the maintenance of health by a person with a communication difficulty; employers’ attitudes may affect the likelihood of a person with intellectual disability obtaining and retaining employment; inadequate support services, uninformed community attitudes, inaccessible houses, public buildings and transport systems – all may restrict a person’s social and economic participation in wide-ranging ways.

## A Significant Proportion of Children and Adults in England Live with Disability

Estimates of the prevalence of disability vary as a function of the methods used.<sup>3</sup> However, it is clear that a significant proportion of children and adults in England live with disability.<sup>3,6</sup>

- 8% of English children aged 7-15 have significant Special Educational Needs (SEN) associated with intellectual, developmental, communication, sensory or physical impairments.<sup>a</sup>
- The prevalence of disability among working age adults ranges from 15% to 20%.<sup>3</sup>
- Among older people, 20% of men and women aged 55-64 report difficulty in at least one of six activities of daily living (e.g., moving about the house, getting dressed). These rates rise to 58% of men and 65% of women aged 85+.<sup>6</sup>

## Intellectual and Physical Disabilities are Associated with Increased Mortality and Morbidity

There is extensive evidence that people with disabilities experience significantly poorer health outcomes than their non-disabled peers.<sup>7-27</sup> It is important to note, however, that these negative outcomes extend to aspects of health (e.g., mental health) that are unrelated to the *specific* health conditions associated with the person’s disability.<sup>10-30</sup> Poorer health outcomes, including health conditions associated with disability, are also experienced by family carers of disabled children and adults.<sup>31-47</sup>

<sup>a</sup> Data extracted from DCSF 2008 Spring School Census.

## There Are Strong Social Gradients, Across the Lifecourse, In the Prevalence of Disability

- *Among children and adolescents* there are clear social gradients in the distribution of most (but not all) intellectual, sensory and physical impairments.<sup>5 48-60</sup> For example, the prevalence of SEN associated with intellectual, developmental, communication, sensory or physical impairments among 7-15 year old children in England rises from 4.7% in the least deprived population decile to 11.1% in the most deprived decile (see Appendix 2 for further details).
- *Among working age adults* there is strong evidence of socio-economic gradients in the onset of functional impairments, and that the overall prevalence of disability is associated with lifetime socio-economic circumstances.<sup>6 61-65</sup>
- *Among older people*, there are strong associations between wealth, the onset of physical impairments and the rate of decline in physical ability over time.<sup>6 65-70</sup> For example, 8% of non-disabled participants in the most wealthy quintile compared to 18% of non-disabled participants in the least wealthy quintile developed difficulties in activities of daily living over a four year period.<sup>6</sup>

These gradients are likely to result from a combination of factors that vary in their significance across the lifecourse.

- *In young children*, social gradients are likely to reflect two processes. First, exposure to adversity (and associated material and psychosocial hazards) prenatally and in the early years will increase the incidence of health conditions and associated disability.<sup>71-76</sup> Second, intergenerational transmission of socially patterned health conditions or impairments are likely to play a significant role in certain contexts (e.g., mild intellectual impairments).<sup>29 30 77 78</sup>
- *In later childhood*, it has been suggested that these social gradients may also reflect the impact of child disability on family social mobility as a result of the direct and indirect costs associated with care.<sup>79</sup> However, it appears likely that any such effects are small as: (1) there is little, if any, evidence that social gradients in child health increase with age;<sup>50 54 56 80 81</sup> and (2) gradients appear to be more pronounced for less severe impairments (see Appendix 2).<sup>52</sup>
- *In adulthood*, downward social mobility resulting from the exclusion of disabled people from the labour market (see below) is likely to play an important role in exacerbating existing social gradients. It should be noted, however, that the *onset* of disability in mid and later life continues to show strong social gradients.<sup>6 67</sup>

### *Disability and Social Mobility*

While there is relatively little *direct* evidence on the association between disability and social mobility, there is abundant evidence that disabled people are disadvantaged with regard to key factors that promote social mobility. These include early childhood experiences, education, employment and labour market experiences, social and cultural capital, health and well-being.<sup>40 82-84</sup>

- *Early childhood experiences* are important determinants of later life chances.<sup>40 71 73 82-85</sup> Young children with intellectual or physical impairments are more likely than their



peers to be exposed to aspects of socio-economic adversity that constrain life chances.<sup>55 58 86</sup>

- *Education* has been identified as one of the most important factors influencing social mobility.<sup>40 82-84</sup> Disabled children have more unauthorised school absences, are more likely to be bullied and to have poorer academic attainment than their peers.<sup>87-93</sup> For example, while 69% of English children without SEN achieved 5 or more GCSEs at grades A\*-C in 2006/7, this rate fell to 23% among children with SEN without a Statement of SEN and to 9% among children with a Statement.<sup>93</sup> Disabled children are also at risk of placement in segregated special schools, including residential special schools, settings that may significantly impede children's social inclusion.<sup>94 95</sup>
- *Employment and labour market experiences.* Disabled adults have significantly reduced employment opportunities.<sup>30 65 89-92 96-102</sup> Rates of full-time employment among working age adults in 2008 were 34% for disabled adults compared to 61% among their non-disabled peers.<sup>93</sup> There has been little change in these rates over recent years.<sup>65</sup> Among those in employment, disabled people are less likely to be employed in high status occupations and are employed at lower rates of pay.<sup>93</sup> The onset of disability among people in employment is associated with increased risk of subsequent unemployment and reduced earnings.<sup>103-105</sup>
- *Social and cultural capital.* Socioeconomically more advantaged families tend to have access to a wider range of social networks and cultural capital that facilitate upward mobility and protect against downward mobility. Disabled people, as well as experiencing socio-economic disadvantage, also tend to have more restricted social capital, partly as a result of prejudicial and discriminatory practices.<sup>92 99 100 106</sup>
- *Health and wellbeing.* Ill health can lead to a decline in socio-economic status.<sup>40 82</sup> As noted above, there is extensive evidence that people with disabilities experience significantly poorer health outcomes than their non-disabled peers, including in aspects of health that are unrelated to their *specific* health conditions or impairments.

Disability is also associated with reduced social mobility of family carers. Childhood disability is associated with delayed entry of mothers into the workforce and increased rates of parental separation, factors that are likely to impede the social mobility of the families supporting disabled children.<sup>107-116</sup> Caring for a disabled adult has been linked to reduced employment opportunities and reduced income.<sup>40 41 117 118</sup>

## Disabled Children and Adults Are More Likely Than Their Peers to Be Exposed to General Socio-Economic Conditions That Are Detrimental to Health

Whatever the mechanisms underlying these associations it is clear that children and adults with disability are at increased risk of exposure to social conditions that, in general, are associated with reduced social mobility, increased social exclusion and poorer health outcomes.<sup>40 71 73 82 85 119-124</sup> As such, disabled people make up a disproportionate proportion of populations who may be generally considered to be 'at risk' of poor health, restricted social mobility and social exclusion.

To date, few studies have attempted to estimate the extent to which the poorer health outcomes experienced by disabled people may be attributable to their increased risk of exposure to socio-economic disadvantage (rather than any disability specific factors). The results of this nascent literature suggest that increased risk of exposure to socio-economic disadvantage may account for:

- 20-50% of the risk of poorer mental and physical health among children with intellectual disabilities;<sup>13-15 125</sup>
- Most or all of the risk of poorer mental health and low rates of well-being among mothers of children with intellectual disabilities or developmental delay.<sup>126 127</sup>

Other studies also point to the importance of social conditions for understanding the association between disability and health. For example, reduced psychological well-being among young disabled people may only be evident under conditions of either social exclusion or economic adversity.<sup>128</sup> Similarly, in later life higher income appears to buffer the psychological impact of becoming disabled.<sup>129</sup>

Thus, poorer socio-economic circumstances appear to both increase the risk of impairments *and* exacerbate their impact. Put another way, poorer circumstances may have a greater impact on the well-being of people with disability.

### Some Disabilities and Associated Health Conditions May Specifically Impede the Attainment of Positive Health

There exists evidence that, after controlling for socio-economic and other factors, (higher) intelligence is associated with (better) health.<sup>23 130-132</sup> People with learning disabilities by definition constitute the tail end of the distribution of this particular aspect of human capital. What is unclear, however, are the mediating pathways which link intelligence and health. These are likely to include such individual factors as variations in health literacy, problem solving, negotiating and help-seeking behaviours. It should be kept in mind, however, that the impact of such individual factors may potentially be ameliorated by appropriate interventions and adjustments.

### The Poorer Health Outcomes Experienced by Disabled People Are Also Likely to Reflect Their Experience of Discrimination and Social Exclusion

Disabled children and adults are at risk of experiencing discrimination associated with their disability (disablism) and of having their human rights violated.<sup>92 99 100 106 133-138</sup> The significance of disability discrimination in the UK is exemplified through the passing of the Disability Discrimination Acts (1995/2005), the stated commitment of the UK government to ratify the 2007 *UN Convention on the Rights of Persons with Disabilities* and the existing policy commitment that '*by 2025, disabled people in Britain should have full opportunities and choices to improve their quality of life and will be respected and included as equal members of society*'.<sup>90</sup> The impact of disability discrimination on health is likely to be both direct and indirect.

- Direct effects of discrimination on health result from the existence of systemic disability discrimination in the operation of health care systems, the direct

consequence of which is to impede disabled people's access to appropriate health and social care.<sup>8 9 139-145</sup>

- Indirect effects of discrimination on health arise through two interconnected pathways. First, discriminatory systems and practices contribute to the social exclusion of disabled people (see below). As a result, disabled people are more likely than their peers to be exposed to living conditions (poverty, unemployment, social adversity, low control, low status, poor housing) associated with poor health outcomes.<sup>71 73 76 82 85 86 119-124 146 147</sup> Second, the direct and indirect experience of disablism and disability discrimination may be expected to have a negative impact on the person's mental and physical health. While no direct evidence is available to support this contention, equivalent processes (the experience of racism and racial discrimination) have been identified as central to understanding ethnic inequalities in health.<sup>148</sup>

All of these effects are likely to be exacerbated among disabled children and adults who are also at risk of discrimination and social exclusion as a result of their ethnic identity, gender, sexual orientation or age.

### *Disability and Social Exclusion*

Social exclusion has been conceptualised as encompassing participation restrictions in four key domains: consumption; production; political and civic engagement; and social interaction.<sup>149</sup> There is extensive evidence to suggest that disabled people are at significantly higher risk of exclusion in each of these areas.

- *Consumption:* As children and adults, disabled people are more likely to experience income poverty and material hardship than their non-disabled peers.<sup>4 5 48 58 86 92 93 99 100 150</sup>
- *Production:* As noted above, disabled adults have significantly reduced employment opportunities.<sup>30 65 89-92 96-101 103-105</sup> In addition, they are at risk of exclusion from other socially valued modes of production, most notably parenting.<sup>29 151 152</sup>
- *Political and civic engagement:* Disabled people are less likely than their peers to vote or otherwise participate in the political and civic life of their communities.<sup>92 99 100</sup>
- *Social interaction.* As children and as adults disabled people are more likely to have restricted social networks, have looser ties to their local community, to experience bullying and to be victims of crime.<sup>87 88 92 99 100 106 153 154</sup> The social disconnectedness of some disabled people is exacerbated by the use of segregated and, at times, geographically remote educational and residential services.<sup>94 155 156</sup>

### *Summary*

- Disabled people experience significantly poorer health outcomes than their non-disabled peers, including in aspects of health that are unrelated to the *specific* health conditions associated with their disability. Poorer health outcomes are also experienced by the carers of disabled children and adults.
- There are strong social gradients, across the lifecourse, in the prevalence of disability.

- These gradients are likely to result from a combination of factors including:
  - The impact of adversity and disadvantage on the onset of health conditions associated with disability, and on disabilities (impairments, activity limitations and participation restrictions)
  - Intergenerational transmission of socially patterned health conditions associated with disability or impairment
  - The impact of disability on social mobility
- As a result, disabled children and adults are more likely than their peers to be exposed to general socio-economic conditions that are detrimental to health. A significant proportion of the risk of poor health of the disabled person themselves and carers appears to be attributable to their increased risk of exposure to socio-economic disadvantage.
- Some disabilities and associated health conditions may specifically impede the attainment of positive health.
- In addition, disabled children and adults are at risk of experiencing social exclusion and discrimination associated with their disability (disablism). The direct effects of such discrimination on health include reduced access to appropriate healthcare. Indirect effects of such discrimination on health operate through increased social exclusion, restricted social mobility and the psychological impact of direct personal experience of disablist actions.

## What Can Be Done About It?

There already exist a plethora of health, educational and social care policies and guidance in England that seek to reduce health inequalities and social exclusion and improve social mobility.<sup>84 157-163</sup> All too often, however, these policies pay scant regard to the specific situations faced by disabled people, the apparent assumption being that the benefits of interventions targeted at deprived areas or families will accrue equally across all social groups. There is considerable evidence, however, that behaviour change interventions (whether ‘upstream’ or ‘downstream’) aimed at reducing health inequalities are likely to be more effective if they are tailored to the specific social and cultural contexts experienced by ‘high risk’ groups.<sup>164</sup> Without such attention to the specific contexts faced by disabled people, there is a real risk that they may fail to benefit from existing ‘generic’ policies.<sup>65 165</sup>  
<sup>166</sup> As the Health Select Committee recently pointed out:

*‘health inequalities are evident across a number of different measures—not only socio-economic status, but ethnicity, gender, age, disability and regional area. This suggests that health inequalities should perhaps be measured and targeted in a multidimensional way’.*<sup>159</sup>

It is also worth noting that the NHS and its constituent parts are under a legal duty to pay due regard to eliminating discrimination and promoting equality of opportunity for disabled people. Therefore the *Commission* will fail to provide them with practical information if it fails to have regard to disabled people in its work.

We therefore recommend that:

- 1) In coming to its recommendations, the *Commission on Health Inequalities in England post-2010* should pay due regard to
  - a) The likely impact of the recommendation on disabled people
  - b) What specific modifications or adjustments need to be made to ensure that disabled people experience equal benefits from the proposed initiatives.
- 2) Monitoring of progress toward reducing health inequalities at local (PCT), regional (SHA) and national (DH) levels should be undertaken in such a manner that data can be disaggregated by disability status and sub-categories of disability. PCTs should be required to include in their annual reports a summary of local progress in tackling the health inequalities faced by disabled people.
- 3) All changes to policy and practice should be developed and rolled out in ways that ensure evaluation and therefore maximise the potential for health gain and for policy learning.<sup>159</sup> All evaluation studies should specifically address the impact of policy/practice initiatives on the health of disabled people.
- 4) A proportion of area based initiatives (e.g., Spearhead Trusts, Local Area Agreements, Sure Start, Improving Access to Psychological Therapies) should be encouraged to emphasise/prioritise issues specific to the situation of disabled people.
- 5) In order to promote disability relevant practice and information within public health and to contribute to the collection, aggregation and dissemination of information on the health of disabled people a Public Health Observatory (PHO) on Disability should be

established linked to one of the existing regional public health observatories (Note: the Department of Health have already committed to establishing a Learning Disabilities PHO<sup>167</sup>)

There also already exists a plethora of English health, educational and social care policies and guidance that seek to improve the life chances of disabled children and reduce the disadvantage faced by disabled adults,<sup>90 140 143 163 167-176</sup> The evidence reviewed above supports the general thrust of these developments in health, education and social care, in particular their emphasis on:

- Prevention and early intervention
- The personalisation of support
- The co-ordination of support (e.g., the introduction of individual care plans by 2010 for all children with complex long term conditions)
- The devolution of resources and power to disabled people themselves (and, for children, their families)
- The move towards socially inclusive patterns of provision and support

We recommend that these existing developments be strengthened in the following ways.

#### *Addressing Disablism*

- 6) The Department of Health to fund a programme of work examining the nature and impact of disablism on health, well-being, social inclusion and social mobility.
- 7) The Department of Health in conjunction with the Equalities and Human Rights Commission to implement a sustained campaign of social marketing aimed at reducing disablist attitudes among the general public.

#### *Improving the Lives, Services and Outcomes for Disabled Children and their Families*

- 8) Local Authorities and partners should adopt a robust attitude towards the new national indicator for disabled children's services (NI 54) and ensure that strategic planning and commissioning takes account of the views of families.
- 9) The Department for Children, Schools and Families should fund the development and evaluation of a national demonstration programme that
  - a) delivers intensive early intervention for pre-school children with or at risk of significant disabilities or early cognitive delay<sup>177-179</sup>
  - b) help families with young disabled children become more resilient
- 10) The Department of Work and Pensions significantly uprate DLA in order to cover the full additional costs associated with raising a disabled child.
- 11) The Department of Work and Pensions introduce new or modify existing benefits in order to provide appropriate financial support to cover the additional disability-related costs borne by disabled parents.
- 12) The Care Quality Commission undertake a review of the adequacy of access to appropriate health and social care support for disabled children with additional emotional or behavioural needs.

- 13) The Standing Commission on Carers urgently review the situation of children providing unpaid care for disabled relatives.
- 14) Local Authority performance is monitored against the proportion of children providing unpaid care for disabled relatives for more than a set number of hours per week.
- 15) The Department for Children, Schools and Families in conjunction with the Department of Work and Pensions take steps to ensure that sustainable high quality childcare is available for all disabled children and that benefit regulation ensure that the availability of childcare actively supports opportunities for the parents of disabled children to enter employment.<sup>180</sup>
- 16) As proposed in the 2008 National Carers Strategy, health checks for family carers (including children providing unpaid care and parents caring for disabled children) should be introduced and incentivised in primary care.<sup>181</sup>

#### *Addressing Barriers to Rewarding Employment for Disabled Young People and Adults*

- 17) The Department for Children, Schools and Families promote and monitor the entitlement to work experience for disabled children.
- 18) The Department of Work and Pensions review the current interface between employment related support programmes and the benefits systems that make it disadvantageous for many disabled people to work more than four hours but less than 16 hours.
- 19) The Department of Work and Pensions review the adequacy of employment support programmes for people with more severe or longer-term disabilities.<sup>182</sup>

#### *Improving Access and Quality in Housing and Supported Accommodation for Disabled Children, Adults and their Families*

- 20) The Department of Communities and Local Government (DCLG) undertake a review of the housing needs of families with disabled children in order to develop specific policies to significantly improve the quality of such housing and develop systems for monitoring progress toward such a goal.<sup>76 86 146 147</sup>
- 21) DCLG to conduct a review to determine whether local authority and registered social landlord housing allocations disproportionately channel disabled tenants to housing situated in concentrations of socio-economic disadvantage
- 22) The Care Quality Commission undertake a fundamental review of the rules and regulations that relate to residential care homes and their interface with charging policies and the benefits system with regard to: (1) housing security and tenure of residents; (2) benefit-related disincentives to employment; (3) adequacy of disposable income with which to progress aspirations around social mobility and community inclusion.

#### *Addressing Inequalities in Health & Social Care for All People with Disabilities*

- 23) A national framework of guaranteed outcomes, based upon human rights principles, should be developed for social care.<sup>144</sup>
- 24) Establish a legal entitlement for self-directed assessment of needs for social care support, irrespective of income or funding available to local authorities.<sup>144</sup>

- 25) The Quality and Outcomes Framework (QOF) is reviewed to ensure that it reflects and orients general practice to better meet the health needs of people with disabilities and their families.
- 26) The Health Select Committee recommendation that tackling health inequalities is made a specific objective of QOF should be implemented and monitoring of performance should include evidence that progress is made in reducing the health inequalities experienced by disabled people.
- 27) GPs should be brought directly within the scope of the DED. (At the moment, as independent practitioners, they are not and their work can only be influenced in DED terms through the commissioning activities of the PCT.)
- 28) The NHS be required to monitor key outcomes and the delivery of major health initiatives (e.g. screening) by disability and sub-groups of disability against population level indicators of need in order to be able to demonstrate compliance with the DDA.

## Recommendations for Future Research/Action Development

There exists a dearth of evidence on the effectiveness of strategies to reduce the health inequalities experienced by disabled people. As such we reiterate the importance of three key recommendations made in the previous section.

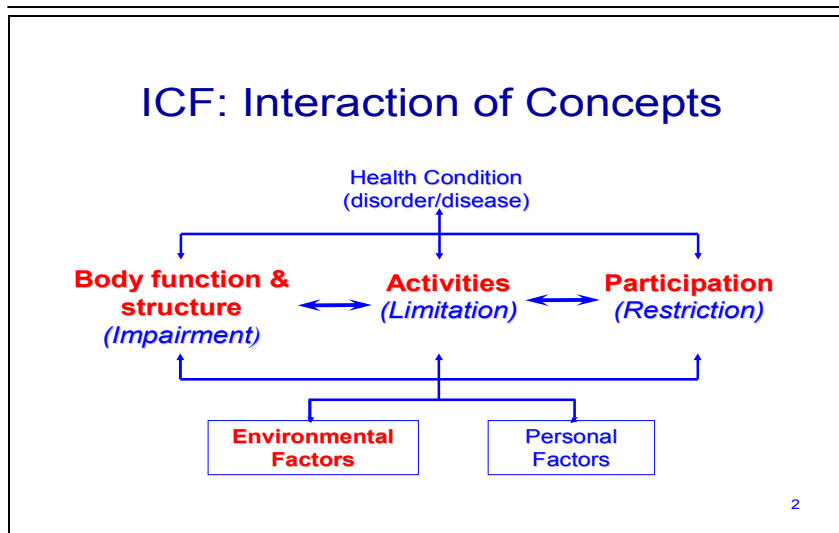
- 3) All changes to policy and practice be developed and rolled out in ways that ensure evaluation and therefore maximise the potential for health gain and for policy learning.<sup>159</sup> All evaluation studies should specifically address the impact of policy/practice initiatives on the health of disabled people.
- 5) In order to promote disability relevant practice and information within public health and to contribute to the collection, aggregation and dissemination of information on the health of disabled people a Public Health Observatory (PHO) on Disability be established linked to one of the existing regional public health observatories.
- 6) The Department of Health to fund a programme of work examining the nature and impact of disablism on health, well-being, social inclusion and social mobility.

In addition we recommend that an over-arching information framework be developed, based on the ICF, to ensure that research and other sources of data build towards a coherent body of knowledge about disability and health.



## Appendix 1: The ICF

The International Classification of Functioning, Disability and Health (ICF) was adopted by the World Health Assembly in 2001 after more than a decade of international collaboration on its development. The classification provides what is sometimes described as a bio-psycho-social model of functioning and disability; this model seeks to blend the key features of pre-existing models, notably the medical and social models of disability. According to the ICF, functioning and disability are experienced as body functions (and impairments of them), activities (and activity limitations) and participation (and participation restrictions). Environmental Factors are specifically recognised and classified, as having a crucial effect on a person's functioning - either as facilitators or barriers. (See following diagram. More information can be viewed on the WHO web site - <http://www.who.int/classifications/icf/en/> <http://www.who.int/classifications/icfbrowser/>)



Thus, disability is multidimensional and interactive. All dimensions are important and any one may affect the other. Impairment affects Activity, Activity and Participation affect Impairment; Environmental Factors affect everything, must be understood and may need to be changed. The approach to care and treatment is assumed to be person-centred, a partnership, holistic. Ethical guidelines for the use of ICF are provided in its Annex 6. The ICF is a multi-purpose classification intended for a wide range of uses in different sectors. It is one of WHO's main reference classifications, the other being the ICD (International Classification of Diseases). The ICF 'has been accepted as one of the UN social classifications and...provides an appropriate instrument for the implementation of stated international human rights mandates as well as national legislation'.<sup>1</sup> The ICF provides a standard language and framework for describing and organising information on functioning and disability. A companion classification, published in 2007, is available for organising information about children and youth (ICF-CY).<sup>2</sup>

The ICF comprises lists of codes, organised hierarchically, within chapters or domains, within the main components. Chapter headings for all the ICF components are listed in the following Table.

**ICF components and domains (chapters)**

<p><b>Body Function:</b>                  Mental Functions                  Sensory Functions and Pain                  Voice and Speech Functions                  Functions of the Cardiovascular, Haematological, Immunological and Respiratory Systems                  Functions of the Digestive, Metabolic, Endocrine Systems                  Genitourinary and Reproductive Functions                  Neuromusculoskeletal and Movement-Related Functions                  Functions of the Skin and Related Structures</p>	<p><b>Activities and Participation:</b>                  Learning and Applying Knowledge                  General Tasks and Demands                  Communication                  Mobility                  Self Care                  Domestic Life                  Interpersonal Interactions and Relationships                  Major Life Areas (incl employment and education)                  Community, Social and Civic Life</p>
<p><b>Body Structure:</b>                  Structure of the Nervous System                  The Eye, Ear and Related Structures                  Structures Involved in Voice and Speech                  Structure of the Cardiovascular, Immunological and Respiratory Systems                  Structures Related to the Digestive, Metabolic and Endocrine Systems                  Structure Related to Genitourinary and Reproductive Systems                  Structure Related to Movement                  Skin and Related Structures</p>	<p><b>Environmental Factors:</b>                  Products and Technology (incl building construction)                  Natural Environment and Human-Made Changes to Environment                  Support and Relationships                  Attitudes                  Services, Systems and Policies</p>

## Appendix 2: Social Gradients in Intellectual and Physical Impairments Associated with Special Educational Needs in England 2008

Odds Ratios of Intellectual, Sensory and Physical Impairments Associated with Special Educational Needs (SEN) in England in 2008 by IDACI Decile										
IDACI decile	MLD	SLD	PMLD	ASD	PD	SPLD	SLCN	VI	HI	MSI
1	5.60	1.99	0.96	0.95	1.30	1.96	2.61	1.66	1.44	1.33
2	4.58	1.91	1.01	1.05	1.33	1.83	2.33	1.54	1.37	1.41
3	3.75	1.82	1.07	1.10	1.33	1.72	2.10	1.49	1.38	1.29
4	3.07	1.59	1.00	1.08	1.23	1.57	1.87	1.33	1.30	1.26
5	2.51	1.46	0.94	1.14	1.20	1.46	1.63	1.28	1.21	1.03
6	2.08	1.31	1.02	1.03	1.14	1.33	1.46	1.21	1.13	1.16
7	1.73	1.22	1.02	1.05	1.08	1.26	1.30	1.17	1.11	1.14
8	1.47	1.14	0.92	1.01	1.03	1.18	1.18	1.07	1.12	1.13
9	1.29	1.09	0.88	1.02	1.02	1.12	1.11	1.07	1.07	1.11
10	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00

*Abbreviations:* IDACI = Income deprivation affecting children index of area deprivation  
 MLD = moderate learning difficulties; SLD = severe learning difficulties; PMLD = profound multiple learning difficulties; ASD = autistic spectrum disorders; PD = physical disabilities; SPLD = specific learning difficulties (e.g., dyslexia); SLCN = speech language or communication needs; VI = visual impairment; HI = hearing impairment; MSI = multiple sensory impairment  
*Data:* Extracted from DCSF Spring 2008 School Census; child age range 4-15; n=6,795,720; SEN level of School Action Plus or Statement of SEN  
*Analyses:* Simple multivariate logistic regression controlling for child age, gender and ethnicity and Local Authority

## References

1. World Health Organisation. International Classification of Functioning, Disability and Health. Geneva: World Health Organisation, 2001.
2. World Health Organisation. International Classification of Functioning, Disability and Health - Children and Youth Version. ICF-CY. Geneva: World Health Organisation, 2007.
3. Bajekal M, Harries T, Breman R, Woodfield K. Review of Disability Estimates and Definitions. London: HMSO, 2004.
4. Gordon D, Parker R, Loughran F, Heslop P. *Disabled Children in Britain: A Re-analysis of the OPCS Disability Surveys*. London: The Stationery Office, 2000.
5. Emerson E, Hatton C. The socio-economic circumstances of children at risk of disability in Britain. *Disability and Society* 2007;22(6):563-80.
6. Breeze E, Lang IA. Physical functioning in a community context. In: Banks J, Breeze E, Lessof C, Nazroo J, editors. *Living in the 21st century: older people in England*. London: Institute for Fiscal Studies, 2008.
7. Emerson E, Hatton C. Socioeconomic disadvantage, social participation and networks and the self-rated health of English men and women with mild and moderate intellectual disabilities: Cross sectional survey. *European Journal of Public Health* 2008;18:31-37.
8. Michael J. Healthcare for All: Report of the Independent Inquiry into Access to Healthcare for People with Learning Disabilities. London: Independent Inquiry into Access to Healthcare for People with Learning Disabilities, 2008.
9. Disability Rights Commission. Equal Treatment - Closing the Gap. London Disability Rights Commission, 2006.
10. Stanish HI, Temple VA, Frey GC. Health-promoting physical activity of adults with mental retardation. *Mental Retardation and Developmental Disabilities Research Reviews* 2006;12:13-21.
11. Rimmer JH, Yamaki K. Obesity and intellectual disability. *Mental Retardation and Developmental Disabilities Research Reviews* 2006;12:22-27.
12. Melville C, Hamilton S, Hankey C, Miller S, Boyle S. The prevalence and determinants of obesity in adults with intellectual disabilities. *Obesity Reviews* 2007;8:223-230.
13. Emerson E, Hatton C. The mental health of children and adolescents with intellectual disabilities in Britain. *British Journal of Psychiatry* 2007;191:493-499.
14. Emerson E, Hatton C. The contribution of socio-economic position to the health inequalities faced by children and adolescents with intellectual disabilities in Britain. *American Journal on Mental Retardation* 2007;112(2):140-150.
15. Emerson E, Hatton C. Poverty, socio-economic position, social capital and the health of children and adolescents with intellectual disabilities in Britain: a replication. *Journal of Intellectual Disability Research* 2007;51(11):866-874.
16. Morgan VA, Leonard H, Bourke J, Jablensky A. Intellectual disability co-occurring with schizophrenia and other psychiatric illness: population-based study. *British Journal of Psychiatry* 2008;193 364-372.
17. Lidstone JSM, ELLS, L J, Finn P, Whittaker VJ, Wilkinson JR, Summerbell CD. Independent associations between weight status and disability in adults: Results from the Health Survey for England. *Public Health* 2006;120:412-417.
18. Hysing M, Elgen I, Gillberg C, Lie SA, Lundervold AJ. Chronic physical illness and mental health in children. Results from a large-scale population study. *Journal of Child Psychology and Psychiatry* 2007;48(8):785-792.
19. Straetmans JMJA, van Schrojenstein Lantman-de Valk HMJ, Schellevis FG, Dinant G-J. Health problems of people with intellectual disabilities: the impact for general practice. *British Journal of General Practice* 2007;57:64-66.

20. Ells L, Lang R, Shield J, Wilkinson J, Lidstone J, Coulton S, et al. Obesity and disability – a short review. *Obesity Reviews* 2006;7:341-345.
21. Einfeld SL, Piccinin AM, Mackinnon A, Hofer SM, Taffe J, Gray KM, et al. Psychopathology in young people with intellectual disability. *JAMA* 2006;296(16):1981-9.
22. Dekker MC, Koot HM, van-der-Ende J, Verhulst FC. Emotional and behavioral problems in children and adolescents with and without intellectual disability. *Journal of Child Psychology and Psychiatry and Allied Disciplines* 2002;43:1087-1098.
23. Batty GD, Gale CR, Tynelius P, Deary IJ, Rasmussen F. IQ in early adulthood, socioeconomic position, and unintentional injury mortality by middle age: A cohort study of more than 1 million Swedish men. *American Journal of Epidemiology* 2009;169(5):606-15.
24. Rimmer JH, Rowland JL, Yamaki K. Obesity and secondary conditions in adolescents with disabilities: Addressing the needs of an underserved population. *Journal of Adolescent Health* 2007;41:224–229.
25. Parkes J, White-Koning M, Dickinson HO, Thyen U, Arnaud C, Beckung E, et al. Psychological problems in children with cerebral palsy: a cross-sectional European study. *Journal of Child Psychology and Psychiatry* 2008;49(4):405–413.
26. Owens PL, Kerker BD, Zigler E, Horwitz SM. Vision and oral health needs of individuals with intellectual disability *Mental Retardation and Developmental Disabilities Research Reviews* 2006;12:28-40.
27. Draheim CC. Cardiovascular disease prevalence and risk factors of persons with mental retardation. *Mental Retardation and Developmental Disabilities Research Reviews* 2006;12:3-12.
28. Llewellyn G, McConnell D, Mayes R. Health of mothers with intellectual limitations. *Australian and New Zealand Journal of Public Health* 2003;27(1):17-19.
29. IASSID Special Interest Research Group on Parents and Parenting with Intellectual Disabilities. Parents labelled with Intellectual Disability: Position of the IASSID SIRG on Parents and Parenting with Intellectual Disabilities. *Journal of Applied Research in Intellectual Disabilities* 2008;21:296-307.
30. Lawton K. Nice Work If You Can Get It: Achieving a sustainable solution to low pay and in-work poverty. London: Institute for Public Policy Research, 2009.
31. Singer GH. Meta-analysis of comparative studies of depression in mothers of children with and without developmental disabilities. *American Journal on Mental Retardation* 2006;111(3):155-169.
32. Hatton C, Emerson E. Does socioeconomic position moderate the impact of child behaviour problems on maternal health in South Asian families with a child with intellectual disabilities? *Journal Of Intellectual & Developmental Disability* 2009;34(1):10-6.
33. Ones K, Yilmaz E, Cetinkaya B, Caglar N. Assessment of the quality of life of mothers of children with cerebral palsy (primary caregivers). *Neurorehabilitation and Neural Repair* 2005;19:232-237.
34. Bailey DB, Golden RN, Roberts J, Ford A. Maternal depression and developmental disability: Research critique *Mental Retardation and Developmental Disabilities Research Reviews* 2007;13:321-9.
35. Ehrlich TR, von Rosenstiel IA, Grootenhuis MA, Gerrits AI, Bos AP. Long-term psychological distress in parents of child survivors of severe meningococcal disease. *Developmental Neurorehabilitation* 2005;8(3):220-224.
36. Hawley CA, Ward AB, Magnay AR, Long J. Parental stress and burden following traumatic brain injury amongst children and adolescents. *Brain Injury* 2003;17:1-23.
37. Manuel J, Naughton MJ, Balkrishnan R, Smith BP, Koman LA. Stress and adaptation in mothers of children with cerebral palsy. *Journal of Pediatric Psychology* 2003;28(3):197-201.
38. Pervin K, Iseri PK, Ozten E, Aker AT. Posttraumatic stress disorder and major depressive disorder is common in parents of children with epilepsy. *Epilepsy & Behavior* 2006;8:250-255.

39. Winjberg-Williams BJ, Kamps WA, Klip EC, Hoekstra-Weebers JEHM. Psychological adjustment of parents of pediatric cancer patients revisited five years later. *Psycho-Oncology* 2006;15:1–8.
40. Nunn A, Johnson S, Monro S, Bickerstaffe T, Kelsey S. Factors influencing social mobility. London: DWP, 2007.
41. Young H, Grundy E, Jitlal M. Care providers, care receivers: A longitudinal perspective. York: Joseph Rowntree Foundation, 2006.
42. Caldwell J. Health and access to health care of female family caregivers of adults with developmental disabilities. *Journal of Disability Policy Studies* 2008;19(2):68-79.
43. Hare DJ, Pratt C, Burton M, Bromley J, Emerson E. The health and social care needs of family carers supporting adults with autistic spectrum disorders. *Autism: The International Journal Of Research And Practice* 2004;8(4):425-44.
44. Hirst M. Young adults with disabilities: Health, employment and financial costs for family carers. *Child Care, Health & Development* 1985;11(5):291-307.
45. Hirst M. Health Inequalities and Informal Care. York: Social Policy Research Unit, 2004.
46. Hirst M. Carer distress: a prospective, population-based study. *Social Science & Medicine (1982)* 2005;61(3):697-708.
47. Princess Royal Trust for Carers. Carers Health Survey: Main Findings. London: Princess Royal Trust for Carers, 2004.
48. Parish SL, Rose RA, Andrews ME, Grinstein-Weiss M, Richman EL. Material hardship in US families raising children with disabilities. *Exceptional Children* 2008;75(1):71-92.
49. Chapman D, Scott K, Stanton-Chapman T. Public health approach to the study of mental retardation. *American Journal on Mental Retardation* 2008;113(2):102-116.
50. Emerson E, Graham H, Hatton C. Household income and health status in children and adolescents: cross sectional study. *European Journal of Public Health* 2006;16:354-360.
51. Leonard H, Petterson B, De Klerk N, Zubrick SR, Glasson E, Sanders R, et al. Association of sociodemographic characteristics of children with intellectual disability in Western Australia. *Social Science & Medicine* 2005;60:1499-1513.
52. Leonard H, Wen X. The epidemiology of mental retardation: challenges and opportunities in the new millennium. *Mental Retardation and Developmental Disabilities Research Reviews* 2002;8:117-134.
53. Heikura U, Taanila A, Hartikainen A-L. Variations in prenatal sociodemographic factors associated with intellectual disability: A study of the 20-Year interval between two birth cohorts in Northern Finland. *American Journal of Epidemiology* 2008;167:169-177.
54. Chen E, Martin AD, Matthews KA. Socioeconomic status and health: Do gradients differ within childhood and adolescence? *Social Science & Medicine* 2006;62:2161-2170.
55. Yang J, Carmichael SL, Canfield M, Song J, Shaw GM, National Birth Defects Prevention Study. Socioeconomic status in relation to selected birth defects in a large multicentered US case-control study. *American Journal of Epidemiology* 2007;167(2):145-154.
56. Chen E, Matthews KA, Boyce WT. Socio-economic differences in children's health: How and why do these relationships change with age? . *Psychological Bulletin* 2002;128(2):295-329.
57. Newacheck PW, Halfon N. Prevalence and impact of disabling chronic conditions in childhood. *American Journal of Public Health* 1998;88(4):610-7.
58. Emerson E, Graham H, McCulloch A, Blacher J, Hatton C, Llewellyn G. The social context of parenting three year old children with developmental delay in the UK. *Child: Care, Health & Development* 2009;35(1):63-70.
59. Dolk H. Cerebral palsy, low birthweight and socio-economic deprivation: inequalities in a major cause of childhood disability. *Paediatric And Perinatal Epidemiology* 2001;15(4):359-63.
60. Varela M, Nohr E, Llopis-Gonzalez A, Andersen AN, Olsen J. Socio-occupational status and congenital anomalies. *European Journal of Public Health* 2009;19(2):161-7.

61. Melchior M, Lert F, Martin M, Ville I. Socioeconomic position in childhood and in adulthood and functional limitations in midlife: Data from a nationally-representative survey of French men and women. *Social Science & Medicine* 2006;63:2813–2824.
62. Richards M, Wadsworth MEJ. Long term effects of early adversity on cognitive function. *Archive of Diseases of Childhood* 2004;89:922-7.
63. Department of Health. Health Survey for England, 4.1.1 Socio-Demographic Profile of Adults with a Disability. London: Department of Health, 2001.
64. Brault MW. Americans with Disabilities 2005. Washington, DC: US Census Bureau, 2008.
65. Palmer G, MacInnes T, Kenway P. Monitoring poverty and social exclusion 2008. York: Joseph Rowntree Foundation, 2008.
66. Guralnik JM. Childhood Socioeconomic Status Predicts Physical Functioning a Half Century Later. *Journals of Gerontology: Series A: Biological Sciences and Medical Sciences* 2006;61A(7):694-701.
67. McMunn AM, Nazroo J, Breeze E. Inequalities in health at older ages: a longitudinal investigation of the onset of illness and survival effects in England. *Age and Ageing* 2009;38:181–187.
68. Ebrahim S. Social inequalities and disability in older men: prospective findings from the British regional heart study. *Social Science & Medicine (1982)* 2004;59(10):2109-20.
69. Lang IA. Neighbourhood deprivation and incident mobility disability in older adults. *Age & Ageing* 2008;37(4):403-10.
70. Minkler M, Fuller-Thomson E, Guralnik JM. Gradient of disability across the socioeconomic spectrum in the United States. *New England Journal of Medicine* 2006;355 695-703.
71. Irwin LG, Siddiqi A, Hertzman C. Early Child Development : A Powerful Equalizer. Geneva: World Health Organisation, 2007.
72. Keating DP, Hertzman C, editors. *Developmental health and the wealth of nations: social, biological and educational dynamics*. New York: Guilford Press, 1999.
73. Marmot M, Wilkinson RG, editors. *Social Determinants of Health* 2nd ed. Oxford: Oxford University Press, 2006.
74. Laplante DP, Brunet A, Schmitz N, Ciampi A, King S. Project Ice Storm: Prenatal Maternal Stress Affects Cognitive and Linguistic Functioning in 51/2-Year-Old Children. *Journal of the American Academy of Child and Adolescent Psychiatry* 2008;47(9):1063-72.
75. Bergman K, Sarkar P, O'Connor TG, Modi N, Glover V. Maternal stress during pregnancy predicts cognitive ability and fearfulness in infancy. *Journal of the American Academy of Child and Adolescent Psychiatry* 2007;46:1454–1463.
76. Beresford B. Housing and disabled children: a review of policy levers and opportunities. York: Social Policy Research Unit, University of York, 2006.
77. Spinath F, Harlaar N, Ronald A, Plomin R. Substantial genetic influence on mild mental impairment in early childhood. *American Journal on Mental Retardation* 2004;109:34-43.
78. McConnell D, Llewellyn G, Mayes R, Russo D, Honey A. Developmental profiles of children born to mothers with intellectual disability. *Journal of Intellectual and Developmental Disability* 2003;28:122-134.
79. Tibble M. Review of existing research on the extra costs of disability. London: Department of Work and Pensions, 2005.
80. Spencer NJ. Social equalization in youth: evidence from a cross-sectional British survey *European Journal of Public Health* 2006;16:368-75.
81. West P, Sweeting H. Evidence on equalisation in health in youth from the West of Scotland. *Social Science & Medicine* 2004;59:13-27.
82. Graham H. *Unequal Lives: Health and Socioeconomic Inequalities*. Maidenhead: Open University Press, 2007.
83. Cabinet Office. Getting on, getting ahead: A discussion paper: analysing the trends and drivers of social mobility. London: Cabinet Office, 2008.
84. Cabinet Office. New opportunities: Fair chances for the future. London: Cabinet Office, 2009.

85. Fabian Commission on Life Chances and Child Poverty. *Narrowing the Gap: The Final Report of the Fabian Commission on Life Chances and Child Poverty*. London: Fabian Society, 2006.
86. Beresford B, Rhodes D. *Housing and Disabled Children*. York: Joseph Rowntree Foundation, 2008.
87. Department for Children Schools and Families. *Bullying involving children with special educational needs and disabilities*. London: Department for Children Schools and Families, 2008.
88. National Children's Bureau. *Bullying and disability*. London: National Children's Bureau, 2007.
89. Cabinet Office. *Improving the Life Chances of Disabled People: Analytical Report* London: Cabinet Office, 2004.
90. Cabinet Office. *Improving the Life Chances of Disabled People: Final Report*. London: Cabinet Office, 2005.
91. Burchardt T. *The education and employment of disabled young people: Frustrated ambition*. Bristol/York: Policy Press/Joseph Rowntree Foundation, 2005.
92. Williams B, Copestake P, Eversley J, Stafford B. *Experiences and Expectations of Disabled People*. London: Office for Disability Issues, 2008.
93. Office for Disability Issues. *Annual Report Annex Annex one: Indicators data*. London: Office for Disability Issues, 2008.
94. Audit Commission. *Out of authority placements for special educational needs*. London: Audit Commission, 2007.
95. UNESCO. *The Salamanca statement and framework for action on special needs education*. Paris: UNESCO, 1994.
96. Berthoud R. *Employment rates of disabled people*. London: Department for Work and Pensions, 2006.
97. Maughan B, Collishaw S, Pickles A. Mild mental retardation: psychosocial functioning in adulthood. *Psychological Medicine* 1999;29:351-366.
98. Rigg J. *Labour market disadvantage amongst disabled people: a longitudinal perspective*. London: Centre for the Analysis of Social Exclusion, London School of Economics, 2005.
99. Emerson E, Malam S, Davies I, Spencer K. *Adults with Learning Difficulties in England 2003/4*. Leeds: Health & Social Care Information Centre, 2005.
100. Grewal I, Joy S, Lewis J, Swales K, Woodfield K. "Disabled for Life'?" attitudes towards, and experiences of, disability in Britain. London: DWP Research Report No. 148, 2002.
101. Hirst M, Thornton P, Dearey M, Campbell S. *The employment of disabled people in the public sector: a review of data and literature*. London: DRC, 2004.
102. Office for National Statistics. *Labour Market Experiences of People with Disabilities*. London: Office for National Statistics, 2002.
103. Jenkins SP, Rigg JA. Disability and disadvantage: selection, onset and duration effects. *Journal of Social Policy* 2004;33(3):479-501.
104. Burchardt T. *Enduring Economic Exclusion: disabled people, income and work*. York: Joseph Rowntree Foundation, 2000.
105. Burchardt T. *Being and becoming: Social exclusion and the onset of disability*. CASereport 21. London: Centre for Analysis of Social Exclusion, London School of Economics, 2003.
106. Shakespeare T. *Disability rights and wrongs*: London, 2006.
107. Porterfield SL. Work choices of mothers in families with children with disabilities. *Journal of Marriage & Family* 2002;64:972-981.
108. Risdal D, Singer GH. Marital adjustment in parents of children with disabilities: A historical review and meta-analysis. *Research & Practice for Persons with Severe Disabilities* 2004;29(2):95-103.
109. MacInnes MD. One's enough for now: children, disability, and the subsequent childbearing of mothers. *Journal of Marriage and Family* 2008(70):758-771.
110. Seltzer MM, Greenberg JS, Floyd FJ, Pettee Y, Hong J. Life course impacts of parenting a child with a disability. *American Journal on Mental Retardation* 2001;106:265-286.



111. Parish SL, Seltzer MM, Greenburg JS, Floyd F. Economic implications of caregiving at midlife: Comparing parents with and without children who have developmental disabilities. *Mental Retardation* 2004;42(6):413-426.
112. Clarke H, McKay S. *Exploring Disability, Family Formation and Break-Up: Reviewing the evidence*. Sheffield: Department of Work and Pensions, 2008.
113. Urbano RC, Hodapp RM. Divorce in families of children with Down syndrome: A population-based study. *American Journal on Mental Retardation* 2007;112(4):261-274.
114. Loprest P, Davidoff A. How children with special health care needs affect the employment decisions of low-income parents. *Maternal and Child Health Journal* 2004;8:171-182.
115. Carers UK. *Out of pocket: A survey of carers' lost earnings*. London: Carers UK, 2007.
116. Carers UK. *Real change, not short change: Time to deliver for carers*. London: Carers UK, 2007.
117. Pickard L. *Caring for older people and employment*. Wetherby: Audit Commission, 2004.
118. Parker G, Lawton D. *Different types of care, different types of carer. Evidence from the General Household Survey*. London: HMSO, 1994.
119. Hills J, Le Grand J, Piachaud D, editors. *Understanding Social Exclusion*. Oxford: Oxford University Press, 2002.
120. Galobardes B, Lynch JW, Davey Smith G. Childhood socioeconomic circumstances and cause-specific mortality in adulthood: systematic review and interpretation. *Epidemiologic Reviews* 2004;26:7-21.
121. Galobardes B, Lynch JW, Davey Smith G. Is the association between childhood socioeconomic circumstances and cause-specific mortality established? Update of a systematic review. *Journal of Epidemiology and Community Health* 2008;62:387-390.
122. World Health Organisation. *Closing the gap in a generation: Health equity through action on the social determinants of health. Final report of the Commission on the Social Determinants of Health*. Geneva: World Health Organisation, 2008.
123. Hanson MD, Chen E. Socioeconomic status and health behaviors in adolescence: A review of the literature. *Journal of Behavioral Medicine* 2007;30:263-285.
124. Marmot M. Social determinants of health inequalities. *Lancet* 2005;365:1099-1104.
125. Emerson E, Einfeld S. Emotional and behavioural difficulties in young children with and without developmental delay: A bi-national perspective. under review.
126. Emerson E, Hatton C, Blacher J, Llewellyn G, Graham H. Socio-economic position, household composition, health status and indicators of the well-being of mothers of children with and without intellectual disability. *Journal of Intellectual Disability Research* 2006;50(12):862-873.
127. Emerson E, McCulloch A, Graham H, Blacher J, Llewellyn G, Hatton C. The mental health of parents of young children with and without developmental delays under review.
128. Emerson E, Honey A, Madden R, Llewellyn G. The Well-Being of Australian Adolescents and Young Adults with Self-Reported Long-Term Health Conditions, Impairments or Disabilities: 2001 and 2006 *Australian Journal of Social Issues* under review.
129. Smith DM, Langa KM, Kabeto MU, Ubel PA. Health, Wealth, and Happiness: Financial Resources Buffer Subjective Well-Being After the Onset of a Disability. *Psychological Science* 2005;19(9):663-666.
130. Batty GD, Deary IJ, Gottfredson LS. Premorbid (early life) IQ and Later Mortality Risk: Systematic Review. *Annals of Epidemiology* 2007;17(4):278-288.
131. Batty GD, Der G, Macintyre S, Deary IJ. Does IQ explain socioeconomic inequalities in health? Evidence from a population based cohort study in the west of Scotland. *British Medical Journal* 2006;332:580-584.
132. Kuh D, Richards M, Hardy R, Butterworth S, Wadsworth MEJ. Childhood cognitive ability and deaths up until middle age: a post-war birth cohort study. *International Journal of Epidemiology* 2004;33:408-0413.

133. Thomas C. *Sociologies of Disability and Illness. Contested Ideas in Disability Studies and Medical Sociology*. Basingstoke: Palgrave Macmillan, 2007.
134. Joint Committee on Human Rights. *A Life Like Any Other? Human Rights of Adults with Learning Disabilities*. London: The Stationery Office Limited, 2008.
135. Abrams D, Houston DM. *Equality, Diversity and Prejudice in Britain: Results from the 2005 National Survey*. Canterbury: Centre for the Study of Group Processes, University of Kent, 2006.
136. The Equalities Review. *Fairness and Freedom: The Final Report of the Equalities Review*. London: The Equalities Review, 2007.
137. The Equality and Human Rights Commission. *Fairness: A new contract with the public*. Manchester: The Equality and Human Rights Commission, 2008.
138. Oliver M, Barnes C. *Disabled people and social policy: from exclusion to inclusion*. London: Longman, 1998.
139. McDonagh JE, Viner RM. Lost in transition? Between paediatric and adult services. *BMJ* 2006;332(7539):435-6.
140. Department of Health. *Transition: getting it right for young people. Improving transition of young people with long term conditions from children's to adult health services*. London: Department of Health, Child Health and Maternity Services Branch, 2006.
141. Office of the Deputy Prime Minister. *Transitions: Young Adults with Complex Needs. A Social Exclusion Unit Final Report*. London: Social Exclusion Unit - Office of the Deputy Prime Minister, 2005.
142. Social Care Institute for Excellence. *Transition of young people with physical disabilities or chronic illness from children's to adult's services: Social Care Institute for Excellence*, 2005.
143. Commission for Social Care Inspection Healthcare Commission and Mental Health Act Commission. *Commissioning services and support for people with learning disabilities and complex needs*. London: Commission for Social Care Inspection, Healthcare Commission and Mental Health Act Commission, 2009.
144. Equality and Human Rights Commission. *From safety net to springboard. A new approach to care and support for all based on equality and human rights*. London: Equality and Human Rights Commission, 2009.
145. Parliamentary and Health Service Ombudsman and Local Government Ombudsman. *Six lives: the provision of public services to people with learning disabilities*. London: Parliamentary and Health Service Ombudsman and Local Government Ombudsman, 2009.
146. Beresford B, Oldman C. *Housing Matters: National evidence relating to disabled children and their housing*. Bristol: Policy Press, 2002.
147. Oldman C, Beresford B. *Homes Unfit for Children: Housing, disabled children and their families* Bristol: Policy Press, 1998.
148. Nazroo J. The structuring of ethnic inequalities in health: Economic position, racial discrimination and racism. *American Journal of Public Health* 2003;93(2):277-284.
149. Burchardt T, Le Grand J, Piachaud D. Degrees of exclusion: Developing a dynamic, multidimensional measure. In: Hills J, Le Grand J, Piachaud D, editors. *Understanding Social Exclusion*. Oxford: Oxford University Press, 2002:30-43.
150. Emerson E. Poverty and people with intellectual disability. *Mental Retardation and Developmental Disabilities Research Reviews* 2007;13:107-113.
151. Olsen R, Tyers H. *Think parent: Supporting disabled adults as parents* London: National Family and Parenting Institute, 2004.
152. Morris J. *The Right Support. Report of the Task Force on Supporting Disabled Adults in their Parenting Role*. York: Joseph Rowntree Foundation, 2003.
153. Guralnick MJ, Neville B, Hammond MA, Connor RT. The friendships of young children with developmental delays: A longitudinal analysis. *Journal of Applied Developmental Psychology* 2007;28:64-79.

154. Frederickson NL, Furnham AF. The long-term stability of sociometric status classification: A longitudinal study of included pupils who have moderate learning difficulties and their mainstream peers *Journal of Child Psychology and Psychiatry* 2001;42(5):581-592.
155. Llewellyn G, McConnell D, Thompson K, Whybrow S. Out-of-home placement of school-age children with disabilities. *Journal of Applied Research in Intellectual Disability* 2005;18:1-6.
156. Emerson E, Robertson J. Commissioning person-centered, cost-effective, local support for people with learning difficulties. London: SCIE, 2008.
157. Her Majesty's Treasury. Child Poverty Review. London: Her Majesty's Treasury, 2004.
158. Department of Health. Tackling Health Inequalities: A Programme of Action. London: TSO, 2003.
159. House of Commons Health Committee. Health Inequalities: Third Report of Session 2008–09. Volume I. London: House of Commons, 2009.
160. Department of Health. Tackling Health Inequalities: 2007 Status report on the Programme for Action. London: Department of Health, 2008.
161. Department of Health. Health Inequalities: Progress and Next Steps. London: Department of Health, 2008.
162. Her Majesty's Treasury. Ending child poverty: everybody's business. London: Her Majesty's Treasury, 2008.
163. Department of Health and Department for Children Schools and Families. Healthy lives, brighter futures: The strategy for children and young people's health. London: Department of Health, 2009.
164. National Institute for Health and Clinical Excellence. Behaviour change at population, community and individual levels. London: National Institute for Health and Clinical Excellence, 2007.
165. Disability Rights Commission. Ending Child Poverty - the Disability Dimension London: DRC, 2006.
166. Disability Rights Commission. Bringing an End to Child Poverty London: DRC, 2007.
167. Department of Health. Valuing People Now: The Delivery Plan London: Department of Health, 2009.
168. Her Majesty's Treasury. Aiming high for disabled children: better support for families. London: Her Majesty's Treasury & Department for Education and Skills, 2007.
169. Department of Health. Valuing People: A New Strategy for Learning Disability for the 21st Century. 2001.
170. Department of Health. National Service Framework for Children, Young People and Maternity Services: Disabled Children and Young People and those with Complex Health Needs. London: Department of Health, 2004.
171. Department of Health. Promoting Equality: Response from Department of Health to the Disability Rights Commission Report, "Equal Treatment: Closing the Gap". London: Department of Health, 2007.
172. Cabinet Office. Reaching Out: An Action Plan on Social Exclusion. London: Cabinet Office, 2006.
173. Department of Health. Valuing People Now: A new three-year strategy for people with learning disabilities. London: Department of Health,, 2009.
174. Office for Disability Issues. Secretary of State Reports on Disability Equality. London: Office for Disability Issues, 2008.
175. Commission for Social Care Inspection. Cutting the cake fairly: CSCI review of eligibility criteria for social care. London: Commission for Social Care Inspection, 2008.
176. Commission for Social Care Inspection. State of social care in England 2006-07. Leeds: CSCI, 2008.
177. Anderson LM, Shinn C, Fullilove MT, Scrimshaw SC, Fielding JE, Normand J, et al. The effectiveness of early childhood development programs: A systematic review. *American Journal of Preventative Medicine* 2003;24(3S):32-46.

178. Campbell FA, Wasik BH, Pungello E, Burchinal M, Barbarin O, Kainz K, et al. Young adult outcomes of the Abecedarian and CARE early childhood educational interventions. *Early Childhood Research Quarterly* 2008;23:452–466.
179. Moran P, Ghate D, Van der Merwe A. What Works in Parenting Support? A Review of the International Evidence. London: HMSO, 2004.
180. Every Disabled Child Matters. Between a Rock and a Hard Place. London: Every Disabled Child Matters, 2008.
181. Department of Health. Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own. London: Department of Health, 2008.
182. Rangarajan A, Wittenburg D, Honeycutt T, Brucker D. Programmes to promote employment for disabled people: Lessons from the United States. London: Department of Work and Pensions, 2008.