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scotland's health is improving rapidly but it is not improving fast enough for the poorest sections of our society. Health inequalities ... remain our major challenge.

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# equally well

report of the ministerial task force on health inequalities  
volume 2



The Scottish  
Government

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volume 2

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# 1. INTRODUCTION

The Ministerial Task Force on Health Inequalities welcomed input from a number of external sources in the course of its work. It drew of the Scottish Government's consultation leading to the Better Health, Better Care action plan towards the end of 2007. The Task Force has published some of its background papers on its web pages already <http://www.scotland.gov.uk/Topics/Health/health/Inequalities/Inequalitiestaskforce>.

The Task Force wishes its working papers to be published at the same time as its report to Cabinet. This will allow those more interested to see in more detail the evidence the Task Force has used and the information presented to it on current and potential future action.

In particular, the Task Force is pleased to publish reports of three constulations it carried out with a wide-ranging Third Sector audience, with managers associated with important local public services and with young people through Young Scot.

The Task Force is grateful to everyone who has contributed to its findings.

**Scottish Government**  
**May 2008**

## 2. BRIEFING PAPER ON HEALTH INEQUALITIES

**By Professor Sally Macintyre, MRC Social & Public Health Sciences Unit, University of Glasgow**

Socio-economic inequalities in health have been observed in the UK since records began. In his 1842 report on the conditions of the labouring poor in Britain, Edwin Chadwick noted that, when he asked for two maps of Aberdeen, one marked with the prevalence of fever and one with the location of the different social orders:

'They returned a map so marked as to disease, but stated that it had been thought unnecessary to distinguish the streets inhabited by the different orders of society, as that was done with sufficient accuracy by the different tints representing the degrees of the prevalence of fever.'

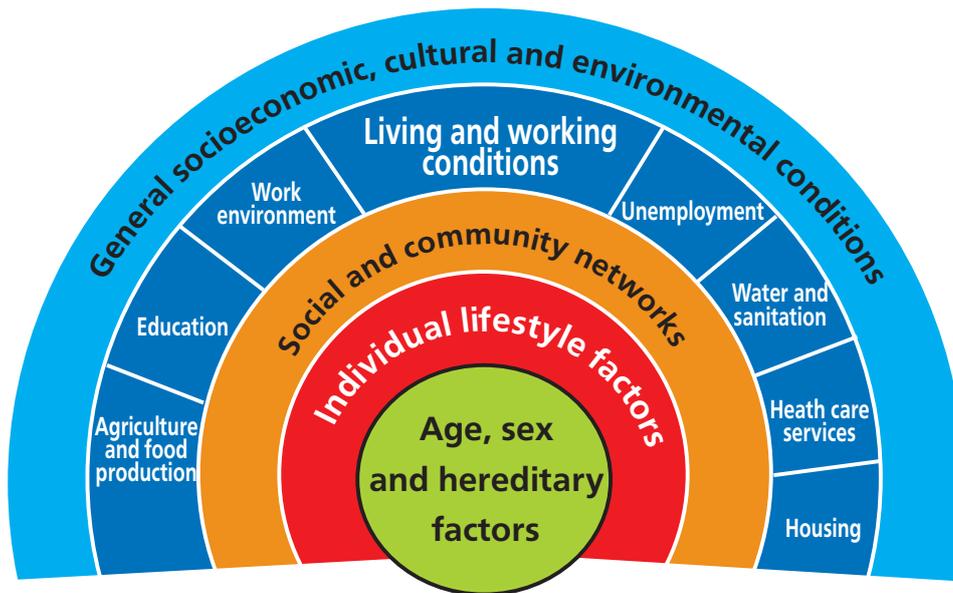
### **What are inequalities in health, and what causes them?**

In all known societies health risks, health-related behaviours, physical and mental health, and life expectancy tend to vary between social groups. Key axes of variation include socio-economic status, gender, ethnicity, and place of residence. This briefing focuses on socio-economic status (SES for short) inequalities but many of the same principles apply to other inequalities.

The most immediate causes of SES inequalities in health are specific exposures (e.g. damp housing, hazardous work or neighbourhood settings, infectious agents, adverse life events), behaviours (e.g. smoking, diet, exercise), and personal strengths or vulnerabilities (e.g. coping styles, resilience, ability to plan for the future). (See Figure 1) Mechanisms can be physical (e.g. exposure to air pollution), psychosocial (e.g. adverse life events), behavioural (e.g. smoking) or combinations of these (e.g. smoking to deal with stress caused by living in a physically threatening environment). Such influences are often referred to as 'downstream' causes.

Intermediate causes are the pathways by which members of different SES groups get to be at lower or higher risk of such exposures and vulnerabilities: (e.g. the education, taxation, and health care systems, the labour and housing markets, planning regulations, crime and policing etc). The most fundamental causes are international political and economic forces, and the forms of social stratification in a given society. For example, in the USA health tends to be strongly associated with the distribution of income and with race, while in the UK it tends to be more strongly associated with social class. Such influences are often referred to as 'upstream' causes.

**Figure 1: Causes of SES inequalities in health**



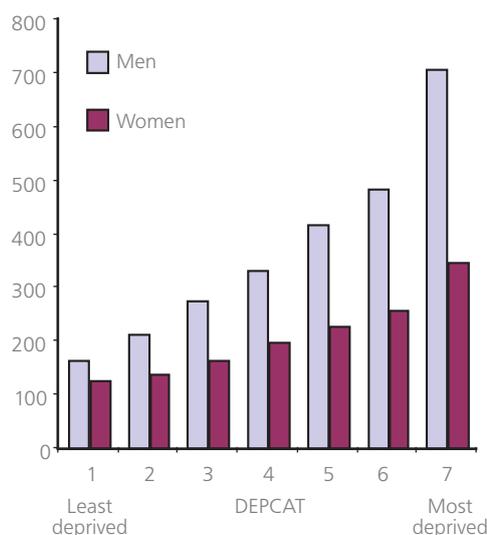
Dahlgren G, Whitehead M. Policies and strategies to promote social equity in health. Copenhagen: World Health Organization, 1992.

Some SES inequalities are generated at or before birth. For example, data from the West of Scotland show that stomach cancer and stroke risk are associated more with one's parents' SES than with one's own position in adult life. Low birthweight is a good marker of the environment in the womb, and thus of the mother's health. It is strongly associated with socio-economic deprivation, and low birth weight babies have continuing health and social disadvantages, not only in childhood but into adult life, as expressed for example in raised risks of coronary heart disease in middle age.

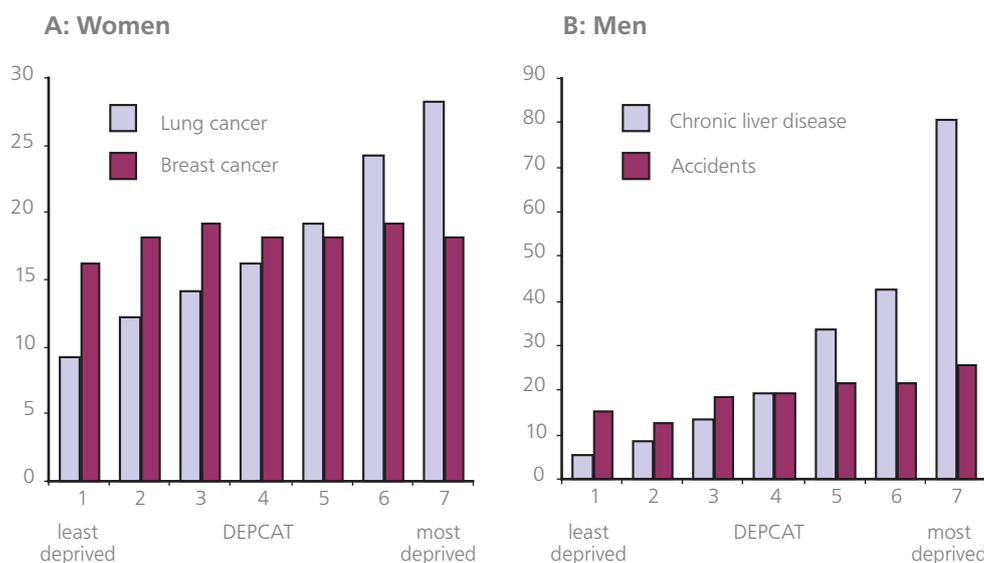
Exposure to socially patterned risks (e.g. to hazardous working environments, smoky environments, poverty) also occurs in adult life. Earlier and later life risks can be cumulative; exposure to damaging environments in both childhood and adulthood is worse than exposure in only one period. Experiences and behaviours in later life can help to reduce risks generated earlier.

### **Social gradients in health and health risks**

Health usually displays a gradient by socio-economic status, so that each successively more advantaged group has longer life expectancy and better health. There is a gradient all the way up the social scale, rather than a threshold between the poor and the rest of society above which there are no social differences. For example, in Scotland death rates decrease even between the three least deprived categories (see Figure 2).

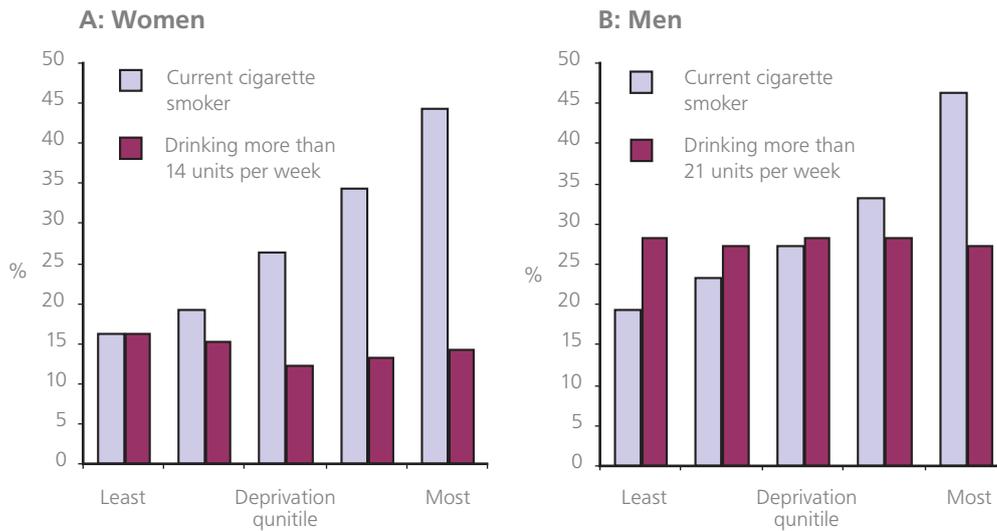
**Figure 2: All cause death rate per 100,000 population, Scotland 2001 – Men and Women**

Although this social gradient is found in most diseases, there are some exceptions, and gradients are steeper for some conditions than for others. For example, among women death rates from lung cancer are strongly socially patterned while those from breast cancer are not (Figure 3A); among men the social gradient is steeper for deaths from chronic liver disease than for deaths from accidents (Figure 3B).

**Figure 3: Death rate per 100,000 population, Scotland 2001**

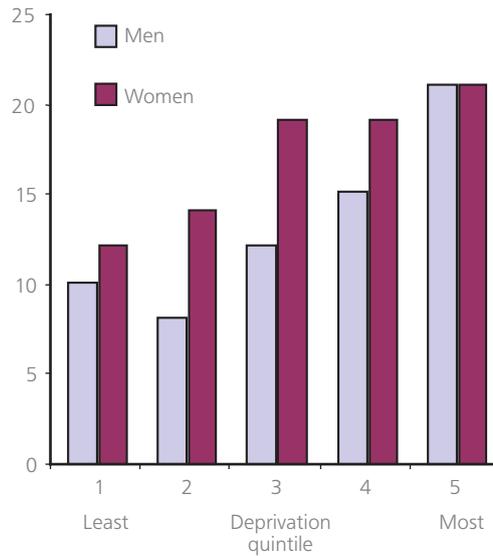
Similarly, gradients by behaviours vary: it is not true that: 'the poor always behave badly'. Smoking rates are much higher in more disadvantaged groups, but the pattern for alcohol is somewhat more complicated. For example, although binge drinking is more common among deprived men, there is little social gradient in weekly alcohol consumption, among men or women (see Figure 4).

**Figure 4: Self-reported smoking and drinking, Scotland 2003**



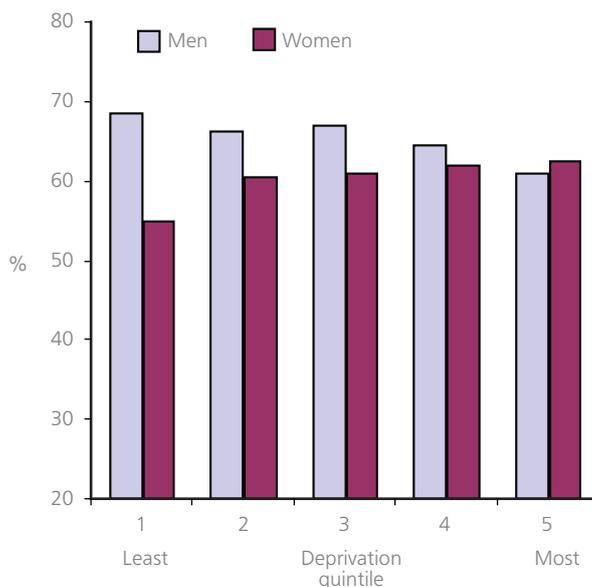
SES gradients are also found in measures of mental health and wellbeing. Figure 5 shows the percentages scoring above a cut-off, indicating probable need for treatment, on a measure indicating psychological distress.

**Figure 5: Psychological distress (GHQ 4+), Scotland 2003**



Although SES gradients are manifest in many biological measures (e.g. birth weight, height, respiratory functioning) they are, somewhat surprisingly, not found in others (e.g. blood pressure and cholesterol, even though these are risk factors for major illnesses, such as cardiovascular disease, which are strongly socially patterned).

Social gradients differ by age, tending to be steep in infancy, flatter in youth, then steeper in adulthood and flatter in old age. There are also gender differences in socio-economic gradients; for example, overweight rises with decreasing SES among women, but the pattern is more mixed or reversed among men (see Figure 6).

**Figure 6: Body Mass Index 25+ Men and Women, Scotland 2003**

SES patterning varies by levels of economic development and by culture, and can change over time as patterns of exposure, and the relative influence of different determinants, change. For example, rates of heart disease and smoking used to be higher in higher social classes whereas in most developed countries they are now consistently higher in lower SES groups. Smoking rates are still higher in higher social classes in Southern countries in Europe. In developed countries smoking has become a more important cause of health inequalities as its prevalence has declined, because the decline has been greater among more affluent people.

### Policy issues and principles

While life expectancy, health and health related behaviours have shown a steady improvement over the last 50 years, more advantaged social groups have seen a faster improvement, which means that the gap between the bottom and top of the social scale has widened. However, this does not mean that social and public-health policies have not had a positive impact on inequalities in health. These inequalities would undoubtedly be much wider were it not for universal health care and education free at the point of use, and a number of measures such as progressive taxation, income support, neighbourhood regeneration, housing improvements, and control of the environment via clean air acts, health and safety at work legislation etc. Thus it is important to maintain such equity enhancing policies.

Ultimately, the most 'upstream' policy would be to reduce inequalities in society. The problem with relying on 'downstream' interventions is that, meanwhile, more people are falling into the river upstream, e.g. smoking cessation services would continually have to deal with new cohorts of smokers. This suggests one needs both upstream and downstream interventions; to create an environment in which people do not start smoking in the first place, as well as helping people to stop.

Some people have objected to attempts to reduce inequalities in health on the basis that it would be wrong to make some people less healthy or successful simply in order to 'level the playing field'. However, policy can focus on levelling up, not down. Noting the health gaps between social groups indicates what might be possible for the whole population, and gives us goals to which we can aspire. If life expectancy at birth in 2001 can be 74.6 years for men and 79.8 for women in Edinburgh, this suggests that life expectancy of 69.2 for men and 76.5 for women in Glasgow could be improved.

Education, employment and income are often seen as key entry points for reducing social and health inequalities. Education provides literacy, numeracy, and analytical and communication skills which increase people's employability and ability to cope with a range of issues including health. Employment builds on these skills and provides income, and income provides access to health promoting resources such as housing, heating, food etc. Education, employment and income also enhance mental and social wellbeing and social inclusion. A long term evaluation of the High/Scope Perry pre-school program delivered as a randomised trial to high risk children in Michigan in the 1960s showed positive effects at age 27 on achievement test scores, grades, graduation from high school, home ownership and earnings, as well as negative effects on crime rates and welfare use, and estimated a sevenfold return on investment.

Most of the major drivers of the distribution of health in the population lie outside the NHS, however, the NHS has an important role to play in promoting health, preventing disease, and ameliorating the health damage caused by disadvantage. The 'inverse care law' (by which services tend to be least available to those who need them most) needs to be addressed across a whole range of services. Both NHS and wider determinants of health inequalities need to be tackled.

Area-based approaches are attractive because they allow for local involvement and ownership, many interventions or policies may be intrinsically area based (e.g. ensuring equitable access to good quality education, housing, health service, retail food outlets, public transport etc.) and it is often reasonably straightforward to identify areas in greater need. However, identifying deprived areas is not the same as identifying deprived people or households, because not all deprived people live in deprived neighbourhoods. It was estimated that if 20% of the most deprived postcode sectors in Scotland in 1991 were targeted, only 41% of unemployed people and 34% of low income households would have been captured. Thus area based initiatives need to be complemented by approaches which target disadvantaged individuals or households.

Box 1 summarises these policy principles, and others derived from the evidence about what works best (see below).

#### **Box 1: Principles for effective policies to reduce inequalities in health**

- maintain and extend equity in health and welfare systems
- address 'upstream' and 'downstream' causes
- level up not down
- reduce inequalities in life circumstances (especially education, employment, and income)
- prioritise early years interventions, and families with children
- address both health care and non health care solutions
- target, and positively discriminate in favour of, both deprived places and deprived people
- remove barriers in access to health and non-health care goods and services
- prioritise structural and regulatory policies
- recognise need for more intensive support among more socially disadvantaged groups
- monitor the outcome of policies and interventions, both in terms of overall cost effectiveness and differential cost-effectiveness
- ensure programmes are suitable for the local context
- encourage partnership working across agencies, and involvement of local communities and target groups

## What do we know about what works to reduce inequalities in health?

It is important to note a distinction between two questions: *does it work to improve health?* and *does it work to reduce health inequalities?* An intervention which, in general, works (e.g. dental health education) might have no effect on *health inequalities* if all SES groups benefit equally; increase them if the rich benefit more; and reduce them if the poor benefit more.

As has been noted in numerous recent reviews (see appendix), there is a lack of evidence about the effectiveness and cost effectiveness of policies, programmes, and projects in reducing inequalities in health. Attempts to conduct reviews in this field have all reported a lack of good primary evidence which could be summarised. Reasons for this lack of information include:

- Many evaluations of policies or programmes focus on inputs, throughputs and customer or professional satisfaction rather than on outcomes (e.g. the mapping exercise for Sure Start in Scotland)
- When evaluations do look at outcomes, health is often not studied (e.g. in 1999 a review found 10 randomised controlled trials of income supplementation schemes. Only one of these, however, looked at *health* outcomes [this showed that birthweight increased in higher risk experimental groups])
- Few interventions are rolled out in ways which permit rigorous evaluation: often they lack clear or measurable goals, baseline information, cost/benefit data, and control or comparison groups or areas
- Most evaluations focus on, and have sufficient sample size for, assessment of the *overall* effect (for example, overall reduction in smoking) but not on *differential* effects by SES
- Policies may take some time to have the desired effects
- Lack of UK studies (e.g. some early years interventions have been trialled in the USA where there is no free universal health care coverage or prenatal care. Additional home visiting for high-risk mothers in that context may have much larger effects than in the UK context where there is already universal access to general practice, prenatal care, health visiting etc.)

***Lack of robust evidence of effectiveness is not a justification for inaction.*** However, governments could learn more about what works by encouraging:

- evaluations which look at the actual health outcomes, rather than only at implementation issues.
- the implementation of policies or programmes in ways which facilitate more conclusive answers about effectiveness and cost effectiveness e.g. collection of baseline data and information about the value of the outcomes, and the use of control or comparison groups (e.g. by randomising areas or individuals to receive the intervention, or to early or late receipt of it).
- evaluations which explicitly examine the issue of differential impact by SES.
- appropriate use of relatively immediate indicators (e.g. breastfeeding rates, birthweight, obesity, respiratory function), as well later functioning, disease or mortality endpoints.
- consideration of the context in which evaluations have been undertaken, and the likelihood of interventions working in the Scottish and/or local context.

## What do we know about what is likely to reduce inequalities in health?

Recently there have been increasing attempts both to:

- conduct studies which specifically examine the differential effects on SES groups of specific policies or programmes, and
- to summarise and review what is known from existing studies.

The Appendix lists some organisations trying to pull together evidence. Many reviews examine the world literature (e.g. reviews of housing improvement, feeding supplementation, tobacco control policies) but some are more focused on Europe or the UK (e.g. area-based interventions). I am not aware of any reviews bringing together studies specifically from Scotland. Some general principles can, however, be established which are likely to be applicable to Scotland.

Interventions to reduce inequalities in health can be directed at one or more of three levels, e.g. in relation to diet:

- the structural or regulatory level (e.g. farming and trade policies, food labelling regulations, addition of vitamins to margarine and folate to flour)
- the local level (e.g. encouragement of food co-operatives, free fruit in schools, planning and rating policies to ensure the provision of affordable and healthy foods in deprived areas)
- individuals or families (e.g. nutrition education in schools or during pregnancy, mass media health promotion advice, weight loss clinics in general practice).

Interventions at the higher, more regulatory or structural, levels (Clean Air Acts, seat belt legislation, food supplementation, banning smoking in public places) appear to do more to reduce health inequalities than information based approaches (e.g. nutrition labelling, anti-smoking adverts, drink driving campaigns, etc.).

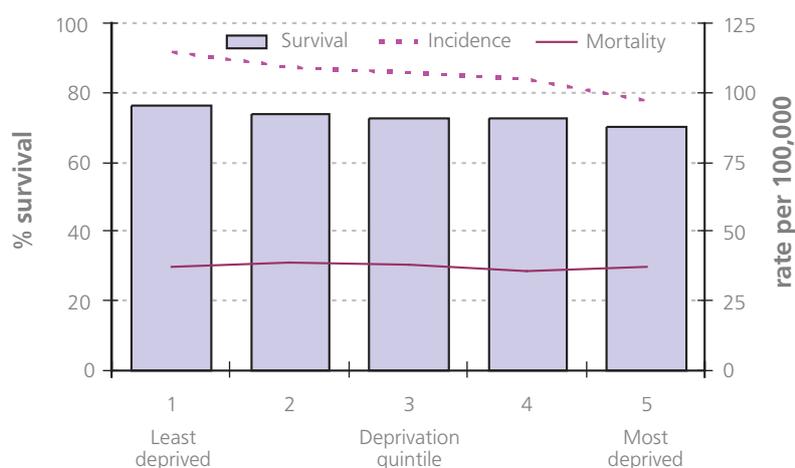
This is because more advantaged groups in society find it easier, because of better access to resources such as time, finance, and coping skills, to avail themselves of health promotion advice (e.g. to give up smoking, improve diet, use fluoride toothpaste etc.) and preventive services (e.g. immunisation, dental check ups and cervical screening). Disadvantaged groups tend to be harder to reach, and find it harder to change behaviour. A dental health education project in Scotland widened health inequalities in dental health because it was more successful among higher SES groups. A mass media campaign intended to reduce socio-economic differences in women's use of folic acid to prevent neural defects resulted in more marked social class differences in use than before the campaign.

This suggests that interventions with more disadvantaged groups may need to be much more intensive and targeted than might be appropriate for more advantaged groups: information based approaches such as food labelling, pamphlets in doctors' surgeries, and mass media campaigns, or those which require people to take the initiative to sign up for, may be less effective among more disadvantaged groups.

Although services may be relatively less effective for poorer people when they do sign up to them, this does not mean that such services do not contribute to reducing inequalities. Four studies in England and one in Glasgow have now found that NHS stop smoking services are effective in reaching smokers living in more disadvantaged areas. Research has consistently shown that more disadvantaged smokers are less likely to quit than their more affluent neighbours, but this can be offset by substantial positive discrimination in service delivery towards such groups. The impact of services in reducing rates of premature death in disadvantaged areas, and of reducing smoking-related inequalities in health, is a function of both reach and success. Very recent research in England has found that NHS stop smoking services are, overall, making a contribution to reducing inequalities, although their contribution is modest. This suggests the need to target resources towards more disadvantaged individuals and areas.

Poorer sections of society may also receive less benefit from lifestyle change or access to services; because they are still vulnerable to other damaging exposures, and/or their health may already be compromised by other factors. For example although the incidence of breast cancer is lower among more deprived women, survival rates are worse among them (a 6% 5 year survival rate between top and bottom deprivation categories, see Figure 6). A study in Glasgow showed that women from deprived areas are more likely to present with locally advanced or metastatic disease. A follow up of this study concluded that women living in affluent areas did not receive better NHS care, and that women from deprived areas seem to have greater co-morbidity. This suggests the need to address wider determinants of health and help seeking behaviour.

**Figure 7: Incidence, mortality and cause-specific survival at 5 years by deprivation quintile, Scotland, female breast cancer patients diagnosed 1991-95**



<http://info.cancerresearchuk.org/cancerstats/types/breast/survival/>

Some apparently promising interventions may not only increase inequalities in health, by benefiting the advantaged more, but may actually harm the more disadvantaged. The initial evaluation in England of Sure Start, an area based programme designed to tackle child poverty and social exclusion, found few significant differences between intervention and comparison areas, but some indication of adverse effects among the most deprived (the children of teenagers, lone parents, and workless households).

An Australian school based bicycle safety training programme was found to increase accident rates among boys and children of poorer families, both of whom already have higher accident rates. A review of UK area based regeneration initiatives showed some improvements in average employment rates, educational achievements, household income and housing quality, all of which may contribute to a reduction in inequalities in health, but it also noted that there can be an increase in housing costs which renders residents poorer, and that the original residents in the regenerated areas may have left the area. It is therefore very important to monitor the outcomes of social and public health policies, not only for their overall impact, but also for their potentially differential effects on socio-economic groups and the possibility of actual harm for some groups.

Boxes 2 and 3 give some examples of the types of interventions which current evidence suggest might be more and less likely to reduce inequalities in health; these are not exhaustive or prioritised, and those listed as less effective may be *effective in themselves*, just not the most effective *in reducing inequalities in health*.

**Box 2: Characteristics of policies more likely to be effective in reducing inequalities in health**

**Structural changes in the environment** (e.g. area-wide traffic calming schemes, separation of pedestrians and vehicles, child resistant containers, installation of smoke alarms, installing affordable heating in damp, cold houses)

**Legislative and regulatory controls** (e.g. drink driving legislation, lower speed limits, seat belt legislation, smoking bans in workplaces, child restraint loan schemes and legislation, house building standards, vitamin and folate supplementation of foods)

**Fiscal policies** (e.g. increase price of tobacco and alcohol products)

**Income support** (e.g. tax and benefit systems, professional welfare rights advice in health care settings)

**Reducing price barriers** (e.g. free prescriptions, school meals, fruit and milk, smoking cessation therapies, eye tests)

**Improving accessibility of services** (e.g. location and accessibility of primary health care and other core services, improving transport links, affordable healthy food)

**Prioritising disadvantaged groups** (e.g. multiply deprived families and communities, the unemployed, fuel poor, rough sleepers and the homeless)

**Offering intensive support** (e.g. systematic, tailored and intensive approaches involving face to face or group work, home visiting, good quality pre-school day care)

**Starting young** (e.g. pre and post natal support and interventions, home visiting in infancy, pre-school day care)

**Box 3: Characteristics of interventions less effective in reducing inequalities in health**

**Information** based campaigns (mass media information campaigns)

**Written** materials (pamphlets, food labelling)

Campaigns reliant on people taking **the initiative to opt in**

Campaigns/messages designed for the **whole population**

**Whole school health education approaches** (e.g. school based anti smoking and alcohol programmes)

Approaches which involve significant **price or other barriers**

Housing or regeneration programmes that **raise housing costs**

**Possibly competing goals**

Because of the likelihood of the better off gaining more from social and public health policies, two public health goals; *improving population health* and *reducing health inequalities*, may sometimes conflict. Targeting the already advantaged may produce more aggregate health gain (e.g. reducing the overall prevalence of cigarette smoking in Scotland) at relatively less cost, whereas targeting the disadvantaged may produce less aggregate health gain (less decrease in overall prevalence) and at greater cost. Value judgments may have to be made about the relative priority to be given to creating aggregate health gain as compared to reducing inequalities.

The views expressed here are my own and do not necessarily reflect the official policies of the Medical Research Council or the Chief Scientist Office of the Scottish Government Health Directorates (who fund my work).

**Sally Macintyre 6 September 2007**

## APPENDIX 1:

### CHRONOLOGY OF SELECTED REPORTS AND ACTIONS ON INEQUALITIES IN HEALTH IN THE UK

**1975** Sir John Brotherton, CMO in Scotland, reviewed mounting evidence for continuing and increasing inequalities in health, despite the introduction of the NHS and Welfare State.

**1980 Black** report on *Inequalities in Health*, making 37 recommendations, prioritizing giving children a better start in life and a wider anti-poverty strategy. Patrick Jenkin, the new Secretary of State, did not endorse the proposals.

**1995 Metters** report '*Variations in Health: What can the Department of Health and the NHS do?*' published. Commissioned a literature review on the evidence of effectiveness of practical public health interventions, which noted a lack of evidence. Recommended that the NHS should have a plan for identifying and tackling variations and evaluating interventions, and should work to ensure equitable access to services.

**1998 Acheson** report '*Independent Inquiry into Inequalities in Health*' published. 39 recommendations; key priorities similar to those of Black report, namely:

- All policies likely to have an impact on health should be evaluated in terms of the impact on health inequalities.
- High priority should be given to health of families with children.
- Further steps should be taken to reduce income inequalities and improve living standards of poor households.

The evaluation group (which I chaired) found that the submissions to the Acheson Group contained a wealth of descriptive and explanatory material on inequalities in health, but much less evidence about the effectiveness of interventions aiming to reduce these inequalities, and virtually nothing on cost effectiveness.

**1999** '*Towards a Healthier Scotland: a White paper on Health*' published. Overarching aim to tackle inequalities; specified 3 action levels for better health:

- life circumstances.
- lifestyles.
- health topics.

It set targets for lifestyles and health topics but not life circumstances.

**2001** Secretary of State for Health (England) published national health inequalities targets: to narrow the gap in life expectancy between areas, and reduce the difference in infant mortality between social classes, by 10% by 2010.

**2001 Health Development Agency** (England) reviews evidence on public health research in the UK. Found that:

- Of published or funded public health research in UK, 4% deal with interventions rather than descriptions of the problem
- Only 10% of them (0.4%) deal with outcomes of interventions
- In specific topic areas evidence about inequalities, and tools for capturing social differences, not very robust
- Very few systematic reviews have focused on effect of interventions on inequalities in health.

**2002** HM Treasury and the Department of Health (England) publish *'Tackling Health Inequalities: a Cross Cutting Review'* (CCR). It identified 5 themes:

- breaking the cycle of health inequalities (by early years interventions)
- tackling the major killers
- improving access to public services and facilities
- strengthening disadvantaged communities
- supporting targeted interventions for specific groups.

**2003** Department of Health (England) publishes *'Tackling Health Inequalities: A Programme for Action'*. This reported how they proposed to implement the CCR, and prioritized 4 themes:

- Supporting families, mothers and children
- Engaging communities and individuals
- Preventing illness and providing effective treatment and care
- Addressing the underlying determinants of health.

**2003** Scottish Executive publishes *'Report of measuring inequalities in health Working Group'*. This recommended against setting targets for the reduction of inequalities, but proposed 23 indicators by which progress could be measured.

**2003** *'Improving Health in Scotland: the Challenge'* endorsed previous commitments to tackling health inequalities as an overarching aim of the health improvement agenda. This had 4 themes:

- Early years.
- The teenage transition.
- The workplace.
- Community-led.

**2004 Wanless Report** *'Securing Good Health for the Whole Population'* (commissioned by HM Treasury) published. Noted that:

'Although there is often evidence on the scientific justification for action and for some specific interventions, there is generally little evidence about the cost-effectiveness of public health and preventative policies or their practical implementation... and little evidence about what works among disadvantaged groups to tackle some of the key determinants of health inequalities.'

**2005 Department of Health (England) 'Tackling health inequalities: Status report on the Programme for Action'. Showed:**

- a continuing widening of inequalities as measured by infant mortality and life expectancy;
- an inconclusive picture on other indicators 'but with progress on child poverty and housing'.

**1996 onwards** increasing efforts to get better evidence on how to reduce inequalities in health, by groups including:

WHO European Office for Investment for Health and Development (Venice)

Health Development Agency (England), now incorporated into:

Centre for Public Health Excellence, NIHC (England)

Campbell/Cochrane Collaboration Health Equity Field

Cochrane Collaboration Health Promotion and Public Health Field

Centre for Reviews and Dissemination (England)

NHS Health Scotland

MRC/CSO Social and Public Health Sciences Unit, Glasgow

# 3. KEY STATISTICS ON HEALTH INEQUALITIES – SUMMARY PAPER

## SCOTLAND IN CONTEXT

### 1.1 Inequalities within Scotland

In Scotland today, there is evidence of significant health inequalities in terms of mortality, physical illness, mental health and wellbeing, lifestyle behaviours associated with ill health and access to and use of health services. Deprivation and socio-economic inequalities are of particular policy interest. Inequalities are also evident according to gender, age, education, ethnicity, sexual orientation and the presence of disability or mental health problems. An overview of statistics on health inequalities is provided in a separate background paper: "Statistics on Health Inequalities – An overview". <http://www.scotland.gov.uk/Topics/Health/inequalitiestaskforce/overviewofstatistics>. In this paper, the term inequalities refers to deprivation inequalities unless otherwise stated.

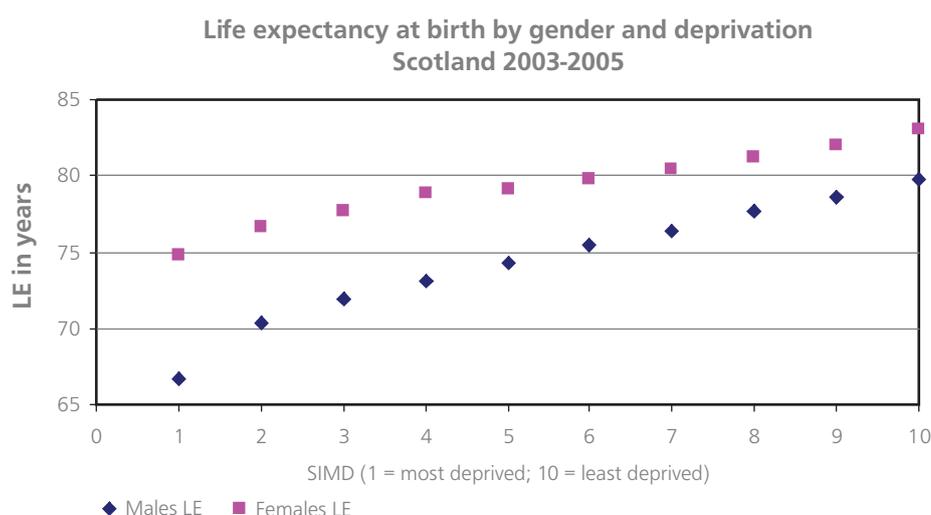
Most of the statistics available on health inequalities are simple breakdowns by a single determinant, which do not take into account the influence of other factors associated with the health indicator concerned. In reality, there will be complex interactions between factors that contribute to the initiation or exacerbation of particular conditions or the lifestyle choices people make. In addition to this, it is difficult to investigate issues affecting some groups, because of the relatively small numbers of people involved and/or because little information has been collected about them. In particular, this is an issue for ethnic minority groups in Scotland, religious groups, groups defined by their sexual orientation and transgender people.

Life expectancy and healthy life expectancy are often used as indicators of the overall health of the population – and of inequalities between different sections of the population. There is a clear pattern of increasing life expectancy with decreasing deprivation in Scotland. Life expectancy is also consistently higher for Scottish women than men<sup>1</sup> (Figure 1).

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<sup>1</sup> General Register Office for Scotland GRO(S)

Figure 1



Source: General Register Office for Scotland GRO(S)

A similar pattern is observed for healthy life expectancy: males in the least deprived fifth of the Scottish population are expected to live 94% of their life in good health – compared with 85% in the most deprived fifth; females in the least deprived fifth are expected to live 93% of their life in good health – compared with 84% in the most deprived fifth of the population.<sup>2</sup>

## 1.2 Scotland compared to the United Kingdom and Europe

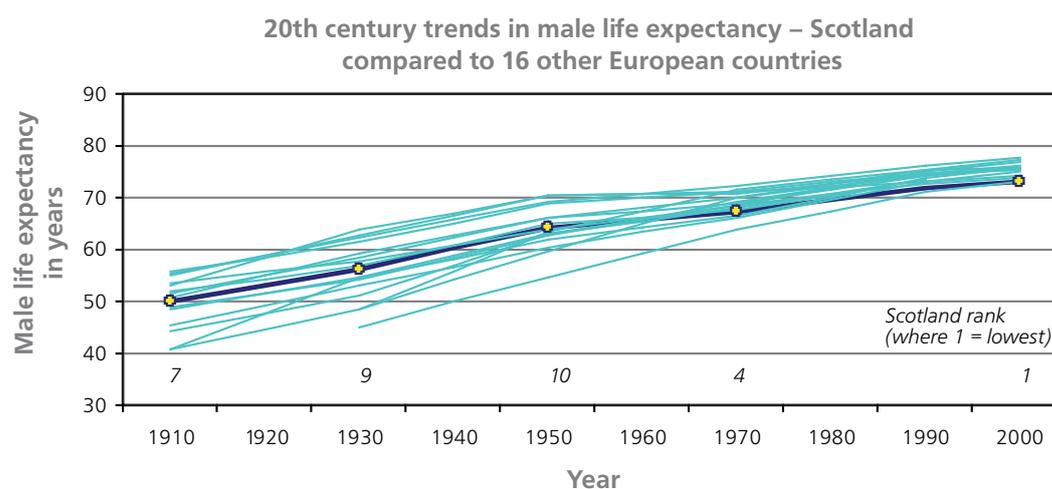
In terms of health and mortality, Scotland generally compares unfavourably with the rest of the United Kingdom, the European average, other small countries in Europe and is frequently more on a par with Eastern European countries than with its more affluent neighbours.

This is often because particularly poor performance in the most deprived and disadvantaged areas or population dominate the overall picture for Scotland. However, some European nations have healthier populations than Scotland despite having higher levels of poverty and deprivation. Ongoing research by the Glasgow Centre for Population Health and NHS Health Scotland is comparing Scotland/West of Scotland with similar regions in Europe (in terms of a shared history of industrialisation and subsequent deindustrialisation) and examining trends in health outcomes (e.g. mortality) and health determinants. Initial analyses have shown that despite many comparable European regions having apparently worse socio-economic profiles, their life expectancy appears to be higher and/or increasing at a faster rate than is the case in Scotland/West of Scotland. In-depth analysis of age and cause specific mortality has highlighted a number of key 'drivers' behind these trends including higher death rates from external causes such as suicide and alcohol misuse for working age men and higher rates of cancer and circulatory diseases amongst women aged 45 to 64. The results of this stage of the project will be published by the end of the year. Thereafter, further work will be undertaken to collate a broad range of health determinant data, and the analysis will be extended to cover regions which – from analysis already undertaken – appear the most similar to Scotland/West of Scotland in terms of their current socio-economic status.

Scotland's relative position in Europe has not always been so bad. Scotland now lags behind because improvements since the beginning of the 20th century have been at a slower rate than for most other European countries<sup>3</sup> (Figure 2).

<sup>2</sup> Wood et al; *Measuring inequalities in health: the case for healthy life expectancy*; Journal of Epidemiology and Community Health; 2006; Vol 60; pp1089-1092.

<sup>3</sup> Leon, David; 2002; Scotland's Health in an International Context

**Figure 2**


Source: Leon D; Government Actuary Department (for 2000 figures)

## 2 Factors contributing to inequalities in life expectancy and healthy life expectancy

Life expectancy is estimated using mortality rates in the population at a given time. Healthy life expectancy is estimated using a combination of mortality rates and indicators of ill-health or disability (people's assessment of their health and/or the presence of limiting long-term illness).

The most common causes of death do not correlate with the most common causes of ill-health (based on GP contact data and inpatient diagnoses) because most of the reasons people attend a GP or hospital are not immediately life-threatening and can be treated (Tables 1 and 2).

**Table 1**

<b>Ten most common causes of death, Scotland 2003-05</b>	<b>Percentage of total %</b>	<b>Estimated deaths per year N</b>
Heart attack	11.3	6,419
Coronary heart disease (CHD)	7.5	4,260
Cancer of the bronchus and lung	6.9	3,919
Chronic obstructive pulmonary disease (COPD)	4.9	2,783
Pneumonia	4.5	2,556
Stroke	4.3	2,442
Dementia	2.5	1,420
Complications arising from stroke	2.5	1,420
Cancer of the breast	2.0	1,136
Cancer (site unspecified)	1.7	966
Other causes of death	51.9	29,480
<b>Total</b>	<b>100.0</b>	<b>56,802</b>

Source: Scottish Public Health Observatory; General Register Office for Scotland

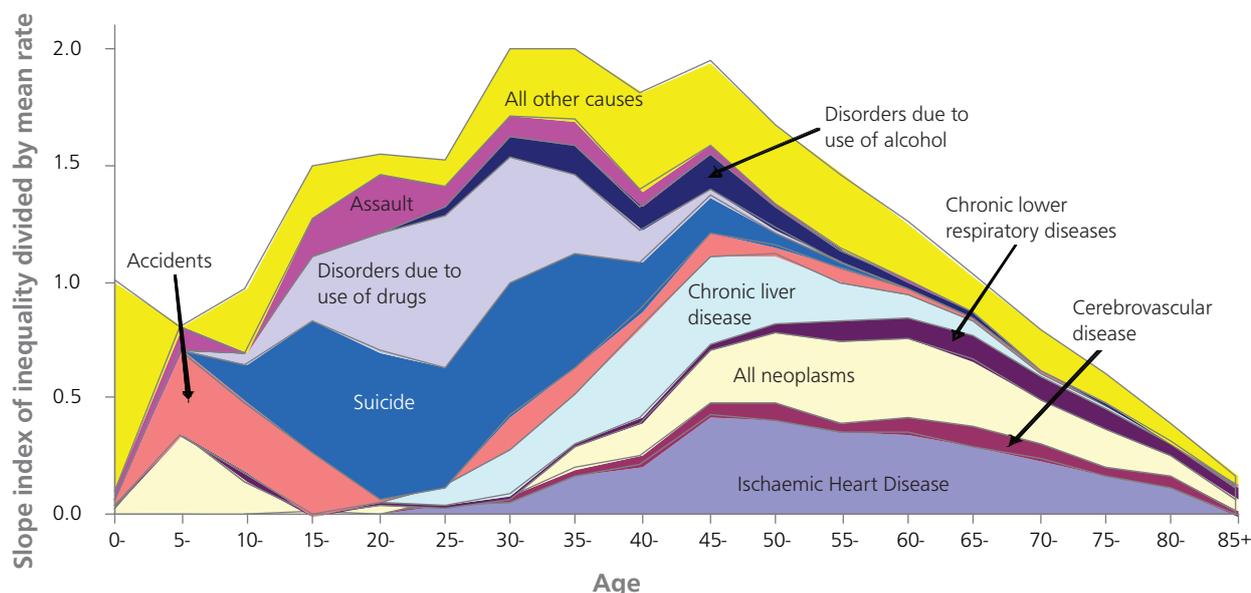
**Table 2**

Ten most common GP consultation diagnoses, Scotland 2005/06	Estimated contacts N	Ten most common in-patient primary diagnoses, Scotland 2005/06	Diagnoses N
Digestive/abdominal signs and symptoms	827,550	Cancers	189,192
Diseases of the skin and subcutaneous tissue	792,100	Digestive system	169,078
General abnormal signs and symptoms	737,000	Circulatory system	140,971
Circulatory and respiratory signs and symptoms	733,700	Injury, poisoning etc.	106,737
Depression and other affective disorders	655,650	Respiratory system	93,929
Back and neck disorders	627,600	Genitourinary system	77,875
Acute upper respiratory infections	609,550	Muculoskeletal and connective tissue	69,343
Diseases of upper respiratory tract	558,650	Eye and related to eye	36,406
Soft tissue disorders	555,100	Skin and subcutaneous tissue	29,206
Hypertension	503,450	Nervous system	28,320

Source: Information Service Division (ISD)

In addition, people's own assessment of their health (on which healthy life expectancy is based) will be influenced by their mental health and wellbeing. Poor mental health and wellbeing has also been widely associated with an increased likelihood of poor physical health and decreased survival. Deprivation inequalities in mental health and wellbeing (of which evidence is presented in the statistics overview paper) are likely to contribute to the gaps in both life expectancy and healthy life expectancy.

Leyland et al<sup>4</sup> highlighted large relative inequalities in deaths amongst young men and women, most notably relating to deaths from accidents, suicide, disorders due to the use of drugs and assault (Figure 3). These relative inequalities do not however take into account the absolute number of deaths. Some of the biggest inequalities observed are based on relatively small numbers of deaths, which are unlikely to be making a significant contribution to deprivation differences in overall life expectancy. Relative inequalities in deaths from cancer, circulatory disease and respiratory disease may look less dramatic, but the number of deaths involved make up a considerable proportion of total mortality – and therefore are more likely to make a significant contribution to overall life expectancy.

**Figure 3****Relative inequalities in mortality by cause, men, Scotland 2001**

4 Leyland et al; *Inequalities in mortality in Scotland 1981-2001*; MRC Social and Public Health Science Unit, Glasgow; 2007

Leyland's analysis also shows that in recent years mortality rates among young men in disadvantaged areas have been increasing at a time when rates across the rest of the population have been decreasing. If this trend were to continue, it could feed through to even higher rates as this group gets older. For example, drug injecting is much more common among young men and women in disadvantaged areas. Many drug injectors have become infected with hepatitis C and the number who are developing serious and potentially fatal liver disease as a result is steadily increasing.

There is ample evidence of deprivation inequalities in mortality from Scotland's biggest killers (coronary heart disease, cancer and stroke). The largest absolute number of deaths from these conditions occur in the oldest age groups, but this is also where inequalities tend to have narrowed. Reductions in the deprivation gap in life expectancy could however be achieved through reductions in the number of premature deaths from these conditions – and from the other conditions most commonly causing deaths amongst the under 65s (Table 3).

**Table 3**

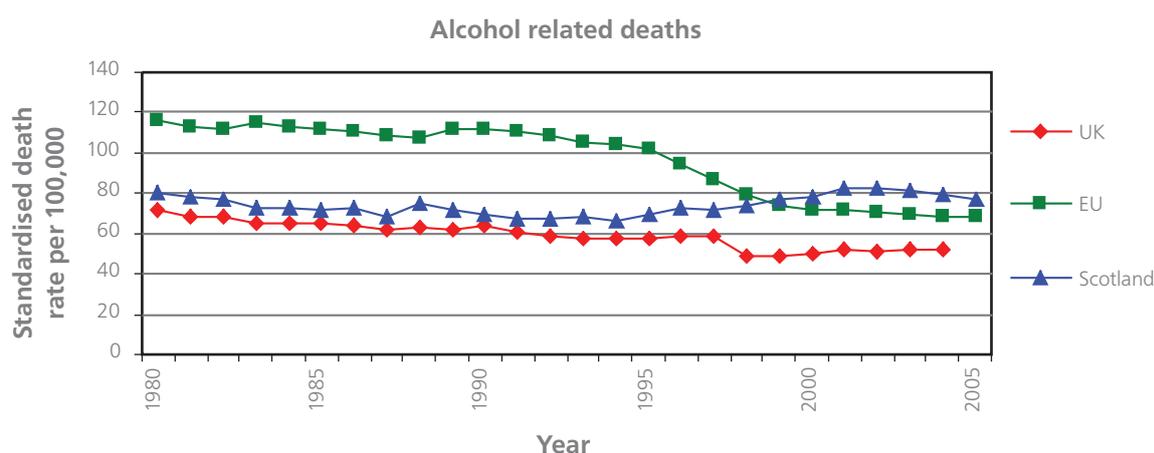
<b>Ten most common causes of death amongst the &lt;65s, Scotland 2003-05</b>	<b>Percentage Estimated of total deaths per year</b>	
	<b>%</b>	<b>N</b>
Cancer of the bronchus and lung	8.2	922
Heart attack	7.8	877
Coronary heart disease (CHD)	6.8	765
Alcoholic liver disease	6.4	720
Cancer of the breast	3.6	405
Alcohol related mental and behavioural disorders	2.6	292
Chronic obstructive pulmonary disease (COPD)	2.5	281
Intentional self harm (hanging, strangulation and suffocation)	2.4	270
Cancer of the oesophagus	1.8	202
Cancer (site unspecified)	1.6	180
Other causes	56.3	6,333
Total	100.0	11,248

Source: Scottish Public Health Observatory

It is also important to consider trends over time, because inequalities in factors lower down the list of common causes of death might become more important in future years. In particular, alcohol related deaths are increasing in Scotland, whilst they are decreasing elsewhere in Europe (Figure 4). If these trends continue, alcohol related deaths could overtake the other main causes of death (for which mortality rates in all deprivation groups are decreasing over time). There are around five times as many alcohol related deaths in the most deprived fifth of areas in Scotland compared with the least deprived fifth of areas.

Another cause of morbidity and mortality which is increasingly becoming a public health priority is chronic obstructive pulmonary disease (COPD). Although there are currently no statistics available on deprivation inequalities in COPD, marked deprivation inequalities in smoking (which is the major risk factor for developing COPD) suggest that deprivation inequalities in COPD are inevitable.

Figure 4



Source: Scottish Public Health Observatory

## 2.1 The role of smoking in health inequalities

It has recently been estimated that smoking accounts for about 24% of all deaths in Scotland, rising to as much as 34% in some areas.<sup>5</sup> It has been estimated that lifelong smokers die on average about 10 years younger than non-smokers.<sup>6</sup> Smoking also causes a great deal of long-term ill-health due to diseases of the heart, lung and arteries and a long list of cancers and other conditions.

There is a currently a clear relationship between smoking and deprivation. The most recent Scottish Household Survey shows adult smoking rates varying from 12% in the least deprived fifth of the population to 41% in the most disadvantaged. This is a huge change from the situation fifty years ago when around 80% of men and 50% of women were smokers across the whole population. The decline in smoking rates can explain much of the decrease in rates of coronary heart disease and almost all the decrease in rates of lung cancer among men. It can also explain much of the widening health inequality between affluent and deprived areas, because smoking rates have dropped much faster in the former. A large international study, involving the United Kingdom, concluded that between half and two-thirds of the inequalities between high and low income men in Europe are due to smoking.<sup>7</sup>

A recent 28 year follow-up study of over 15,000 men and women in Renfrew has shown clearly that even the most affluent smokers experience higher mortality rates and die sooner than non-smokers living in the most disadvantaged areas.<sup>8</sup> The study also found that the differences in mortality rates between smokers and non-smokers were much larger than those between high and low income groups of the same smoking status (Figure 5). It has also been shown that people who stop smoking can expect to live longer as a result, recovering 9 years if they stop at age 30 down to 3 years at 60. These findings show clearly that there is a huge health inequality between smokers and non-smokers, regardless of socio-economic circumstances.

<sup>5</sup> Atlas of Tobacco Smoking in Scotland, Health Scotland 2007

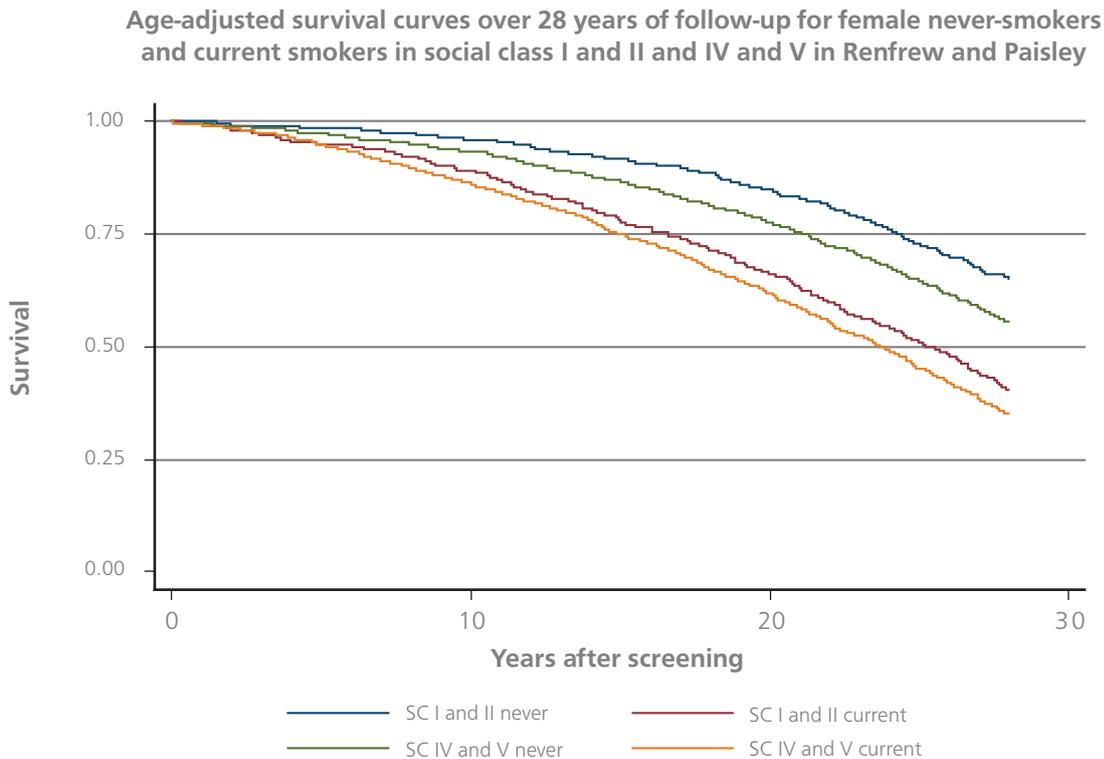
<sup>6</sup> Doll R, Peto R, Boreham J, Sutherland I. Mortality in relation to smoking: 50 years observations on male British doctors. *BMJ* 2004; 328: 1519-33.

<sup>7</sup> Jha P, Peto R, Zatonski W, Boreham J, Jarvis M, Lopez A. Social inequalities in male mortality from smoking: indirect estimation from national death rates in England and Wales, Poland and North America. *Lancet* 2006; 368: 367-70.

<sup>8</sup> Gruer L, Hart C, Watt G, Gordon D; 2007; Smokers die younger, regardless of sex or social position: 28 years of follow-up of a large prospective cohort in the United Kingdom. Submitted for publication.

At the same time, smoking explains at least half the health inequalities related to socio-economic circumstances in Scotland because smoking rates are currently much higher in more disadvantaged areas. For these reasons helping people to stop smoking and discouraging children and young people from starting, regardless of their social circumstances, should remain the top priority for health improvement in Scotland for the foreseeable future. Equally, targeting efforts to help more disadvantaged people stop smoking offers the best opportunity for reducing health inequalities related to socio-economic circumstances in the medium term.

**Figure 5**



Source: Gruer et al

**2.2 Other risk factors**

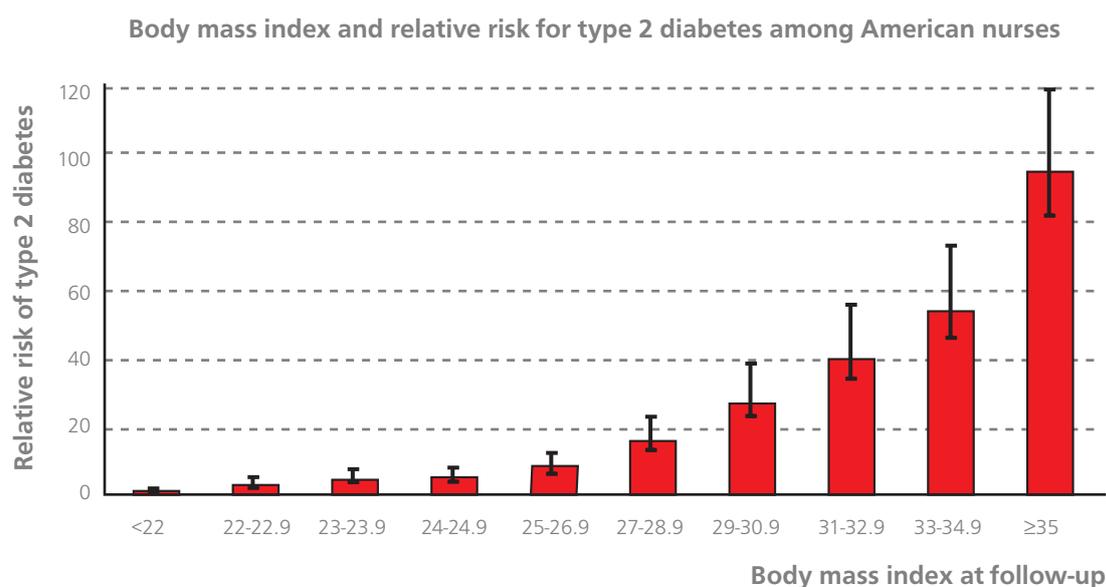
Relationships between other lifestyle or risk factors and deprivation are however less clear, for example:

- Binge drinking amongst men appears to increase with increasing deprivation, but weekly consumption of alcohol does not follow the same pattern.
- There is no clear relationship between physical activity and deprivation for adults or children.
- Rates of obesity increase with increasing deprivation for adult women, but not for men or children.

It is likely that this lack of clear evidence of simple relationships with deprivation is due to the complexities of factors determining lifestyle choices and outcomes such as obesity rather than an absence of inequalities.

Just as smoking in itself is a cause of severe health inequalities, so is obesity. Follow up studies are increasingly showing the big increases in risk due to obesity of diabetes, heart disease, breast, bowel, prostate and other cancers, osteoarthritis, dementia and other conditions. Figure 6 shows the huge increase in risk of diabetes that accompanies increasing levels of obesity as measured by body mass index. Thus although the relationship between obesity and socio-economic circumstances is not clear cut, the relationship between obesity, regardless of social circumstances, and health inequality is unarguable. Obesity is a growing cause of ill-health that threatens to cancel out many of the health gains made over the past 20 years.

**Figure 6**



Source: Colditz et al 1995

Relationships between unemployment or poverty and poor mental and physical health are also well documented. Not only does poor health prevent people from being economically inactive, there is also evidence that being unemployed or in financial difficulty increases the likelihood of becoming disabled,<sup>9</sup> increases stress<sup>10</sup> and leads to low levels of social inclusion, which is a risk factor for poor mental health and coronary heart disease.<sup>11</sup>

9 Burchardt et al (2003)

10 Mackenback et al (2005)

11 Bosmoa et al (2007)

## 2.3 Health inequalities in the early years

There is mounting evidence of markedly widening inequalities between higher and lower income groups in a range of factors that have a profound influence on the future health of children now being born in Scotland. This is observed in both routine statistics and those from various studies, notably Growing Up in Scotland which published its first report in early 2007. This is a prospective study of a representative sample of about 8000 babies and toddlers and their parents, recruited in 2005.<sup>12</sup> It shows that children born to parents in the lowest income quintile are much more likely than others to have been affected by maternal smoking, drinking or drug use during pregnancy, to have a single, teenage mother, not to have been breast-fed, to be exposed to secondhand tobacco smoke at home, to be weaned onto an unhealthy diet, to have poor dental health, and to receive relatively little stimulation. For many of the estimated 41,000-59,000 children in Scotland with at least one parent who is a problem drug user and at least as many again with one or both parents who are problem drinkers, the prospects may be even bleaker.<sup>13</sup> All these adverse interacting factors are creating profound disadvantage for large numbers of children which contrast starkly with the unprecedented prospects for good health experienced by children at the other end of the social spectrum. Success in reducing these inequalities is essential if the health gap is not to become even wider for the next generation.

## 3 Trends in inequalities over time

Improvements over time in Scottish life expectancy and healthy life expectancy have been observed. However, healthy life expectancy is increasing at a slower rate than life expectancy – meaning that people are living longer, but that more of these years are spent in ill health (Figure 7).

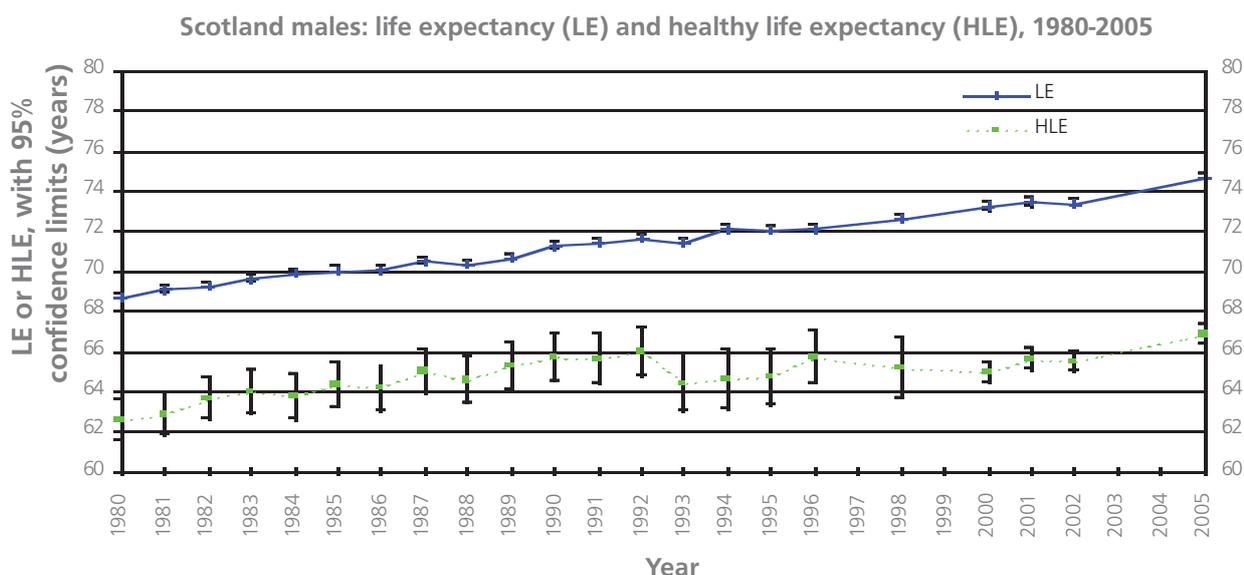
Improvements in life expectancy have been greatest amongst the least deprived population. The deprivation inequality gap in life expectancy therefore appears to be widening over time – and particularly for males (Figure 8). The gender inequality gap is, however, narrowing over time.

Evidence of trends over time in deprivation inequalities in healthy life expectancy is not currently available. The Scottish Public Health Observatory is however due to publish a report with updated estimates of healthy life expectancy in autumn 2007, which should address this.

<sup>12</sup> <http://www.growingupinScotland.org.uk/>

<sup>13</sup> Gruer L et al. Hidden Harm: responding to the needs of children of problem drug users. London, Advisory Council on the Misuse of Drugs, Home Office 2003. [www.drugs.gov.uk](http://www.drugs.gov.uk)

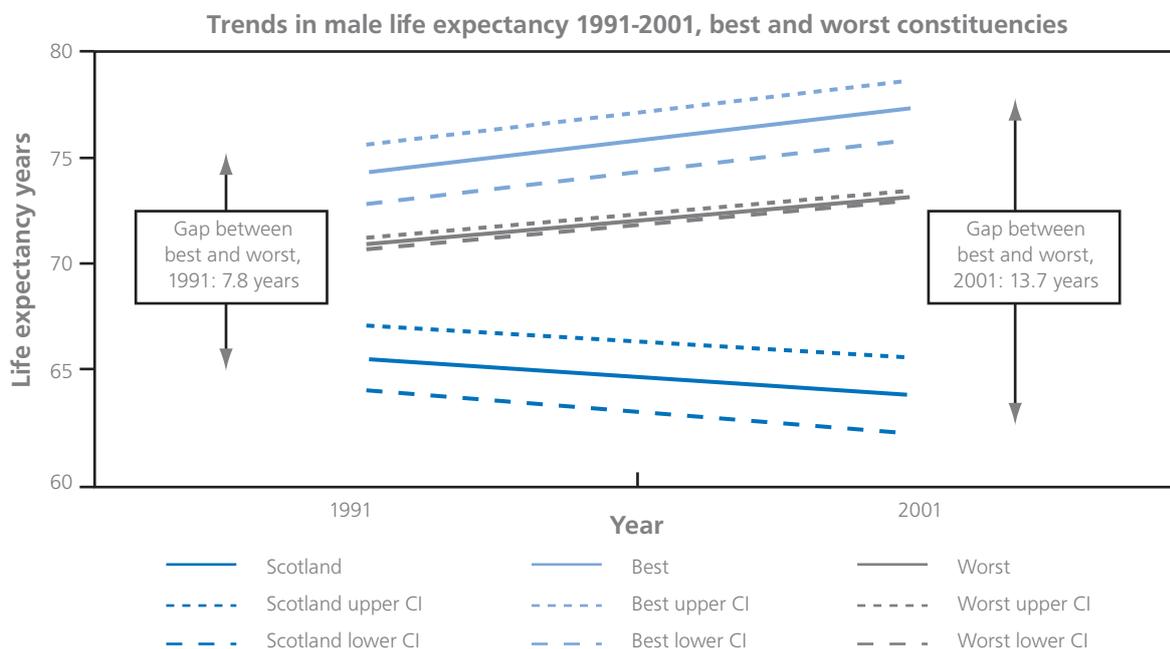
Figure 7



Source: Scottish Public Health Observatory

Note that a similar pattern is observed for females, but with life expectancy and healthy life expectancy 5 years and 2 years higher respectively.

Figure 8



Assessment of whether there has been a widening or a narrowing in inequalities for individual indicators is hindered by the fact that the majority of routinely published statistics focus on current inequalities and do not show trends over time. A few key examples are however available. A narrowing in deprivation inequalities over time has been observed for:

- Dental health of children (reduction in signs of decay has been greater in the most deprived areas, coinciding with a higher increase in dental access in the most deprived areas).

- Breastfeeding (higher percentage increase in breastfeeding rates at 6-8 weeks in the most deprived areas compared to the least deprived areas).

Meanwhile, a widening over time has been observed for all cause mortality (hence the widening gap in life expectancy). This would suggest that there has been a widening in deprivation inequalities for many causes of death.

Evidence of trends in deprivation inequalities is available from target monitoring information. In 2004, the Scottish Executive set targets “to improve the health and the quality of life of the people of Scotland and to deliver integrated health and community care services making sure there is support and protection for those members of society who are in greatest need”. National inequalities targets were set to reduce health inequalities by increasing the rate of improvement across a range of indicators for the most deprived communities by 15% by 2008. The indicators selected were:

- Smoking during pregnancy.
- Adult (aged 16+ years) smoking rates.
- < 75 coronary heart disease mortality.
- Teenage pregnancy (aged 13-15 years).
- Suicide amongst young people (aged 10-24 years).
- < 75 cancer mortality.

The target itself is concerned with improvement in the most deprived areas. For all the indicators, rates are decreasing in the most deprived areas and all but one (teenage pregnancy) are currently on track to meet their 2008 target level.

Improvement in the rest of the population has also been monitored to identify trends in inequalities. The measure of inequality used (ratio of the rate in the most deprived areas to the rate in the most affluent areas) suggests that since the start of the target period, inequalities have widened for four of the six indicators, because the improvement in the most affluent areas has been greater than in the most deprived areas. The two indicators currently showing a narrowing in health inequality during the target period are suicides amongst young people and <75 mortality from coronary heart disease. However, it is important to note that there is fluctuation in the inequality ratio from year to year and often the longer term trend in inequality is not consistent with the trend during the target period. Most notably this is the case for <75 deaths from coronary heart disease, which shows a broadly increasing trend in inequality since the early 1990s (see Figure 7).

Please note also that alternative measures of inequality do not necessarily paint the same picture (see Section 5 of this paper).

## 4 Should inequalities be tackled using a geographical approach?

### 4.1 Area based definitions of deprivation

Deprived populations tend to be concentrated in particular geographical areas, hence the use of area based definitions to identify them. However, not all people living in areas defined as deprived are disadvantaged and vice versa. Targeting only areas defined as having the highest concentrations of deprived population will not include deprived people living elsewhere.

In addition to this, most indicators showing deprivation inequalities demonstrate a linear relationship between increasing deprivation and worsening outcomes or health. Targeting only the most deprived therefore fails to address the intermediate groups and so will not improve inequalities observed in the rest of the population.

## 4.2 The Glasgow effect

Inequalities between the health of people in Glasgow and West Central Scotland compared to the rest of the country are well documented. Glasgow has some of the highest levels of deprivation in Scotland as well as some of the most affluent small areas in the country. The evidence indicates that inequalities between Glasgow and the rest of Scotland are present regardless of deprivation or social class, for example:

- Leyland et al showed that the male mortality rate in each social class was higher in Glasgow than in Clydeside as a whole, and was higher in Clydeside than in the whole of Scotland and concluded that differences in the social structure of the population could not clearly explain the region's higher mortality rate.
- The Glasgow Centre for Population Health has demonstrated that following adjustments for socio-economic circumstances, health in West Central Scotland is significantly worse than elsewhere in Scotland. This was observed for indicators of mortality, physical illness, mental health and lifestyle behaviours associated with health.

Coupled with the fact that the population of this region represents over a quarter of Scotland's total population and that it has some of the highest levels of deprivation, this evidence suggests that putting a particular emphasis on improving the health of people in the Glasgow region should improve the overall population health for Scotland and reduce overall health inequalities. It also suggests that the determinants of health in the Glasgow region may be different to the rest of Scotland, perhaps calling for different approaches than would be used elsewhere.

## 5 Measurement of inequalities

### 5.1 Measures of deprivation

Since 2004, the recommended measure of deprivation is the Scottish Index of Multiple Deprivation (SIMD). Before the development of SIMD, the measure traditionally used in health analysis was the Carstairs Index. The Carstairs Index does not identify the most deprived areas as accurately as SIMD, because it is based on fewer indicators of deprivation and is produced for larger geographic areas. Therefore, deprivation inequalities often appear greater when SIMD is used.

The majority of routinely published statistics are now based on SIMD. However, the inequalities targets developed by the Scottish Executive are based around the Carstairs Index split into five groups, because this was the recommended measure at the time of their development. It is important to be aware that analysis of these indicators using SIMD identifies higher levels in the most deprived areas and larger inequalities between the most and least deprived.

In addition to this, some analyses compare the most deprived fifth (20%) with the least deprived fifth of areas (quintiles), whilst others use the extreme 10% groups (deciles) and others use the most deprived 15% of the population compared to the rest of the population. Comparison of the most extreme groups will usually indicate the biggest inequalities.

***It is recommended that where possible future targets use SIMD deciles to define deprivation.***

### 5.2 Inequality measures

Since the development of the 2004 inequalities targets, various studies have investigated alternative methods of analysing and monitoring inequalities over time. The methods investigated include:

- absolute range (absolute difference between rates in the most and least deprived groups).
- relative range (ratio of rate in the most deprived areas to rate in the least deprived areas – *currently used for the existing targets*).

- slope index of inequality (SII) and relative index of inequality (RII) (which are sensitive to the mean health status of the population and can be interpreted as the absolute effect on health of moving from the lowest socioeconomic group through to the highest).
- concentration index (which allows analysis of the extent to which poor health is concentrated amongst those in the most disadvantaged groups).
- population attributable risk (PAR) (which measures the proportion of disease in the study population that is attributable to exposure to a particular factor and thus could be eliminated if that exposure were eliminated).

These different methods have pros and cons, for example: ratios in themselves do not give information about absolute improvement and will not inform about performance across the intermediate groups of population; the slope index of inequality and relative index of inequality only work well if there is a reasonably linear relationship between deprivation and the health indicator of interest. It is also important to note that measures of inequality will not necessarily work in localised situations where gradients between deprivation groups defined at a national level might not apply.

A recent review of approaches to measuring socio-economic inequalities in health (by the Scottish Public Health Observatory) recommended that measures are selected on a case by case basis and concluded that using a combination of approaches is often the best way to ensure that inequalities are fully understood.

***It is recommended that a combination of measures is used to measure inequalities associated with targets.***

### 5.3 Measuring the costs of health inequalities

A reduction in health inequalities, by improving the health of those most deprived, is likely to result in a reduction of costs to the NHS and society as a whole. Such cost savings are difficult to estimate, because of the methods involved and also because of the wide range of inequalities that exist. However, despite these difficulties, this type of analysis has been attempted for several health issues and these suggest that there are significant costs associated with preventable illnesses, particularly when wider economic and social costs are set alongside costs to the NHS. For example, in 2002-03 alcohol is estimated to have cost NHSScotland £110.5m and the wider economic, human and social costs amounted to some £736m.<sup>14</sup> Of the topics on which costs have been calculated for Scotland (alcohol, smoking, obesity, mental illness, teenage pregnancy, asthma), mental illness is estimated to incur the highest costs – £1574m to the NHS and £7,071m in wider economic and social costs.<sup>15</sup> A similar analysis for England also ranked mental illness as having the largest societal cost. There are a number of important caveats regarding the presentation of information on the cost of inequalities and these are discussed more fully in the background paper: “Statistics on health inequalities – an overview”.

#### October 2007

<sup>14</sup> Alcohol Misuse in Scotland (January 2005)

<sup>15</sup> Lister et al (2005) ‘The Societal Costs of Potentially Preventable Illnesses: A possible approach’

# 4. COSLA PAPER: THE ROLE OF LOCAL GOVERNMENT

## TACKLING HEALTH INEQUALITIES – THE ROLE OF LOCAL GOVERNMENT

### Summary

- COSLA's submission to the Joint Ministerial Task Force on Health Inequalities addresses two main issues: how do we tackle the causes of health inequalities; and how do we respond to the consequences of health inequalities? In doing so, it makes the point that public services are currently well equipped to deal with the manifestation of health inequalities, but that we need to become more effective at dealing with the causes.
- The submission argues that the key to success in tackling the causes of health inequalities lies in effective targeted intervention during the early years of a child's development. This is best done in an holistic manner that links work on health inequalities to the development of an early years strategy.
- We need to become more adept at understanding what works in tackling the causes of health inequalities. To this end, it is suggested that knowledge sharing networks should be established to ensure that practitioners have the tools, skills and resources to make an impact on health inequalities.
- As a key provider of education, regeneration, housing, green spaces and support to the unemployed and offenders, local government is a key player in helping to tackle the consequences of health inequalities. We are committed to maintaining and improving these crucial services, thus improving the health and well-being of all members of the community, but particularly those living in disadvantage.
- It is imperative that resources are directed in a manner which supports success. There is a need for both central and local Government to consider how to fund the transition from reactive crisis management to proactive early intervention and prevention. COSLA therefore proposes a long-term twin-track approach to resourcing change: we need to invest both in our capacity to respond to crises and in our capacity to stop crises happening in the first place. We think this is an issue for both the Scottish Government and local government to consider together.

- In order to make a real impact on the health inequalities agenda, we need to obtain strategic and political buy-in. The primary vehicle for delivering change at the strategic level will be Single Outcome Agreements (SOAs). Within SOAs, there are currently a range of indicators and outcomes that in some way relate to the health inequalities agenda. What we need to consider going forward is whether the current framework could be fine-tuned to allow for a more considered approach to tackling health inequalities.
- Council Leaders have approved the submission.

## Purpose

**1.** The purpose of this report is to provide an input to the Joint Ministerial Task Force on the role of local government in contributing to the Health Inequalities agenda. It sets out the general policy context and explores some of the challenges attached to tackling the causes and consequences of health inequalities. It concludes by setting out a range of general principles that underpin the approach of local government to achieving a sustainable, mainstreamed and strategic approach to health inequalities.

## Policy Context

**2.** The Scottish Government's Joint Ministerial Task Force on Health Inequalities was established with the primary aim of agreeing priorities for cross-cutting government activity that will achieve measurable outcomes in reducing health inequalities. Work to date has highlighted a number of key priorities:

- Children's very early years, where inequalities first arise and may influence the rest of people's lives.
- The high economic, social and health burden imposed by mental illness, and the corresponding requirement to improve mental wellbeing.
- The "Big Killers" including cardio-vascular disease and cancer. Risk factors for these, such as smoking, are strongly linked to deprivation.
- Drug and alcohol problems and links to violence that affect younger men in particular and where inequalities are widening.

The Task Force has adopted a thematic approach to the health inequalities issue, to ensure that work is progressed across the breadth of national policy. A similar discussion has been taken forward within the local government community. From our position, we feel that in tackling health inequalities we need to give consideration to two fundamental issues:

- How do we tackle the causes of health inequalities?
- How do we respond to the consequences of health inequalities?

## Tackling the Causes of Health Inequalities

**3.** Evidence provided to the Task Force by the Scottish Government’s Chief Medical Officer suggests that a psycho-social-biological model can explain the causes of health inequalities. While poverty, smoking and poor diet impact on health inequalities, it is the physical, emotional and mental development of a child’s early years that has the greatest impact. It has been established that there is a strong relationship between deprivation, chaotic social circumstances, the body’s hormonal response to stress and the subsequent risk of ill health. In other words, the end result for an adult who has had to cope with a chaotic environment as a child may be an increased risk of developing heart disease, having a stroke and/or a variety of other common illnesses; he or she is also more likely to have had their schooling disrupted and to have demonstrated offending behaviour. The implication, then, is that in order to tackle health inequalities, we need to develop a sophisticated approach to early intervention and to identifying children living in chaotic circumstances.

**4.** For this reason, it will be important for the Scottish Government and COSLA to work together to develop the proposed *Early Years Strategy*. We need to become more successful at providing services to children and parents who are hardest to reach, in order to ensure that the physical, emotional and mental well-being of the child is nurtured and protected. There are four key aims which should govern this work:

- Building parenting capacity and skills pre and post birth.
- The creation of communities which support the positive development of young children.
- The delivery of integrated services which meet the needs of children and families.
- The development of a suitable workforce to support early intervention.

**5.** The aspirations of the early years strategy and work on health inequalities will be underpinned by reform and culture change in children’s services across the public sector, in line with the *Getting it Right for Every Child* agenda.

**6.** The Early Years Strategy will provide opportunity and challenge. Opportunity is presented insofar as effective implementation will allow us to become much more effective at crisis prevention, thus having to devote less resource to crisis management. We will also become more successful at providing services to children and parents who are hardest to reach.

**7.** Yet, this represents a significant challenge for local government. To a large extent our statutory services are designed to manage crises when they happen – this is a necessary consequence of our statutory obligation to protect the well-being of children. Indeed, there will be occasions where the state needs to respond to negligent parents by taking the child out of the family environment and into formal care, with the local authority acting as the corporate parent. It is important that an interventionist option continues to be available to local authorities in order to protect the future well-being of children.

**8.** However, if we want to make an impact on health inequalities, we need to ensure that there is a more concerted effort to deliver pro-active services and that intervention is targeted at high risk families. Evidence suggests that child-focused, goal-directed, well-structured interventions have the best outcomes. This might involve developing intensive support mechanisms for high-risk families until the child reaches school age. Wrap-around provision, were it available, would undoubtedly create a service option that could help to reduce the impact of chaotic environment in the early years.

**9.** As part of this targeted approach, more sophisticated information sharing arrangements need to be developed between local authorities and community planning partners. It is not enough to identify a geographical area with multiple deprivation and expect service provision to reach the most vulnerable. Rather, activity has to be driven specifically at those individuals and families who experience multiple deprivation and ensure that services are tailored to their needs. This might mean an even closer working relationship between statutory services delivered by health boards, local authorities, and police authorities.

**10.** Yet, it has proved to be extremely difficult to target the appropriate client group, to reach those families who are furthest from the labour market, who are suspicious of statutory services and who often experience multiple social problems. A good example of this is Sure Start Scotland. It is delivered through local authorities and their community planning partners and costs around £60m per year. It funds a range of projects including family centres, parenting programmes, early entry to pre-school and a range of other support for young children with a focus on integrated multi-agency approaches. One of the major challenges faced by Sure Start has been engaging the hardest to reach and most disadvantaged members of the community. Consequently, there is evidence to suggest that the programme's impact has been quite limited, with some of the most vulnerable families actually finding themselves relatively worse off: Sure Start may have supported those with a moderate level of need, but has often failed to reach those with the greatest level of need.

**11.** It is evident, then, that we have an extremely challenging agenda: we are beginning to understand more clearly the causes of health inequalities, but we have a poorer understanding of what works in tackling the causes of those inequalities. It will be important for both spheres of Government to address this issue as a matter of urgency. Potential responses to the problem are expressed in more detail later in this paper.

### Responding to the Consequences of Health Inequalities

**12.** In addition to developing intervention aimed at tackling the causes of health inequalities, we also need to consider how best we should respond to the manifestation of those inequalities. In other words, a significant proportion of the population will already have lived through the chaotic early years that give rise to vulnerabilities to ill health.

**13.** Most of the major drivers of the distribution of health in the population are influenced by the services and activities that councils provide or promote. The basic skills, behaviours and attitudes which are necessary to support a healthy and productive life are in part shaped by the social and civic opportunities engendered by local government activity.

#### *Education*

**14.** Education is often seen as a key entry point for reducing social and health inequalities. It provides literacy, numeracy, and communication skills, all of which increase people's employability and general well-being. It has the potential to combat broader social problems, to prevent children and teenagers falling into crime and violence. The Task Force has heard of the damage caused by drug and alcohol problems and the related problem of violence that affects younger men in particular. Education provides an opportunity to address these issues.

**15.** Within education, much of our work to date has focused on health promotion. The health promoting schools initiative has helped integrate health promotion within the curriculum and school improvement plans, to the extent that health promotion is a now mainstream part of school activity.

**16.** Local authorities have also made great stride towards providing pupils with healthy, nutritious school meals and other snacks. The *Hungry for Success* programme revolutionised school meal nutrition in Scotland. The more recent Schools (Health Improvement and Nutrition) (Scotland) Act 2007 has put school nutrition and health promotion on a more formal footing. However, it is clear that more work is needed to convince pupils of the benefits of a nutritious school meal – especially in secondary schools. This was demonstrated in the findings of a recent HMIE report *Hungry for Success*.

**17.** Education, from pre-school to adult and community learning, will remain a powerful way of influencing attitudes to health and nutrition. The challenge will be to ensure that the ongoing work fits within the early intervention agenda and genuinely tackles health inequalities. We must work to ensure that the whole community benefits from health education.

### *Employment and Worklessness*

**18.** Employment provides access to health promoting resources such as housing, heating, and diet. Vibrant local economies provide diverse local employment opportunities. The reform of the enterprise network and the transfer of the Business Gateway and regeneration functions to Local Government will enable local authorities to develop more integrated business start up services to actively promote and assist in the creation of new businesses in local areas, which in turn will create job opportunities. The creation of employment in local areas particularly afflicted by deprivation will provide opportunities for disadvantaged people to acquire income and therefore other health promoting resources.

**19.** By taking on the regeneration function of Scottish Enterprise, councils will take the lead on enhancing the capacity of local areas to assist in retaining and attracting employment. In addition, local authorities will have the responsibility to lead on a variety of local regeneration initiatives which seek to solve both social and economic problems by regenerating areas which suffer from poverty and health inequalities.

**20.** Indeed, this highlights another area of local government activity: ameliorating worklessness. There is a recognition that employability services are necessary in order to provide the most vulnerable families with the skills to function autonomously in the labour market. The health of long-term unemployed people is significantly worse than it is for people in employment. However, the pathway to employment for the most disadvantaged groups remains long and arduous. Local government has been working with key partners to ensure that that pathway becomes easier to navigate. This might involve offering effective, reliable, local and affordable childcare to lone parents with a desire to enter employment; or it might mean ensuring that people with physical and learning disabilities are provided with appropriate routes into the labour market; or it might involve the facilitation or procurement of training opportunities. Whatever services are provided, local authorities continue to recognise the value of partnership working. It is recognised that a sophisticated approach to tackling worklessness means the development of a holistic approach that combines anti-poverty measures and social opportunity. It is also about offering specific advice and resources to help people overcome financial exclusion, fuel poverty and benefits issues.

### *The Physical Preconditions of Health*

**21.** The physical conditions in which individuals live have a big impact on their health. The most immediate causes of inequalities in health are specific exposures such as damp housing, hazardous neighbourhood settings (including acts of violence), or exposure to air pollution.

**22.** Links can be made to health inequalities in several areas of environmental policy. Access to green-space and outdoor leisure pursuits – which can contribute to well being and promote physical activity – can be a function of both income and geography. Sustainable and active methods of transport which promote both environmental and health goals are promoted by access to services and facilities such as cycle paths. Other issues which link these policy areas include air quality and the ability of different geographic areas to cope with adaptation to climate change. All of these matters are actively being addressed by local government.

**23.** Quality housing is also necessary for good mental and physical health. Councils are committed to the delivery of quality, affordable, accessible and sustainable housing across all tenures. The demand for affordable housing currently outstrips supply. Through the Ministerial Housing Supply Task Force, which focuses on the barriers to house building (e.g. lack of infrastructure), COSLA aims to increase the numbers of houses being built in areas experiencing specific housing pressures. Maintaining and improving housing stock reduces health inequalities by improving individuals' physical environment and reducing fuel poverty. Local authorities have set out in their Standard Delivery Plans how they will meet the 2015 Scottish Housing Quality Standard target.

**24.** Moreover, COSLA and the Scottish Government are working in partnership with other stakeholders to meet the challenging 2012 homelessness target. Homeless pregnant women and families with children are already identified in legislation as a priority group in need of appropriate housing. Local authorities are working hard to tackle homelessness through early intervention and prevention measures, and by offering appropriate accommodation to support homeless people.

**25.** In working towards its commitment to delivering quality, affordable, accessible and sustainable housing across all tenures, COSLA also recognises that an improving physical environment needs to be complemented with an improving social environment. More green spaces and a reduction in crime and anti-social behaviour are key ambitions of local government, thereby improving community safety and individuals' mental health and wellbeing.

### Policy Commitments

**26.** As noted above, most of the major drivers of the distribution of health in the population are influenced by the services and activities that Councils provide or promote: education, social work, housing, economic regeneration and community safety all impact on the health inequalities agenda.

**27.** At this stage, COSLA's proposed commitment to the health inequalities agenda is based on a long-term approach aimed at achieving a sustainable, mainstreamed and strategic approach to health inequalities. To that end, we have identified the following key principles:

- Universal service provision tailored to individual need.
- Effective early intervention.
- Shared learning to help us to understand what works in tackling health inequalities.
- A strategic approach to partnership working through Single Outcome Agreements.
- A longer-term twin-track approach to resourcing change.

*Universal service provision tailored to individual need*

**28.** Some of the key services that lie at the heart of reducing health inequalities – social work, economic development, education – are areas in which local government has significant expertise. To a large extent these services are provided on a universal basis, e.g. all children receive an education. In other areas, local government services are targeted at certain sections of the community: e.g. anti-poverty measures, or social housing. With respect to health inequalities, the evidence base suggests that we have to focus on those members of the community who are most likely to become vulnerable to ill health. In other words, we need to mould universal service provision to individual need. A key implication of this is that it is not enough to identify a geographical area with multiple deprivation and expect service provision to reach the most vulnerable. Rather, activity has to be driven specifically at those individuals and families who experience multiple deprivation and ensure that services are tailored to their needs.

*Effective Early Intervention*

**29.** If we want to make an impact on health inequalities, we need to ensure that there is a more concerted effort to deliver pro-active services e.g. health promoting schools, or oral health provision at the pre-school stage. Particular emphasis should be placed on the importance of intervention during the early years, since it is during this stage of our development that our health and mortality are largely determined. This creates a hugely challenging agenda for local government. We need to become more successful at providing services to children and parents who are hardest to reach, in order to ensure that the physical, emotional and mental well-being of the child is nurtured and protected. To this end, the Early Years Strategy will be of vital importance in tackling health inequalities.

*Shared learning to help us understand what works in tackling health inequalities*

**30.** To tackle health inequalities effectively, our Community Planning Partnerships and Community Health Partnerships will need to be signed up to delivering on the health inequalities agenda. Councils will therefore need to work even more closely with partners to provide disadvantaged groups with faster access to better and more joined-up services.

**31.** The current evidence base suggests that child-focused, goal-directed, well-structured interventions have the best outcomes. To this end, we need to ensure that practitioners are informed by the emerging evidence base when developing services designed to tackle health inequalities. However, while we are becoming clearer about the social and biological causes of health inequalities, we know less about what effective intervention looks like. As such, there is a need to adopt a developmental approach to the problem, which allows practitioners to learn from each other.

**32.** Another way of expressing this may be through a continuous improvement approach, which is based on three broad principles: a holistic examination of process and results to generate best practice; a systematic consideration of the whole process in order to avoid unintended consequences elsewhere; and a learning approach that allows for the re-examination of the assumptions that underpin practice.

**33.** To this end, it is suggested that knowledge sharing networks should be established to ensure that practitioners have the tools, skills and resources to make an impact on health inequalities. We need to develop an evidence based approach by creating networks that help us to understand what works in tackling health inequalities. Clearly, we will need to draw upon existing structures and processes. Yet, that is not to say we cannot add value to current arrangements. Indeed, we would hope to work with the Scottish Government and other key partners to ensure that a physical resource – in the form of a team of officers – is made available to support this process. Ultimately, we want to develop a process that provides community planning partnerships with the knowledge, skills and capacities to tackle health inequalities.

*A strategic approach to partnership working through Single Outcome Agreements*

**34.** In order to make a real impact on the health inequalities agenda, we need to obtain strategic and political buy-in. The primary vehicle for delivering change at the strategic level will be Single Outcome Agreements (SOAs). It is the longer term intention of the new outcomes framework that the whole public sector is held to account by a common set of objectives.

**35.** One of the benefits of addressing health inequalities in this manner is that we can also simultaneously address other challenges: if we manage to achieve measurable outcomes in reducing health inequalities, we will probably also have improved outcomes on educational attainment, poverty reduction, community safety and so on.

**36.** SOAs will ultimately create an environment for more effective strategic decision making at the community planning partnership level. There will be a need for the community planning partners to develop more integrated corporate plans, thereby cementing agreed priorities. This should also allow resources to be channelled to these strategic priorities.

**37.** Within SOAs, there are currently a range of indicators and outcomes that in some way relate to the health inequalities agenda. What we need to consider going forward is whether the current framework could be fine-tuned to allow for a more considered approach to tackling health inequalities. This is not a short-term consideration; this will need to be assessed after SOAs bed-in. Neither will it just be for councils to reflect on this: the Scottish Government must also consider the profile it wants to attach to health inequalities.

*A longer-term twin-track approach to resourcing change*

**38.** The policy commitments outlined above come with a cost. In the short-term, councils and community planning partners would be looking for some financial support to develop some of the suggested activity. In particular, we would be interested in exploring whether we could secure central funding for a continuous improvement approach to health inequalities and to evaluate the success of intervention.

**39.** This by itself, however, may not deliver the change we need to see. To address health inequalities it is likely that public sector resources will have to focus on early intervention and prevention, and as part of that develop a more anticipatory and proactive approach to working with disadvantaged groups. If we do not do this, we will merely be falling back on a strategy that addresses the manifestations of disadvantage rather than tackling the source of disadvantage. Consequently, nothing will change: poverty and other social inequalities will continue to place vulnerable families at risk. However, while there is a strong rationale to move service design away from reactive services, this is a high risk strategy for councils: if priority resources flow away from crisis management, the capacity to respond to vulnerable families will be reduced. The alternative is to take a long-term twin-track approach to resourcing change: we need to invest both in our capacity to respond to crises and in our capacity to stop crises happening in the first place. While recognising the limited scope for manoeuvre during the current spending cycle, it may be flagged up as a strategic priority that warrants consideration going into future spending reviews.

**Conclusion**

**40.** Health inequalities are widening and urgently need to be addressed. Emerging evidence about the causes of health inequalities allows us to alter this trend. Effective early intervention, strategic and political leadership, continuous improvement and a longer-term resourcing strategy are all important factors in tackling the problem. Local government is determined to add value to this agenda: going forward, we want to establish agreed priorities for cross-cutting government activity that will achieve measurable outcomes in reducing health inequalities.

**March 2008**

# 5. SMARTER SCOTLAND: EARLY YEARS AND YOUNG PEOPLE

## REDUCING HEALTH INEQUALITIES IN THE EARLY YEARS

**Note:** *This paper was written and considered in advance of the publication of a joint policy statement by the Scottish Government and COSLA on early years and early intervention.*

### Overview

This paper considers the opportunities for reducing health inequalities that originate in the period from pre-conception to age 8. Inequalities that appear in this age range often have a significant bearing on outcomes in later life or are markers for later inequalities. This is one of the reasons the Task Force has taken a strong interest in early years.

Note that the paper refers to a number of specific projects or programmes. A Glossary is attached which explains the main features of these.

### The Evidence

Biomedical research has progressed hugely in recent years and makes clear connections between stresses in the pre-birth period and during the early years and a range of health inequalities. A recent research review from the Harvard University Centre for the Developing Child states “science has shown that toxic stress in early childhood can result in a lifetime of greater susceptibility to physical illness ... as well as mental health problems ... and substance abuse”. Such stresses can arise from a range of sources – poverty, neglect, inconsistent parenting, disease, violence, poor diet, poor housing, debt and exposure to harmful substances such as alcohol, tobacco and drugs.

At the same time, we have a developing body of UK and Scottish social research that provides some stark evidence of the early experiences of Scotland’s children. Research tells us that young parents and those from deprived backgrounds in Scotland are much less likely to breastfeed or access antenatal care and that their children are more likely to have asthma, be subjected to tobacco smoke in the home and to have accidental injuries. The Millennium Cohort Study has shown differences in development of up to a year at age 3 and that this is closely linked to deprivation. There is strong evidence of inequalities being transmitted from one generation to the next.

## Early Years Framework

In early years, health inequalities are closely linked to social and educational inequalities. The root causes of a range of inequalities are often common, as are possible approaches to improvement. This is the rationale behind the Government's plan to develop an early years framework that considers early intervention in a joined-up way. The themes for the framework have been agreed by Cabinet and were launched by Ministers during a debate on 31 October. The four themes are:

- Building parenting and family capacity.
- Creating communities that provide a supportive environment for children and their families.
- Meeting the needs of children and families in a holistic way.
- Developing workforce models to deliver this.

The Cabinet Secretary announced on 31 October that the framework would be taken forward in "full partnership" with local government and other partners. This has become a specific commitment in the concordat with COSLA that accompanies the spending review announcements. The thinking in this paper needs to be seen, in this context, as seeking views on the range of issues that might form the basis for initial discussions with our partners.

There is a strong evidence base that argues that early intervention is likely to have the best outcomes for children. A key principle in our approach is therefore that working in a preventative way to build resilience is more effective than intervening later once problems are already apparent. Indeed, some of the biomedical research would suggest that it is difficult if not impossible to overcome some types of inequality that appear in the first few years of life and that later interventions are often a form of managing problems rather than solving them.

The early years framework has a time horizon of 10 years in recognition of the scale of the change that is likely to be required to turn around some of the problems we currently face.

## Current Policy

The bulk of children's services are delivered through the universal health and education systems. The universality of antenatal care, home visiting, immunisation and education services is a strength in that they have very broad reach and are generally non-stigmatising to vulnerable parents. It is important, though, that we consider how effective these services are at engaging some groups of parents and delivering the intensity of support that families with higher needs require.

At the other end of the spectrum, there are some very targeted services such as children and families social work, drug rehabilitation and services for looked after children that focus on families in greatest need. Such highly targeted services often have some stigma associated with them and can find it difficult to secure full engagement from parents.

Sitting somewhere in between is Sure Start Scotland, which provides a mix of universal and highly targeted services that often operate in a multi-agency way, with health often in the lead in the programmes that are regarded as most effective. The reach of Sure Start services can be fairly limited i.e. the services it provides tend to be based on small scale local projects that vary from area to area.

Our philosophy is therefore to build on the strengths of universal services in terms of their reach and relative lack of stigma, but to build into that system much better risk identification and more targeted support for those with higher needs. There is still very much a role for targeted services, but if we can create pathways to them via universal services then we can hope to improve engagement and uptake of additional support.

Some aspects of current policy are already moving in this direction. Health for all Children (Hall 4) is a surveillance, assessment and need identification tool which NHS Boards have been asked to implement as part of the universal service they provide to young children. If used properly, the expectation is that it will deliver access to more intensive support for those with greater needs, and one of our priorities must be to build on the progress made to date to make sure this is properly implemented.

A further development in a similar direction has been Starting Well, the national health demonstration project for early years. It aimed to demonstrate that child health in Glasgow, particularly in deprived areas, could be improved by a programme of activities that both supported families and provided them with access to enhanced community-based resources. It has been independently evaluated and showed some small positive effects to date, although the full impact can only be realistically evaluated in the longer term. There has also been a range of broader learning that has emerged from the project around home visiting, skills mix, operating in a multi-agency environment and the role of the voluntary sector. The demonstration period has now ended and a version of the approach mainstreamed in the form of local Parent and Child Together (PACT) teams across Glasgow.

### What Works In Reducing Health Inequalities

The Harvard research review identifies a number of approaches that can be effective in reducing inequalities in early years:

- **High quality, evidence-based antenatal care** that identifies risks early and takes effective action to deal with them.
- Schemes to improve **maternal nutrition during pregnancy** – there is a specific manifesto commitment in this area.
- Measures to **alleviate poverty** in families with young children e.g. tax credits, benefits, employability support, free or subsidised childcare. There is a manifesto commitment to increase the availability of high quality, flexible childcare.
- Measures to **improve the quality of interaction between parents/carers and children in the very early years**. High quality home visiting services and parenting programmes are a particular focus here, but reserved areas such as maternity leave and pay are also relevant.
- High quality, centre-based **pre-school provision** – there is a manifesto commitment to increase pre-school provision by 50% for 3 and 4 year olds.
- There is evidence that **school education** and the level of attainment is important in health outcomes.
- **Targeted interventions/programmes for children at particularly high risk** and effective risk management.
- **Reducing environmental hazards.**

There are also other areas such as **immunisation** against common preventable diseases where we can look to reduce inequalities. Overall immunisation rates in Scotland are adequate but there is scope to improve the rate amongst families in more deprived circumstances

Research reviews make clear that **no single policy or approach has been shown to be a complete solution**. We need to make progress in all these areas if we are to make a real impact on health inequalities and wider outcomes, and even then we should be wary of regarding early intervention as some kind of magic bullet.

There is good evidence that **quality matters**. For example the Nurse Family Partnership research closely links outcomes to qualifications of the home visiting staff. Similarly, the UK Effective Provision of Pre-School Education (EPPE) study provided evidence of the link between the quality of pre-school provision and outcomes achieved. Poor quality services have reduced impact or can even make things worse.

Area-based programmes such as the Sure Start programme in England have struggled to help the most vulnerable, with more motivated parents at the top end of the income and educational scales benefiting most from services. In some cases, the relative position of the most disadvantaged became worse. The conclusion we draw is that **area-based programmes are not a solution on their own**, and that approaches based around individuals and families are probably the bigger part of the way forward.

The children's services reforms being taken forward through **Getting it Right for Every Child** are a critical component in joining up the many individual strands of policy that we can consider. This is because GIRFEC provides a unifying approach based around identifying and then meeting the needs of the individual child which will be critical in making a multi-agency approach to children's services work on the ground.

While universal services, and some health services in particular, are not regarded as threatening by vulnerable families, there is fairly clear evidence that there is plenty of room to **improve engagement with families with higher needs**. The evidence on the degree to which such services fail to engage parents suggest this should be an initial priority, as it would seem likely that there is a strong connection between this and lower rates of breastfeeding and other inequalities amongst younger mothers and those from more deprived backgrounds. There is also likely to be scope for improvement in the way services such as pre-school support and build capacity in families with higher needs, and for education services to promote parenting skills as children develop into young adults i.e. the parents of the future.

Finally, we need parts of the system that focus on specific age groups to work together to provide a **continuum of care for children and families** and to ensure key **transitions are appropriately managed**. There is strong evidence that we need to **sustain the intervention** for many families beyond early years. While we can hope to build capacity in some families to the point where it will be self-sustaining, for others the benefits will quickly fade out if we do not offer continuing support.

### Children and families with higher needs

**The groups that need particular attention if we are to address health inequalities that originate in early years are substance-misusing parents, parents who are in or have been in prison, mothers with mental health problems or learning disabilities, mothers suffering from domestic violence and mothers who have been in care. Child-related factors that would point to increased need of support include low birth weight, disabilities and being looked after. Poverty is often a pressing issue for many parents and children with higher needs.** Some families suffer from a complex combination of these factors and others that are strongly associated with them, such as debt, unemployment and poor housing. It is often only by addressing these wider stresses that we can hope to build capacity and make a real difference to the quality of interaction between parents and young children.

There is evidence that outcomes for children of teenage mothers are markedly poorer and that these inequalities appear in pregnancy and the early years. Young mothers experience multiple source of disadvantage - they are more likely to live in low income households and more likely to live in the most deprived areas of Scotland. Young and poorer mothers were less likely to attend ante-natal classes, breastfeed, attend baby or mother and toddler groups, and more likely to find it difficult to know who to ask for help and to actually ask for such help. It appears that these inequalities are related more to deprivation and to education than to age i.e. it is not being young that leads to poor outcomes but that teenagers who become mothers tend to live in poverty and have poor educational attainment and it is these factors that are strongly associated with poor outcomes.

Nevertheless, if we take the preventative approach to its logical conclusion, we need to reduce the numbers of young women becoming pregnant, whilst supporting those who become teenage parents to maintain links with education and their local communities in an attempt to break the cycle of deprivation which teenage parenthood can lead to.

### Priority Action

Based on the above analysis, the key actions would appear to be as discussed below. There are some important caveats to note here. In some areas the research evidence comes from the United States, where the health, welfare and education systems are very different. For example, there is no universal home visiting service in most of the US and pre-school entitlement also tends to be limited. Evidence from the US regarding the quality of services also needs to be treated with care as workforce structures and qualifications are not necessarily directly comparable.

There is therefore a need to test some of the evidence and assumptions in a Scottish context. Part of that process will be engaging a wide range of stakeholders in the debate through the process for developing the early years framework. It is also likely that further evidence and ideas will emerge through that process that we will want to incorporate into the framework. Until we have gone through that process, which will take place during the first half of 2008, the following priorities need to be considered as provisional.

First and foremost, we need a **continuing focus on children's services reform through Getting it Right for Every Child**. GIRFEC is the foundation for multi-agency working at the level of the individual child and the driving force behind a culture shift to see meeting the needs of the child in a holistic way as the key to effective service delivery. Given the impact of parenting and parental stresses on the quality of care and interaction with children, we should also **start examining the practicality of moving GIRFEC to the family level**. This will be extremely challenging as it implies adult services shifting their outlook to focus more on the impact on young children.

Closely related to this is the need for the different **agencies that work with children and families to operate more closely in partnership**. No single agency or programme can deliver on its own and some of the biggest challenges from pilot projects and other initiatives in this area are finding effective structures within which many public and voluntary sector partners can work effectively together. Without making progress on this at local level, chances of success are very low. It is possible to go further, as the early years framework will, to see meeting the needs of children and families as also involving a strong **community dimension** where there is a sense of collective responsibility for the welfare of young children.

**Improving the ability of antenatal services to reach higher risk groups and improving the use of evidence-based approaches to identify and manage risks during pregnancy** would seem to be an obvious initial focus. In 2004, an NHS Health Scotland audit found that the evidence of effective interventions to support the transition to parenthood was limited and uncoordinated. There is now a recognised need to maximise the potential for all maternity care episodes (face to face or otherwise) to be used as teaching and support opportunities for all women but especially those in the most vulnerable groups.

In addition, there is Scottish-based evidence that younger and more vulnerable women begin maternity care later and are much less likely to attend antenatal classes. This probably means much more use of outreach and one-to-one support for vulnerable women during pregnancy. There is a clear **opportunity to link this to other initiatives such as improving nutrition during pregnancy and improving support for breastfeeding.**

**Implementing or piloting evidence-based parenting interventions such as nurse-family partnership (NFP), Triple P, Webster Stratton or mellow parenting** would also seem to be an area we should look at, as there is some evidence from studies in the US and elsewhere that these programmes can have positive benefits for parents and children. This might also look at combined parent and child programmes such as the Perry pre-school or Early Head Start models. NFP is being piloted in England and it may be that we can use evidence from that to make progress quickly. Similarly, Triple P and mellow parenting are being delivered in various places in Scotland, mostly through local Surestart programmes. What we need to decide here is whether to scale up one approach or, possibly more likely, set some national expectation that local partners will make available one or more evidence-based programmes from this list to families who meet certain criteria.

Given the role that wider issues such as housing, debt, poverty etc play in the stresses that impact on families with young children, we should examine whether we can create a **holistic family support service** that can deal with a wide range of issues that families face. A particular focus should be on providing a coherent set of supports for families with higher needs and especially those whose needs are multiple and complex. There may be a role for more **children and family centres** to provide a hub for a range of services that families need. There are a variety of different models of family centre and we need to look carefully at those, as well as whether co-location or more effective joint working using a more distributed model is the better approach. For the most complex cases, we may want to consider models based on the **Dundee Families Project** where families are assigned a key worker who provides often daily intensive support to the whole family and works to build a set of wider supports around them.

We need to make progress with implementing the commitment to extending pre-school entitlement but also examine **earlier entry to pre-school for high risk groups**. There is evidence from EPPE that an earlier start and longer duration of pre-school has benefits for disadvantaged children and we are running pilots in three local authority areas (Glasgow, Dundee and North Ayrshire) at present. Initial outputs from the evaluation study are unlikely to be available before Autumn 2008.

Looking at the early school age years, plans are currently being developed to **increase the healthcare capacity in schools**, harness existing skills and shape new roles. The approach here needs to be appropriate across the wider age range that school education provides for.

Perhaps the biggest shift we need to make is in the outlook of children's and relevant adult services. We need to move away from an old-fashioned view of delivering services to children and their families towards one that is focused on **working alongside parents and children to build capacity.**

Finally, we need to maintain a focus on **reducing child poverty**. This will partly involve working with and lobbying Whitehall departments on issues such as employment rights and tax credits. In terms of issues under devolved control, we need to continue to improve employability services for parents and underlying enablers such as affordable and accessible childcare. The Government will bring these issues together in a new anti-poverty framework for Scotland.

## Resource Implications

There is likely to be considerable scope to change existing roles to achieve more in terms of health inequality, but some actions that we could consider would involve significant new capacity.

Some approaches such as group parenting programmes e.g. Triple P have relatively modest costs associated with them of a few hundred pounds per family (low thousands if delivered on an individual basis). Other options based on intensive one-to-one support from highly skilled practitioners such as NFP cost in the region of £5000 per family. Expanding pre-school services for two year olds costs £2500-3000 per child. Creating joint infrastructure such as family centres also involves significant costs, with evidence from England that the public funding for a typical family centre is around £400,000 per annum on top of initial start-up costs. We will be developing more sophisticated cost models as part of the early years framework, and all the above figures are based on historic costs that will increase over time.

There is evidence of a positive rate of return on some types of early years investment, for example the Perry Pre-school project showed a rate of return of 7 to 1 at age 27 when reductions in welfare payments, criminal justice costs and wider social costs in later life were examined. The Nurse Family Partnership model claims a 4 to 1 payback ratio but Early Head Start shows a rate of return of just 1.23 to 1. There is less evidence from a UK perspective of a positive rate of return from more generalised early intervention programmes, to some extent because fewer UK evaluations make that sort of calculation. It is important to reinforce one point here – prevention approaches will almost certainly not pay for themselves in the short run and will only do so in the long term through effective targeting and delivering high quality services.

A key issue will be the extent to which existing spend can be redirected in the short term and how high a priority early intervention is in comparison to other pressures.

## Measures of Success

There is a range of measures that we could consider in the short term to measure progress. For example, we can track the degree to which higher risk parents access antenatal support, breastfeeding rates, admissions to A&E, infant mortality, low birth weight, childhood obesity, dental decay at age five and many more relevant indicators. The Growing Up in Scotland (GUS) study provides a particular opportunity to track the developing health of a range of Scottish children and see the links between different behaviours, circumstances and child health. There are also options to develop sophisticated cross-sectional analysis through GUS.

The Chief Medical Officer has also suggested some more innovative measures based on stress hormone levels that are worthy of consideration.

In the longer term, measures of success are likely to be similar to those for health inequalities more generally.

## Workforce Implications

The workforce implications of some of the priority actions identified above are potentially profound. Perhaps the biggest implications flow from two areas:

- Delivering a more holistic service.
- Moving to working alongside families and supporting the role of parents.

In moving towards delivering a more holistic service, there are a variety of workforce models we can consider. For families with higher needs, we may look towards key worker models, or an enhanced lead professional role. There may well also be merit in looking at a family care worker role at practitioner level which can work across health, education and social care services and which has particular expertise in supporting parents. A possible extension to this would be a Scandinavian-style pedagogue role at graduate level. We will still need to retain specialist roles in a number of areas, but they will need to be able to work within a multi-agency environment as enhancing the role of multi-disciplinary teams is also likely to be part of the picture.

The second point regarding moving to working alongside families is also challenging. In part, this could be about broadening the skills base of some key practitioners such as nursery nurses so that they are better equipped to support parents and parenting. It also suggests a much higher focus on skills related to engaging parents, particularly those with higher needs, across many parts of the workforce.

There may also be an enhanced role for the voluntary sector here, which has a good track record in engaging families with higher needs. They also have a good track record in delivering holistic models of support through the Dundee Families Project and a range of other projects. We need to think hard about our relationship with the voluntary sector if we are to give them a greater role.

### **External Views**

We are at the beginning of a process of developing an early years framework which will give key external stakeholders the opportunity to work in partnership with the Scottish Government to refine our understanding of what works and what the priority actions should be.

The broad scope of the early years framework means that the process will encompass a very wide range of stakeholders, including all of those that would be considered stakeholders in health inequalities in early years.

Engaging with service users will be a particular priority in the coming months. Meeting their needs more effectively is central to the approach set out here.

**December 2007**

## GLOSSARY

### Sure Start

Sure Start Scotland is an early intervention programme for children in the 0-5 age range. It is managed by local authorities alongside partners in health and other services and the Grant-Aided Expenditure assessment is around £60m in 2007-08. It funds a range of projects including family centres, parenting programmes, early entry to pre-school and a range of other supports for young children with a focus on integrated multi-agency approaches. Two mapping exercises have been carried out but there has never been an outcome-based evaluation done on the programme because of various factors including the lack of a baseline.

Sure Start in England is constructed as an area-based intervention for young children, with more centrally-directed elements. It is the subject of a very large evaluation study that to date has found that the programme's impact has been quite limited, with some of the most vulnerable families actually finding themselves relatively worse off.

### Bookstart

Bookstart was the first national baby-book-gifting scheme in the world when it began in 1992. Bookstart works with libraries, health visitors and early years professionals to give the gift of free books to every child at around 2 months, 18 months and 3 years old, along with guidance materials for parents and carers. Bookstart seeks to promote the importance of books and the benefits of early book-sharing, such as parental bonding and promoting emotional intelligence, as well as building good communication and listening skills, and helping to lay the foundations of early literacy. The Scottish Government provides £1,050,000 to Bookstart in Scotland for financial year 2007-08.

### Starting Well

Starting Well is the national health demonstration project for early years. Phase one of the project (2000-2004) focused on intensive home visiting support to all families with new-born babies in two deprived communities in Glasgow. In Phase 2 (2005-6) the universal service provided in the two areas moved to a targeted approach to those most likely to gain from the interventions. Support was provided by a skill mix team comprising health visitors, lay health support workers, nursery nurses and a bilingual worker and included a parenting education programme (Triple P). The strengths of the programme include the use of home visiting as this is convenient for families and creates a "power shift" between parent and professionals. Health Visitor-led skill-mix teams were valued by families and professional teams. The employment of health support workers from the local community through a voluntary organisation led to many benefits, for example then families greatly valued the contribution of these lay workers to their emotional and practical support.

### Nurse Family Partnership (also known as the Olds Model)

NFP is a home visiting programme set up by Professor David Olds at the University of Colorado. It targets low income, first-time parents and their children. The home visitors are highly educated registered nurses who receive more than 60 hours of specialised training. The visiting programme starts no later than the 28th week of pregnancy and goes on for a total of 2½ years involving 64 visits to each family. Visits last, on average, 75-90 minutes and nurses have a case load of around 25. Published research findings show that NFP mothers are less likely to abuse or neglect their children, have subsequent unintended pregnancies, misuse alcohol or drugs; and are more likely to maintain stable employment and reduce dependency on welfare. 15 year follow-up studies show 50% lower arrests, 80% fewer convictions and significantly lower substance abuse and sexual activity.

## Triple P

The Positive Parenting Programme is a family intervention model developed in Australia. It is used by a number of public agencies in Scotland, usually as part of health or Sure Start programmes. It is a multi-level programme with 5 levels of intervention based on the needs of the family. These interventions include a universal population-level media strategy targeting all parents, two levels of brief primary care consultations targeting mild behaviour problems and two more intensive parent training and family intervention programs for children at risk for more severe behavioural problems. Triple P has a strong research base covering a variety of variations on the core model including self-directed versions for use in remote areas.

[http://www.triplep.net/files/pdf/Parenting\\_Research\\_and\\_Practice\\_Monograph\\_No.1.pdf](http://www.triplep.net/files/pdf/Parenting_Research_and_Practice_Monograph_No.1.pdf)

## Solihull/Mellow Parenting

The Solihull Approach is an integrated model of working for professionals who work with families with emotional and behavioural difficulties. It has been successfully used by a wide range of professionals around the UK in their individual and group work with families. The model brings together three well developed concepts, which are Containment from Psychoanalytic theory, Reciprocity from Child Development and Behaviour Management from Learning Theory. The mellow parenting course which is based on the Solihull approach has a good research base and is used by several local authorities in Scotland.

## Webster Stratton

This is a parenting programme that teaches positive parenting skills such as anger management and which teaches children key social skills such as empathy and conflict management. Delivery is via group work modelling, including discussion and role play, bolstered by home-based activities and support for parents. It includes several individual programmes. Rigorous evaluation has shown effectiveness in addressing a number of parent and child outcomes but that these are less effective when individual elements are used in isolation. A UK-based study of the Incredible Years part of the Webster Stratton programme found reduced antisocial behaviour but that children were still experiencing peer relationship difficulties.

## Perry Pre-School

This was a US programme from the late 1960s that combined high quality pre-school education for 3 and 4 year olds with weekly home visits to families by trained teachers. These visits reinforced the curriculum and provided support for parents to engage with their children in cognitively and socially enriching activities. Although the programme could not establish the unique contribution of the parent component, it demonstrated long term benefits in school performance, fewer special education placements, higher rates of qualification, reduced teen pregnancy, higher rates of employment, and lower rates of juvenile crime and adult arrests.

## Early Head Start

Several different models of Early Head Start have been trialled in the US. A national evaluation looked at a model that combined intensive family support services with centre-based childcare and education from birth to 3 years. It found small effects on cognitive, social and emotional development, as well as several areas of parenting and economic self-sufficiency. Some individual programmes performed better by enrolling parents earlier and implementing rigorous performance standards.

## Dundee Families Project

The Dundee Families Project is operated by NCH Scotland with funding from Dundee City Council and works with families who have lost or are about to lose their tenancy as a result of anti-social behaviour. Many families have a complex combination of problems and are supported by a key worker who builds a range of supports around the family, looking at the various stresses that may be having an impact in a holistic way. Some families are housed in a core block where they are in close proximity to their key workers while others are supported in their existing home. Case loads are very low – around 4 families to each worker – and the support lasts for an average of around 2 years. Evaluation to date has been relatively informal but has shown a range of positive outcomes. A version of the project opened recently in Aberdeen and several sites using a similar model are now operating in England.

## Child and Family Centres

Child and family centres are community-based centres which provide a range of services for parents and young children in the 0-5 age range. Services often include pre-school, childcare, parenting groups and classes, healthcare and advice services. They are usually targeted at disadvantaged families and located in areas of concentrated deprivation. They are normally operated by local authority education or social work departments. There are approximately 120 child and family centres in Scotland. In England, there is a massive programme of investment in Sure Start Children's Centres, with a target of 3500 centres by 2010.

# REDUCING HEALTH INEQUALITIES AMONG YOUNG PEOPLE

## Context

1. The recent OECD report on the quality and equity of schooling in Scotland found Scottish education to have many strengths. Scotland performs at a consistently very high standard in the Programme for International Student Assessment (PISA). Few countries can be said with confidence to outperform it in mathematics, reading and science. Scotland also has one of the most equitable school systems in the OECD. Only a very small proportion of Scottish 15 year olds are assessed in the lowest bands of performance. Headteachers are amongst the most positive of school principals in the OECD in judging the adequacy of staffing and teaching resources, and students are generally very positive about their schools. Underpinning the impressive international performance of Scottish schools is a system of near-universal and high quality pre-school education.
2. However, the report also recognised challenges. One major challenge facing Scottish schools is to reduce the achievement gap that opens up about Primary 5 and continues to widen throughout the junior secondary years (S1 to S4). Children from poorer communities and low socio-economic status homes are more likely than others to under-achieve, while the gap associated with poverty and deprivation in local government areas appears to be very wide.
3. Little of the variation in student achievement in Scotland is associated with the ways in which schools differ. Most of it is connected with how children differ. Who you are in Scotland is far more important than what school you attend, so far as achievement differences on international tests are concerned. Socio-economic status is the most important difference between individuals. Family cultural capital, life-style, and aspirations influence student outcomes through the nature of the cognitive and cultural demands of the curriculum, teacher values, the programme emphasis in schools, and peer effects. The geographical perspective that national data afford also show that deprivation intensifies the effects of family socio-economic status and of a predominantly academic culture in schools through the concentration of multiple disadvantages in schools serving poor communities.

4. The Task Force's approach is to get behind the causes of health inequalities and as such they are interested in reducing inequalities in life circumstances and addressing underlying issues of poverty and deprivation. In this context, education plays a key role in building capacity and resilience in individuals and communities and preventing future health inequalities. This paper outlines relevant current policy and action and identifies routes forward.

### Current Policy and Action With an Impact on Health Inequalities

5. Current work to develop a strategic approach to young people and in particular *Getting it Right for Every Child* (GIRFEC), the *More Choices, More Chances* Strategy, the reform of education from 3 to 18 under the *Curriculum for Excellence* programme and the Early Years Strategy should act to address underlying issues of poverty and deprivation and thereby health inequalities.

6. GIRFEC provides the framework within which all services will deliver a personalised, effective response to young people. In bringing together GIRFEC, *Curriculum for Excellence* and other key strategies we will: improve the delivery of opportunities and support to all young people, identifying priorities and gaps and working with partners to fill them; promote awareness and understanding of the rights of children and young people and encourage them to take individual responsibility for ensuring the best outcomes for all young people; and ensure young people at risk can access the support and opportunities they need.

7. In terms of health inequalities the most significant policy is the reform of Scottish education from age 3 to 18 under *Curriculum for Excellence*. The outcomes that are being sought through this programme are very much in line with the approach that is being taken by the Task Force and also reflect one of the fifteen national outcomes agreed by the Scottish Government and COSLA in November 2007. Specifically, *Curriculum for Excellence* is about providing the best possible education for all our children and young people, wherever they are being educated, to help them become successful learners, confident individuals, responsible citizens and effective contributors.

8. It is important to note that *Curriculum for Excellence* is not about a national curriculum that is imposed through central guidance. It is about changes to learning and teaching, being less prescriptive in terms of content but having a strong focus on understanding and transferability of skills. In particular *Curriculum for Excellence* will ensure a focus on literacy and numeracy and skills for life, skills for work and skills for learning. It will also have Health and Wellbeing as one of eight groupings of experiences and outcomes.

9. In terms of **literacy and numeracy**, there will be separate curriculum outcomes in these areas and reinforcement across the curriculum with every teacher having the responsibility of promoting numeracy and literacy from age 3-18.

10. Young people need **skills for life, skills for work and skills for learning** to play their part in a global economy where the prevalent constant is rapid unpredictable economic and technological change. An ever increasing proportion of jobs are likely to be found in highly skilled areas so there is a focus on raising the bar in terms of academic attainment. Education also has a role in helping to engender a culture of resilience, self-reliance and inquiry founded on an expectation of lifelong learning and retraining. Individuals need to be equipped to move between jobs and industries and this is also reflected in the skills strategy to "place the individual at the heart of learning and skills development". Skills for life, skills for work and skills for learning will be delivered across the curriculum.

- 11. The Schools (Health Promotion and Nutrition) (Scotland) Act** places a legal duty on Scottish Ministers and education authorities to endeavour to ensure that schools are health promoting. This new duty is a key driver for change in health inequalities. It places health promotion at the centre of school education, with a whole-school approach to promoting the physical, social, mental and emotional wellbeing of all pupils. The guidance for the health promotion duty *will/has be/been* released at the same time as the draft outcomes and experiences for **Health and wellbeing**, one of eight groupings of experiences and outcomes in CfE. They cover learning in mental, social, emotional and physical health to promote resilience, confidence, independent thinking and positive attitudes and dispositions. The framework for curriculum design will make it clear that health and wellbeing is both a whole-school issue and a curriculum area its own right and because of this a range of people will be involved in the delivery of the experiences and outcomes. Taken together, the Health and Wellbeing outcomes and experiences, and the Health Promotion Guidance will describe the expectations for promoting the health and wellbeing of children in school.
- 12.** The Act also places duties on Local Authorities to: ensure that food in schools complies with nutritional regulations; promote the uptake of school lunches and free school lunches; and protect the identity of pupils receiving free school lunches. These duties will commence in August 2008.
- 13.** There is a dedicated More Choices More Chances project within **Curriculum for Excellence** which provides a rigorous challenge and proofing role across the programme to ensure that proposals will meet the needs of all young people, including those in need of 'more choices more chances'. In this way we are proofing the programme in relation to underlying issues of poverty and deprivation.
- 14.** The transformation of the education system through Curriculum for Excellence therefore provides a strong vehicle for improving life outcomes for ALL young people, increasingly enabling schools to work effectively with partners, including young people and families, to provide more engaging and personalized learning both in and out of school, for example through youth work and volunteering and to provide the support that may be required to engage with learning. In doing this, it will help us to meet the concerns raised in the recent OECD report on quality and equity in schooling in Scotland.
- 15.** In addition there are a number of other key policies relevant to reducing health inequalities. The **Additional Support for Learning Act (2004)** supports early intervention and a personalised, approach to additional support needs, in order to address inequality and promote positive outcomes for children and young people. Under the Additional Support for Learning Act education authorities have a duty to establish procedures for identifying and meeting the additional support needs of every child for whose education they are responsible. Other agencies such as Health Boards are under a duty to help an education authority meet their duties under the Act if requested to do so, unless of course it would be incompatible with their own statutory duties or unduly prejudice their ability to carry out their functions. A child may require additional support for a variety of reasons. These may include those who are being bullied, are living with parents who are abusing substances, are living with parents with mental health problems, are on the child protection register, are young carers have experienced a bereavement, or are not attending school regularly, as well as those who have behavioural or learning difficulties, mental health problems, or specific disabilities such as deafness or blindness.

**16. Home-school link workers** play a valuable role in supporting vulnerable and hard to reach families to engage with education services. They promote Inclusion and Social Justice by providing specific services such as home visiting, individual support and advocacy to vulnerable families. For example, home-school link workers provide workshops for pre-5 centres and primary schools in literacy and numeracy and provide packages of support for family literacy and numeracy which support engagement with education and link with the school health resource, with family planning services, and community health services to ensure that those at risk get continuity of support from family to community to school.

**17. The Scottish Schools (Parental Involvement) Act 2006** introduced a new framework to assist parents to support their children's learning at home and in school, to strengthen home-school partnerships and to give parents a stronger voice in school education. Education authorities are required to prepare a strategy that sets out how they will support all parents to be involved in their children's learning. The Scottish Government has provided a practical toolkit which includes examples and activities to help schools and parents strengthen home-school links and to make the most of their community. The Parentzone website also provides information for parents aimed at promoting healthy eating, fitness and emotional health and wellbeing.

# 6. WEALTHIER AND FAIRER SCOTLAND

## ANTI-POVERTY ACTION TO REDUCE HEALTH INEQUALITIES

### Introduction

1. There is a clear, consistent relationship between the distribution of poverty and that of adverse health outcomes. This paper will briefly review trends in poverty; discuss the relevance of poverty to the specific health inequalities that are priorities for the Task Force; and identify anti-poverty action with the greatest potential for addressing these health inequalities, both at individual level and in regeneration of our most deprived communities.

Poverty is defined in a variety of ways (see technical annex). By regeneration of communities, we mean not only physical regeneration, but a wider set of actions intended to increase economic activity and employment, improve business confidence, deliver better educational outcomes, enhance skills, achieve greater levels of community safety and improve environmental quality.

2. Tackling poverty, inequality and deprivation will support delivery of the Purpose of the Government's Economic Strategy:

To focus the Government and public services on creating a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth.

The *Government Economic Strategy* (GES) has, of course, set out how we will deliver on that Purpose. The GES's focus is on maximising Scotland's richest resource – its people – and on making Scotland a wealthier and a fairer place. The GES is clear, therefore, that delivering sustainable economic growth must also involve delivering on the Government's three "Golden Rules" of Solidarity, Cohesion and Sustainability.

The Solidarity Golden Rule is the primary focus for the Government's efforts to tackle poverty, inequality and deprivation; it involves providing the opportunities, and incentives, for all to contribute to Scotland's sustainable economic growth.

As outlined in the GES, the Solidarity Golden Rule is backed up by the following time-bound, national target:

*Solidarity*: to increase the overall income and the proportion of income earned by the three lowest income deciles as a group by 2017.

Work to achieve the Solidarity target will also support the related Cohesion Golden Rule, which gives priority to achieving more balanced growth across Scotland’s regions, ensuring that all Scotland’s communities have a fair chance to succeed.

The following Purpose target is also of particular relevance to the Task Force:

To match average European (EU15) population growth over the period from 2007 to 2017, supported by increased healthy life expectancy in Scotland over this period.

3. Although clearly relevant to the anti-poverty and regeneration policy context, actions (e.g. early years interventions) that have been fully addressed elsewhere in this report will receive only a brief reference in this paper. Enterprise and employment themes will be addressed elsewhere.

### Trends in poverty within Scotland (1996-2006)

4. Targeted approaches by previous administrations to addressing social and economic exclusion have successfully lifted some sections of the population out of poverty, but the twin challenges of persistent poverty and increasing income inequality across the entire population remain. Although there has been an overall (10%) decline in the number and proportion of individuals who live in poverty within Scotland over the past decade (annex), this decline has not affected population subgroups equally (Table 1).

**Table 1: % population sub-groups in relative poverty (before housing costs), 1996-2006**

Population Subgroup	1996-7	2005-6
Children	31%	21%
Working age adults	16%	15%
Pensioners	30%	20%

The greatest reduction has been amongst children and pensioners. However, 880,000 people (18 per cent of the population) still remain in relative poverty. The risk of poverty is highest among families with no-one in employment, but a sizeable and growing proportion (38%) of those in poverty live in families where at least one individual is in work. This reflects the fact that over 500,000 Scottish employees are low paid (paid less than 60% of the median full-time hourly wage).

### The impact of poverty on health inequalities

5. Health inequalities associated with poverty are increasing. In Scotland, our healthiest communities are moving along a diverging path from those with the worst health and wellbeing; life expectancy continues to rise in the most advantaged areas of the country whilst, at best, remaining unchanged – or falling – in Scotland’s poorest communities.

6. There is strong evidence to suggest that poverty is a powerful driver of the most significant health inequalities.

7. Early years: intrauterine growth retardation and low birth weight are much more prevalent among lower socio-economic groups, and a poor start in life results in long term, damage in the structure and function of the developing child. These early biological effects interact with subsequent adverse environmental and behavioural influences to amplify health risks in later life. Strains on families resulting from low household income also influence family functioning, children’s emotional development and their subsequent relationships outside the immediate family, behaviour and potential to learn at school.

**8. Risk factors for the “big killers”:** cardiovascular disease and cancer, e.g. smoking: these conditions (jointly responsible for 55% of all deaths in Scotland in 2006) are driven by cumulative life circumstances from the early years onwards. They underpin much of the overall variability in death rates between socioeconomic groups in adulthood. Socioeconomic disadvantage also worsens individuals’ outcomes after the onset of chronic disease, including shortened survival and increased likelihood of labour market exclusion.

**9. Mental wellbeing and mental illness:** in 2006, a national survey of the Scottish population classified 14% as having good mental wellbeing, 73% average and 14% poor. 28% said that they had personally experienced a mental health problem. People on lower incomes and those who lived in more deprived areas were most likely to rate their general health as poor and to be more susceptible to mental illhealth. Those with a low income and resident in a deprived area are known to be at heightened risk of dying by suicide, with the gap between suicide rates in the highest and lowest social classes increasing as socio-economic deprivation worsens.

**10. Drugs, alcohol and violence:** alcohol and drug use are important drivers of health inequalities in younger people. Detailed analysis of death records between 1981 and 2001 concluded that this was largely explained by socioeconomic disadvantage and was mediated through increasing death rates from suicide, chronic liver disease and mental and behavioural disorders due to the use of drugs and alcohol.

### What Anti-Poverty Action is Effective in Reducing Health Inequalities?

**11.** Actions at a (whole population) regulatory or structural level that seek to improve health and wellbeing are likely to be among the most powerful levers for tackling health differentials associated with income inequality.

**12.** Evidence presented to the UK Acheson Inquiry into Inequalities in Health in 1997 suggested two legitimate policy responses relevant to the influence of poverty on health inequalities. The first is to accept that widening income inequalities are an inevitable aspect of improved productivity, economic growth and national prosperity, although these positive changes should ultimately lead to an improved health profile for the majority of the population. The second is to implement a fiscal programme aimed at fundamentally arresting and reversing the trend in income inequalities, in the hope that would lead to reduced health inequalities also.

The first of these approaches is out of line with the Government’s overarching Purpose. As indicated above, this makes clear that increasing sustainable economic growth should go hand in hand with a fairer sharing out of Scotland’s wealth. This recognises that all of Scotland’s people are potential assets to be released for the benefit of everyone, and greater social equity will provide the opportunities – and incentives – for all to contribute to Scotland’s sustainable economic growth.

Although the second approach is not mainly within the devolved powers currently available to the Scottish Government the Government’s anti-poverty discussion (see below) is examining whether devolved powers might be enlarged to embrace key areas related to tackling poverty such as tax/benefits arrangements and welfare to work policy.

Devolved policies can play an important role in tackling the root causes of poverty, through impact on people’s life circumstances. These are addressed in the remainder of this paper.

## Recommendations for Action

**13.** Levers are available to the Scottish Government under the current devolution settlement to tackle poverty in 3 broad ways:

- Prevention of poverty and tackling the root causes
- Helping to lift people out of poverty
- Alleviating the impact of poverty on people's lives

These are the subject of *Taking Forward the Government Economic Strategy: A Discussion Paper on Tackling Poverty, Inequality and Deprivation in Scotland* published by the Scottish Government on 31 January 2008 (available from the Scottish Government website.) This paper is the basis for a national discussion which will lead to the production of a framework for tackling poverty, inequality and deprivation later this year.

## 14. Tackling the root causes of poverty

### 14.1 Early Years Influences

Recommendations for reducing health inequalities in the early years of childhood were fully outlined in the Early Years paper and will therefore not be reproduced here. However, it is important that reserved policies address child poverty through redistributive child benefit and tax measures. Some key levers under devolved control include enablers such as changes in employer attitudes and practices, and affordable and accessible childcare, which is often a real barrier to employment.

### 14.2 Fairer Scotland Fund

The Fairer Scotland Fund (FSF) is a new fund to be deployed by community planning partnerships worth £145m per year over the next three years. The FSF amalgamates seven previous funding streams and their monitoring regimes. It will support Local Authorities, their Community Planning Partners (CPPs) and the Third Sector to work together to tackle challenges around poverty, deprivation and employability in their communities. It will focus on the causes of poverty, rather than solely addressing the symptoms, with a strong emphasis on interventions at a sufficiently early stage for vulnerable individuals, families and disadvantaged communities. The FSF will make a major contribution to tackling health inequalities by seeking to lift people out of poverty by helping them towards and into employment, as well as addressing the requirements of those with multiple and complex needs and addressing the challenges faced by those for whom work is not a readily available or straightforward option.

The FSF should promote more effective, outcome-focused, collaboration between local partners at CPP level, with health and wellbeing outcomes at the forefront. Importantly, the FSF will not be expected to 'sort' disadvantage on its own; it will act as the catalyst for galvanising mainstream resources and budgets towards lasting change. Commitment from NHS Boards to the community planning fora and the use of NHS skills and resources will be vital.

The performance management framework supporting the FSF operates within the new framework of national and local outcomes and indicators. Specific outcomes to be delivered will be included in the Single Outcome Agreement (SOA) between each Local Authority and Scottish Government. CPPs will work in partnership to achieve agreed outcomes relevant to local needs, through investment of FSF and mainstream resources. There is a clear emphasis on achieving key health outcomes, and on delivering on the Government's targets relating to healthy life expectancy and Solidarity in particular.

## 15. Helping to lift people out of poverty

### 15.1 Multiple and Complex Needs Initiative

Many public service providers find it difficult to deal with clients who have multiple, or a complex combination of, problems. These clients are often excluded from accessing the services they require and will often be living in poverty.

The Scottish Government's Multiple and Complex Needs Initiative, being run by the Scottish Government's Social Inclusion Division, aims to improve public services for people who may not have benefited from recent improvements to service delivery because they find it difficult to access services and/or to get what they need from them. Pilot projects are exploring ways in which different services can engage with service users and attract them to use their services, how they assess and deal with their particular set of service needs/problems, and therefore how they can improve service outcomes for them. Of the 14 projects, eight are working with people who have multiple and complex needs as a consequence of health issues such as sensory impairment, HIV/AIDS, mental health issues in minority ethnic communities and offenders.

An evaluation of the projects is being undertaken to identify what does and doesn't work, and the key lessons learnt will be disseminated to a broad range of service providers. The insights gained, for example in terms of holistic approaches, shifts in staff culture and working across traditional organisational and professional boundaries, will support the Task Force's approach to redesign of public services and provide good practice examples.

### 15.2 Maximising the Potential of Social Enterprise

Social enterprise is a business model which offers the prospect of greater equity of economic power and a more sustainable society by combining market efficiency with social and environmental aims. Social enterprises have potential for addressing health inequalities directly, through initiatives such as community food initiatives, community transport schemes, housing associations, and leisure trusts. They can provide crucial services and support for vulnerable communities and also employment opportunities. The Scottish Budget allocated a £93.6m transformational package for the Third Sector as a whole. A Scottish Investment Fund (£30m over three years) will support enterprise in the third sector through strategic investment in individual organisations supported by integral business support and management development. It will be helpful if specific criteria for investment include reducing health inequalities.

### 15.3 Maximising the Potential of Public Sector Organisations in Financial Inclusion

The NHS as a universal service can help connect with vulnerable people to provide information, advice and referral on appropriate financial products and services. These, in turn, can contribute to reducing poverty and alleviating the impact on mental and physical health related to debt and managing life on a low income.

Individuals who are most deprived and most in need tend to gravitate away from financial services and many access them only when their needs are acute, rather than being engaged at an early stage. Innovative models of good practice with wider potential for replication include the following:

- The Financial Services Authority is collaborating with the Royal College of Midwives to distribute its free "Parent's Guide to Money". The guide was developed with help from parents and health professionals. It tells parents what they need to know about all aspects of finance and helps them to benefit from financial support and to make sound financial decisions.
- The Perth Citizens Advice Bureau has successfully piloted outreach services in a pharmacy in Blairgowrie. This has helped provide advice – particularly on benefits – to those who are sick, long-term ill or disabled.

- North Lanarkshire Council and the Scottish Association for Mental Health have collaborated on a project to reduce the impact of financial exclusion experienced by unemployed people with mental health problems. The focus has been on key issues of accessibility to advice services, the health impacts of increasing money advice and income maximisation and the role that improved welfare benefits advice can have in promoting employability.
- Renfrewshire Council have supported a financial inclusion advisor to work with Cancer and Palliative Care patients. The service provides home visiting, surgery and hospice based advice and assistance on benefit reviews, applications and representation, as well as money and debt management advice. By supporting patients and their families it is hoped that the impact of ill health and job loss will be minimised. The success of this approach has been recognised with Macmillan Cancer Support funding provided to expand the project.
- Citizens Advice Bureaux are working in 11 GP practices across Edinburgh to provide money and welfare rights advice to vulnerable patients.

Local Community Health Partnerships (CHPs), can play a key role in maximising beneficial joint working between the NHS and financial inclusion services through engaging with people at risk of poverty and linking them in with appropriate financial inclusion activity.

#### **15.4 Early Intervention on Poverty to Promote Mental Wellbeing and Prevent/Minimise the Health Impacts of Alcohol and Drugs Misuse**

As noted above, there are strong correlations between poverty and the incidence both of mental health issues, and health issues related to alcohol and drugs misuse. It is suggested therefore that the work being taken forward on Towards a Mentally Flourishing Scotland and on strategic approaches to tackling alcohol should link closely with the anti-poverty discussions being undertaken by the Government, with a view to identifying 'upstream' anti-poverty interventions that can contribute to the promotion of mental wellbeing and reduce the negative health impacts of alcohol and drugs misuse.

### **16. Alleviating the impact of poverty on people's lives**

Scottish Government policies in a number of areas can help to improve the quality of life of people currently living in poverty, working in tandem with UK Government fiscal policies. Current Scottish action includes freezing/phasing out of Council Tax, free school meals, free prescriptions, free personal care and concessionary travel for disabled and older people.

#### **16.1 Promoting Benefit Take-up**

Although take-up of means-tested benefits has reached a plateau, some £4 billion a year still goes unclaimed across the UK. There remains a need for high quality welfare rights services, with careful consideration of their range and accessibility. For example, locating advice services in primary care can help to reach older and disabled people. The extra resources acquired by clients tend to be directed towards extra spending on fuel, food, education, recreation and transport, with resultant improvements in general health, living standards, reduction in social exclusion and local economic benefits.

Scottish Government has been exploring with DWP, its agencies, HM Revenue & Customs and a range of other bodies, what role we might play in helping people maximise their benefits and tax credits. Pilot benefits take-up campaigns directed at older people and a longer term initiative designed to maximise benefit take-up across a range of eligible people is now being planned by a broad partnership involving UK and Scottish Governments and NHSScotland. An important part of this work will be to examine increase benefits and tax credits in order to help improve the health and wellbeing of claimants.

Local projects could also be scaled up. In a scheme in Glasgow, members of the West of Scotland Seniors Forum operate a freephone information “hotline” operated by older volunteers who have undertaken intensive training programmes and provide advice to other older people on keeping warm in the winter and accessing the help available. The volunteers also provide practical assistance to people who are having heating or insulation fitted: for instance, taking someone out for the day while work is being carried out. Although there is no clear evidence about the health gain to be secured from alleviation of fuel poverty (see below) promising and practical initiatives such as this one could be replicated elsewhere and their impact on health evaluated.

## **16.2** Tackling Fuel Poverty

Fuel poverty – not being able to heat a home to an acceptable standard at a reasonable cost – is caused by a combination of three factors; low household income, high fuel costs and poor energy efficiency in the home (in terms of ineffective insulation and inefficient central heating and often poor housing design). Progress in reducing fuel poverty was made between 1996 and 2002 as fuel prices fell but this has subsequently reversed, in parallel with the steep increases in gas and electricity prices which occurred from 2003 onwards. As the Scottish Government only has control of the energy efficiency element of fuel poverty, it is very difficult to act effectively when fuel prices rise or when incomes do not rise sufficiently to offset the price rises. However the Scottish Government has been able to successfully raise the energy efficiency of the housing stock over time, though still more progress is required on this front.

A range of measures aimed at addressing fuel poverty has been in place for some time, The bulk of Scottish Government funding is concentrated on the Central Heating Programme (CHP) which is available very widely across the pensioner population of Scotland, depending on whether pensioners require their first central heating system or a replacement system for one that has broken down. Such is its popularity (even without widespread publicity) this programme currently has a 5-6 month waiting list (broadly around the historical average) and a priority scheme has recently been introduced to help those without heating or hot water. The CHP in particular has been running since 2001 and now only 3% of Scottish pensioner households have no form of central heating. It is therefore somewhat surprising that fuel poverty has risen so steeply in recent years.

Evaluation of these initiatives, which have themselves changed in character and scope over time, has been somewhat limited to date. There are inevitably lessons to be learnt from existing programmes – where these have worked and where they have failed – helping to improve their effectiveness and inform the development of future schemes. This is why the Scottish Government has announced an internal review of fuel poverty programmes, the main findings of which will be shared with stakeholders in early 2008.

The benefits of installing central heating in particular were assessed in a recent University of Edinburgh study but it stopped short of saying that the wider availability of central heating was bringing identifiable health benefits across Scotland. As there is no clear evidence about the health gain to be secured from alleviation of fuel poverty and in particular central heating, it is imperative that programmes are accompanied by a well designed health impact assessment.

**February 2008**

## TECHNICAL ANNEX: POVERTY IN SCOTLAND

Poverty is defined and measured in different ways. At its simplest, poverty can be defined as low income. However, although low income is a major component of poverty, it is usually found in association with a broader set of closely connected factors associated with social disadvantage, including unemployment, poor skills, poor housing and fractured personal and family relationships.

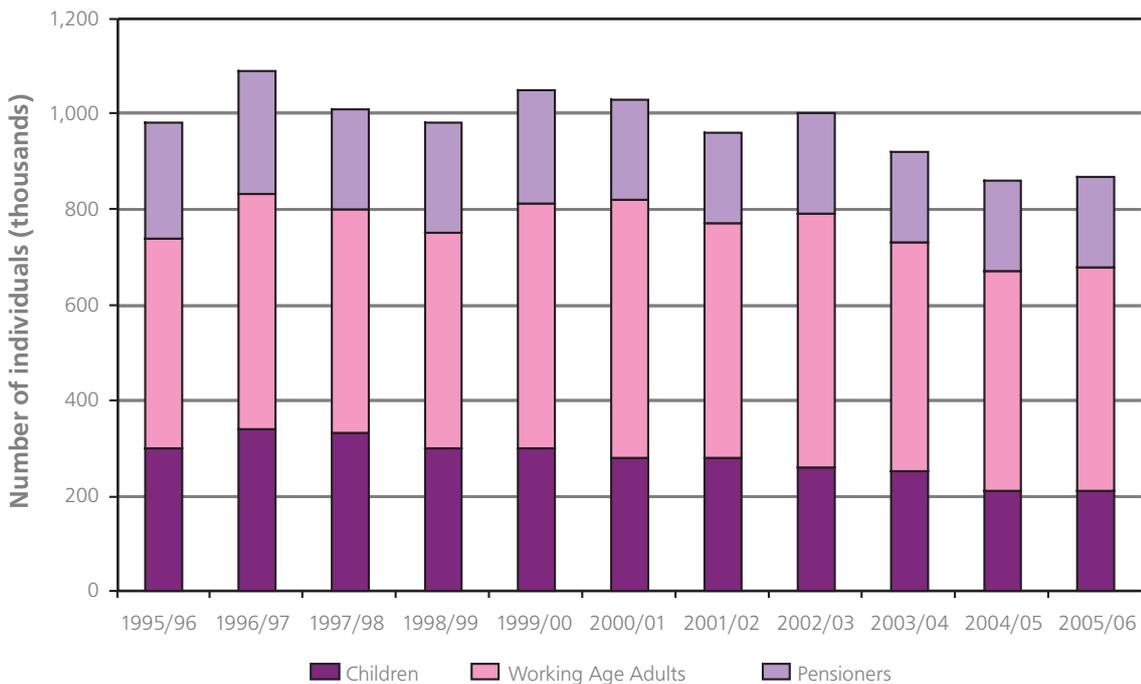
Poverty can be considered in absolute or relative terms. *Absolute poverty* refers to a set standard which does not change over time. *Relative poverty* is defined as having a household income less than 60% of the current UK median after adjustment for household composition.

For a single person, to be poor is to live on less than £145 per week, before housing costs. The equivalent figure for a couple is £217, or for a couple with two children aged 5 and 14, £332 per week.

There are 880,000 individuals living in relative poverty before housing costs in Scotland. This represents 18% of the population.

The number of people in poverty in Scotland has fallen by 10% in the last 10 years. The reduction has been greatest amongst children and pensioners. However last year the number of working age adults in poverty rose by 10,000.

**Chart 1: Number of people in poverty, Scotland 1995-96 – 2005-06**



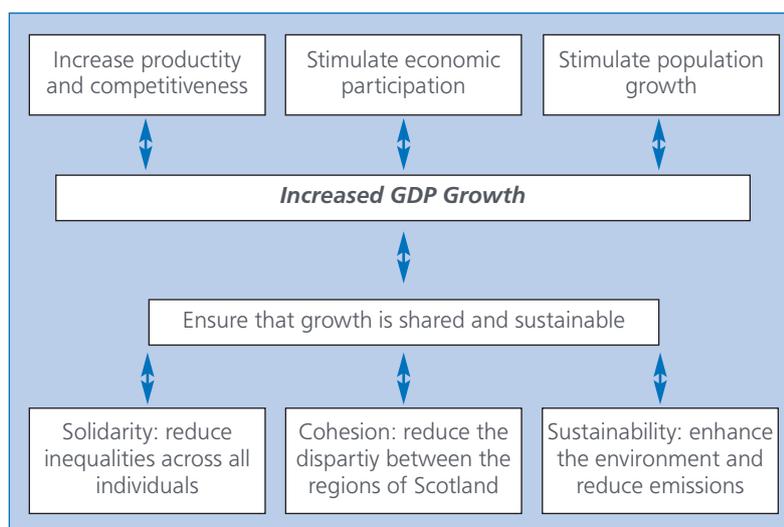
Source: Family Resources Survey, Households Below average Income datasets.

## ENTERPRISE AND EMPLOYMENT ACTION

### Introduction

1. This paper will, firstly, consider how health inequalities are influenced by employment and wider macroeconomic conditions; and, secondly, identify relevant policy actions with the greatest potential for addressing Scotland's growing health inequalities.
2. The *Government Economic Strategy* (GES) provides the route map for this Government to deliver on its overarching Purpose, increasing sustainable economic growth (Figure 1).

**Figure 1: Key components of Scotland's Government Economic Strategy**



3. One of the key components of economic growth is increased labour market participation. Despite improvement in labour market participation compared with our historic position, Scotland still lags behind the strong regional economies in the South East of the UK. Over 600,000 people in Scotland are classified as economically inactive; latest figures show that 285,000 people of working age (representing 9% of the working age population) are Incapacity Benefit claimants. Increased growth is dependent on the creation of more employment opportunities in Scotland and on ensuring that more of our working age population become economically productive.

4. The GES is, however, targeted at making Scotland wealthier *and* fairer. Therefore, delivering on sustainable economic growth must also involve delivering on our three Golden Rules of Solidarity, Cohesion and Sustainability. The Solidarity Golden Rule is directly relevant to increasing employment opportunities in Scotland; it involves providing the opportunities, and incentives, for *all* to contribute to Scotland's sustainable economic growth. Moreover, the related Cohesion Golden Rule, involves putting greater priority on achieving more balanced growth across Scotland. As indicated in Paper 15, the Solidarity and Cohesion Golden Rules are underpinned by the following time-bound, national targets:

*Solidarity Golden Rule:* to increase the overall income and the proportion of income earned by the three lowest income deciles as a group by 2017.

*Cohesion Golden Rule:* to narrow the gap in participation between Scotland's best and worst performing regions by 2017.

**5.** As shown in Figure 1, population growth is one of the three key drivers of increased GDP growth. Accordingly, Scotland's GES recognised that this will be achieved by a combination of changes, including inward migration and increased healthy life expectancy. It therefore defines the following population growth target:

*To match average European (EU15) population growth over the period from 2007 to 2017, supported by increased healthy life expectancy in Scotland over this period.*

### **The influence of employment and macroeconomic conditions on health inequalities**

**6.** Being in employment has powerful health enhancing potential, because:

- Employment is generally the most important means of obtaining adequate economic resources, essential for material wellbeing and full participation in today's society.
- Work meets important psychological and social needs in societies where employment is the norm.
- Work is central to individual identity, social roles and social status.
- Employment, education and income are the principal drivers of the steep socio-economic gradients observed in mortality, physical and mental health outcomes.

**7.** In their 2006 systematic review, Waddell & Burton concluded that, on balance, being in "good work" is generally better for health and wellbeing than unemployment. It identified the following workplace characteristics through which people gain benefits from employment:

- Safety
- Fair pay
- Job security
- Personal fulfilment and development, balancing effort and reward
- Good communication
- Control over pace of work and key decisions that affect the workplace
- Task discretion, minimising requirement for monotonous and repetitive work
- Skill levels allow employees to cope with periods of intense pressure
- Accommodating, supportive and non-discriminatory
- Social capital is supported through informal friendship networks or formal associations, enhancing resilience

**8.** Economic growth can provide both benefits and risks to health.

Potential benefits include:

- Increased consumption of goods and services
- Reduced unemployment and poverty
- Greater wellbeing, although wellbeing may not increase above a certain level of income
- Improved public services

Potential harmful consequences include:

- Problems from increased consumption, including obesity and alcohol related harm.
- Environmental consequences of growth, such as increased urbanisation, loss of green space, decreased biodiversity and pollution.
- Increased working hours, poor work-life balance and mental health problems.
- Increased income inequality.
- Increase in crime and social exclusion, due to polarisation and inequality.

As indicated above, the focus of the *GES* is to promote the benefits of economic growth, and, through the achievement of the Golden Rules, to negate the potentially harmful social and other consequences of that growth. Evidence shows that comparable independent nations, particularly Denmark, Finland and Norway, have achieved higher than average economic growth whilst retaining considerably greater social equity than Scotland.

**9.** With respect to the key health inequalities identified by the Task Force, the following points should be noted:

- Early years: Two-thirds of all low-paid employees in Scotland are women. If affordable childcare is unavailable, this exacerbates household poverty and other adverse environmental influences in the early years.
- Cardiovascular disease and cancer: In combination with other factors that show social clustering in time and place (including educational attainment, income, the social environment, individual behaviour and prevailing economic circumstances), worklessness is an important contributor to cardiovascular health inequalities. Job insecurity and short term work represent part of the continuum of adverse employment circumstances, with growing evidence that these new patterns of employment also exert an adverse impact on cardiovascular risk factors.
- Mental wellbeing and mental illness: Worklessness and poor working conditions are strongly associated with poor mental health, with some evidence that this is a major causal pathway underpinning the cardiovascular mortality effects discussed above. The Labour Force Survey 2005-06 estimated that 10.5 million working days were lost from work in the UK due to stress, depression or anxiety (43% of all days lost).
- Drugs, alcohol and violence: People from the most deprived areas in Scotland are three times more likely to be admitted to hospital with an alcohol-related diagnosis than people from the most affluent areas and men from the most deprived areas are seven times more likely to die from an alcohol-related condition than men from the most affluent areas. There are inevitably consequences for people's productivity and ability to sustain employment.

### What types of economic and employment policies can reduce health inequalities?

**10.** As discussed at an early stage in the Task Force's work, actions at a regulatory or structural level have potential to reduce health inequalities as well as interventions at an individual level.

With respect to this policy area, two reserved matters might be raised as part of the National Conversation; these are Health and Safety legislation and the UK's current "Welfare to Work" arrangements. Given the substantial overlaps between the regulatory aspects of Health and Safety and devolved responsibilities for workplace health and wellbeing, devolution of Health and Safety legislation could improve efficiencies, synergise health promotion and health and safety functions and achieve better prioritisation of the Scottish Government's strategic objectives. Devolution of aspects of 'Welfare to Work' policy could potentially create a more seamless set of employability arrangements to move workless people towards and into the labour market.

**11.** The Scottish Government’s existing powers can be used to reduce health inequalities. Action within these powers can broadly be categorised as follows:

- Policy action at individual level.
- Policy action directed towards workplaces and employers.
- Policy action at the wider economic level.

**12.** Action at individual level principally concerns a range of employability initiatives. By “employability” we mean the combination of factors and processes which enable people to progress towards or get into employment, to stay in employment and to move on in the workplace. Evaluations of employability initiatives suggest that the following factors are important determinants of effectiveness:

- holistic, client-centred, customised provision of training and support.
- based on assessment of local demographics, social environment and market demand.
- build on existing service provision.
- credible with employers and potential clients.

**13.** Action directed towards workplaces and employers seeks to ensure that work is sustainable, is not counterproductive to physical or mental health and wellbeing and offers the possibility of progression to pay levels that protect people from poverty. It also offers opportunities to actively promote healthy lifestyle choices, by offering, for example, healthy food choices, physical activity opportunities and smoking cessation services.

**14.** Health inequalities are fundamentally shaped by the wider economic environment, thus policy actions at this level are very powerful levers for achieving more equitable health distribution. Relevant “upstream” action includes balanced development and integration of both the enterprise and health agendas, building supportive business environments and systematic investment in learning and skills.

## Recommendations for policy action

### 15. Policy action at individual level

A wide range of employability interventions seeks to move people closer to, or into, work. What is suitable for an individual will be determined by the reason for their being out of work, the nature and degree of any incapacity, their skill level, and the length of time they have been out of work.

Workforce Plus is Scotland’s employability framework, with delivery of national targets to reduce economic inactivity in seven local authorities. Action is delivered via local Workforce Plus partnerships and the approach is now being replicated more widely.

#### a) Improving services that get people into employment

NHS Boards need to work proactively with community planning partners and local Workforce Plus partnerships to enable people to retain or return to work.

Working for Families helps parents and carers to access employment, training or education by providing additional support, in particular, with affordable childcare. The approach operated over the last four years across 21 Local Authorities; decisions around its future mainstreaming will be made by Community Planning Partnerships based on local needs. However, given the positive outcomes achieved to date, it is expected that many aspects of Working for Families will continue, with potential for new areas to adopt it, using resources identified within the Fairer Scotland Fund.

b) Stronger focus on people with specific problems/out of work longer

Workforce Plus acknowledges the need to deliver person-centred services that meet the needs of individuals, whilst offering greater support to some specific groups. Accordingly, well designed interventions use person-centred approaches to initial engagement, including outreach work, to engage with those who are furthest from the labour market. Workforce Plus also has a particular focus on helping clients with learning disabilities and mental health problems; it has appointed a learning disabilities co-ordinator to help Community Planning Partnerships progress their work on employability in the context of learning disability. It has also commissioned the Scottish Development Centre for Mental Health to support Workforce Plus partnerships, locally and nationally, in achieving the objectives of Workforce Plus for people experiencing mental illness.

The Welfare Benefits system is currently a reserved competency and any changes to the existing eligibility criteria and its assessment system would require negotiation at UK level.

c) Achieving a more effective NHS contribution

It is essential that senior management in Health Boards and CHPs understand the important link between health and work in order to develop health services that reflect this. One of the key learning points from a “Working for a Healthier Scotland” conference in November was the need to secure “buy in” at a strategic level that employability is a major part of the jigsaw to improved health and wellbeing.

Healthcare professionals, particularly GPs and others in Primary Care, are well placed to work with patients who would benefit from being supported either directly into employment or, more commonly, into services that will help those at a distance from work to progress towards employability. However, employability is a complex field and it is clear that much more needs to be done to help healthcare professionals understand more easily where they can refer patients in their journey towards improved employability and enable their patients to access employability services appropriate to each person’s individual circumstances, such as additional therapy, rehabilitation, skills and training. Achieving these aims in a systematic way will require work with NHS Boards, Community Health Partnerships (CHPs), the Royal Colleges and associated training providers to develop an understanding of the beneficial links between work and health and enable health professionals to access appropriate services for their patients.

The Condition Management approach is currently used by health professionals as part of the Jobcentre Plus Pathways to Work programme. Early engagement through general medical practices can be successful, providing that local support services are part of the engagement and wider delivery system. An employability adviser in a Paisley general practice setting engages with the practice healthcare team, providing simplified routes to Jobcentre Plus and its associated services. This has achieved improved health for patients and successfully changed cultures within the practice in relation to employment.

d) Supported employment schemes

Supported employment is a widely recognised method of assisting disadvantaged individuals into the labour market by providing a range of client-focussed interventions to support clients and employers. The Scottish Union of Supported Employment (SUSE) has set out a blueprint outlining roles and responsibilities of different organisations in promoting and delivering supported employment, from early engagement to finding work and aftercare support, citing quality standards as a crucial element.

## 16. Policy action directed towards workplaces and employers

### a) Increase awareness of business benefits derived from investing in workplace health

Evidence from around the world shows that investing in workplace health and wellbeing makes good business sense. Employers who have invested in making the workplace more pleasant, have given employees more power over how they do their work and have engaged with their workforce on measures that promote health and wellbeing have reported a significant return in workforce loyalty, a better image in the community, reduced sickness absence, improved morale and increased productivity.

### b) Use effective approaches to influencing employers more consistently

Evidence is emerging on the motivating factors that drive businesses to adopt healthy working policies in the workplace. However, workplace health promotion currently tends to be the preserve of more enlightened businesses, who take a holistic rather than purely financially-based view of the benefits. More employers need to be convinced of the strong business case underpinning healthy workplace strategies to encourage their widespread adoption, particularly in small and medium sized enterprises (SMEs). Further case studies are needed on the range of business benefits, as well as encouraging existing Healthy Working Lives award winners to be champions and mentors. These activities need to become more systematic through the existing business support infrastructure.

### c) Specific action on improving mental health in the workplace

The economic consequences of lost working days in the UK due to stress, depression or anxiety are profound, accounting for over 40% of all days lost. However, a recent survey of 500 UK companies found that 80% had no policy to deal with stress or mental ill health in the workplace and only 3% believed they had an effective policy. Only 37% of employers indicated that they would consider employing someone with a mental health problem.

Specific areas of activity to address mental health issues include:

- Risk assessment for work-related stress using the Health and Safety Executive (HSE) guidance "Tackling Stress: the Management Standards Approach".
- Raise awareness of those groups who may be particularly subject to bullying and harassment in the workplace through good equal opportunities policies, anti-discriminatory practices and clear routes for reporting problems.
- Eradicate stigma and discrimination against people with mental health problems, especially amongst employers.
- Training resources for employers and managers on tackling stress in the workplace and managing people with mental health difficulties.
- Support rehabilitation and provision of psychological therapies.

### d) Implementation of Scottish Action Plan on Health and Safety

The Action Plan, published in March 2007, contains non-legislative measures to achieve some broad outcomes which contribute to reducing health inequalities through safe and healthy work. These include:

- Expansion of business access to health and safety advice and occupational health support via a range of complementary routes.
- Increased worker involvement in health and safety.
- A role for Scottish Government as "standard-bearer" for the health and safety performance of Scotland's public sector.

Delivery is being coordinated in partnership with a range of organisations who make up Scotland's "health and safety system".

e) Extend availability of vocational health and rehabilitation services

Health and safety legislation requires management of workplace risks which could cause ill health or exacerbate existing conditions. However, evidence shows that occupational health is not well understood, especially by small businesses, and that occupational health provision and adoption of rehabilitation policy is very low. In response to this, the SCHWL is developing an "intelligent customer" function to give practical advice on the type of occupational health services appropriate to individual businesses. This is likely to include referral to NHS and other specialist services where appropriate.

In particular, better coverage of SMEs is needed, where organisations do not have their own occupational health provision. Potential solutions include bringing together occupational health advice and provision for SMEs in a local area contract and encouraging larger employers to extend their provision down their supply chains.

The NHS is frequently the first contact point for those with conditions that may compromise their ability to gain or maintain employment. There is a need for improved, rapid access to relevant treatments in order to support a return to work as quickly as possible.

## 17. Action at the wider economic level

Several specific actions within the five channels of the GES Strategic Priorities have powerful potential to influence health inequalities in Scotland. These include; enterprise support to geographical areas facing multiple deprivation; improved planning systems that balance development of good quality, health promoting and sustainable places with the requirements for economic growth; support to businesses employing people from deprived communities; and ensuring that the supply of education and skills in Scotland can respond to employer demand.

a) Improved integration of spatial planning and health agendas

The GES outlines a set of actions that will create a more streamlined approach to planning and development across urban and rural Scotland. This will ensure that planning systems optimise the requirements for economic growth in ways that support the health promoting potential and sustainability of geographical communities.

b) Improved integration of enterprise and health agendas

Workplace health is typically viewed as an issue belonging to "health" not "business" – the SCHWL, for instance, operates under the NHS. The fact that the community of professionals working towards a "healthy workforce" are drawn almost exclusively from the health community limits the potential progress of initiatives to address health inequalities in the workplace.

Business Gateway will be in a position to influence employers' attitudes and behaviours towards the health of their workforce, and that of potential recruits.

c) Learning and skills

Scotland's Skills Strategy (2007) aspires to a Smarter Scotland that engages more effectively with a globally competitive economy, based on high value jobs. It seeks to promote progressive and innovative business leadership, entrepreneurship and innovation, where small businesses are encouraged to grow, with strong, coherent support for businesses of all sizes. The Strategy also contains a strong equity dimension that seek to ensure that all people in Scotland can realise their aspirations and achieve their potential.

d) Investment in Urban Regeneration Corporations and major infrastructure projects

The Scottish Government is investing a total of £87 million in Urban Regeneration Companies (URCs) over the SR 07 period, which is expected to lever over £500 million of private sector investment. The Government are keen to see URCs bridging the gap between physical, economic and social regeneration and, as such, have encouraged them to take a holistic approach to the regeneration of their areas, recognising that although much of their investment will be in place transformation, many of the outputs and outcomes needed if an area is to be regenerated will relate to areas such as employability, educational attainment, community safety and health.

As a result, the URCs have an important coordination role to ensure that their respective work programmes are complemented by interventions aimed at achieving outcomes in these areas, many of which will be the responsibility of local partners. The URC network are also developing approaches around the use of community benefit clauses in procurement to ensure that opportunities for people in the most deprived communities are maximised. The extent to which this is achieved will be captured in the monitoring and evaluation framework that is being developed to monitor the impact of the URCs' activity.

e) Maximising the contribution of public sector organisations

Thirteen NHS Boards are involved in pre-employment activity, with each Board having developed clear, structured and well supported pathways for people from marginalised groups to access employment opportunities. A draft business case and a "gold standard" template detailing success factors for successful implementation, continuation and mainstreaming of pre-employment activity has been developed. These resources will help Boards to build the case for widening their recruitment pool as part of standard employment practice.

Social and environmental requirements can be included in public contracts if they comply with the requirements of EC Treaty Principles (including equal treatment, transparency and proportionality) and procurement rules. The Community Benefits in Procurement (CBIP) programme has enabled piloting of the methodology for including targeted recruitment and training opportunities in public sector contracts in a manner that is consistent with procurement legislation. It has identified key lessons for the public sector to facilitate the inclusion of the community benefit clauses in future contracts.

## Conclusions

This paper has identified specific policy actions at individual, organisational and the wider economic environmental levels that all have the potential to increase or decrease existing health inequalities. Understanding the net effect of these actions on health inequalities is complex and will necessitate use of health impact assessment and evaluation approaches alongside adoption of new policy actions.

**February 2008**

# 7. GREENER SCOTLAND

## **ACTION ON PHYSICAL ENVIRONMENTS TO REDUCE HEALTH INEQUALITIES**

### **Introduction**

1. This paper examines two of the Task Force's key principles:
  - To improve the whole range of circumstances and environments that offer opportunities to improve people's life circumstances and hence their health.
  - To reduce people's exposure to factors in the physical and social environment that cause stress, are damaging to health and wellbeing, and lead to health inequalities.
2. As in Professor Sally Macintyre's briefing for the Task Force, health inequalities would be wider today if it were not for a number of equity-enhancing policies on the physical environment over the past decades, including neighbourhood regeneration, housing improvements and control of the environment via clean air acts etc. Some of the policies Sally reported as more likely to be effective in reducing inequalities in health include:
  - Structural changes in the environment eg area-wide traffic calming schemes, separation of pedestrians and vehicles.
  - Legislative and regulatory controls, e.g. house building standards.
  - Improving accessibility of services, e.g. through better transport links, affordable healthy food.
3. This paper explores action in these and related policy areas. While there are undoubted general benefits to health from such activity, it is difficult in many cases to identify what specific action, over and above current policies and programmes, will help to reduce health inequalities. The paper also looks at the importance of how environmental policies are implemented which will help to make them more effective in addressing health inequalities.

### **Environmental justice**

4. The term "environmental justice" was first used in the USA in the late 1970s. It described the aspiration of more meaningful community involvement in environmental decision-making, together with a reduction in, and a more equitable distribution of, environmental burdens.

**5.** A 2004 research review by the Sustainable Development Research Network on environment and social justice concluded that:

- Problems of environmental injustice affect many of the most deprived communities and socially excluded groups.
- Both poor local environmental quality and differential access to environmental goods and services have a detrimental effect on the quality of life experienced by members of those communities and groups.
- In some cases, not only are deprived and excluded communities disproportionately exposed to an environmental risk, they are also disproportionately vulnerable to its effects.

**6.** The core relationship between environmental justice and health inequalities is founded on the premise that where there is a “stacking up” of “environmental bads”, combined with an absence of “environmental goods”, ill health and reduced quality of life result, and that this is evidence of an “environmental injustice”. Therefore, tackling health inequalities should take account of the co-incidence of poor health outcomes and poor environmental quality, and consider those local environments as part of the solution to the health problems.

**7.** More is required in order to allow the Scottish public fuller involvement in environmental decision-making. This is based on the expectation that, when the public have visible and viable routes for involvement, their sense of exclusion and hopelessness will be reduced, with consequential secondary positive health outcomes.

**8.** Action on environmental justice should include the following:

- The UK Government Office for Science Foresight report Tackling Obesities 2007 suggests that people living in more deprived communities may suffer the health impacts of living in less walkable, more degraded environments; and that the health risks of being obese may be compounded by other health impacts associated with deprived environments. There could be a win-win outcome from improving environments and access to healthy food in terms of regeneration, better health, health and social inclusion.
- Quality of neighbourhood improvements - tackling problems locally and addressing local environmental ‘bads’ will lead to improvements in the local environment, and safer, healthier communities. Scottish evidence indicates that those who report the highest levels of local environmental ‘bads’ are also more likely to be anxious, depressed and in a poor state of health. They are less likely to ‘take a walk’, and more likely to smoke. The latter two activities point to behaviours closely related to key health inequalities (obesity, cardio-vascular disease, diabetes). This evidence suggests that low level ‘street incivilities’ are connected to (if not the cause of) important health inequalities, and as such, these environmental conditions should be addressed as part of achieving better health outcomes for groups at risk.
- In terms of mental health, the same Scottish study found that people reporting experience of living with high levels of environmental ‘bads’ were also less trusting of others and more fearful of being a victim of crime.
- The absence of ‘environmental goods’ emerged in this Scottish study as a key factor in the health outcomes explored. The absence of green, safe or pleasant places to walk or play is strongly correlated with how happy people feel about living in their area, whereas the presence of large infrastructural ‘bads’ is not.
- Neighbourhoods and communities that experience traffic congestion and high levels of urban traffic are susceptible to health inequalities in terms of air pollution and pedestrian accidents (see Transport and Air quality sections below).

- Waste infrastructure - moving away from over-dependence on landfill which can have a significant negative impact upon some communities. The evidence about physical health impacts from landfill or incineration is contested, but it is generally accepted that proximity to waste infrastructure is not conducive to good health and wellbeing, at both individual and community level.

**9.** On public involvement in environmental decision-making:

- The reform of the planning system embodies key elements of encouragement for the public to be involved in the planning system, but Scottish evidence suggests that the public is generally not able to easily access information about their local environment.
- Better, more effective access to and signposting of environmental decision-making information would encourage a higher level of public participation, and engender a better sense of individual and community wellbeing in such communities.

**10.** Activities already underway in the reform of the planning system, in the development of a new National Waste Plan for Scotland, and the forthcoming Flooding Bill already anticipate key improvements in localities experiencing both environmental 'bads' and absence of 'goods'. It is essential that health criteria are embedded in assessments for major initiatives in these areas, to allow a co-ordinated approach to policy development, and critically, to the gathering of evaluative data from which we can learn. It is especially important to embed consideration of the negative health impacts of 'street level incivilities' in local community planning activities.

**11.** Government will invest in further 'mapping' research and data gathering of environmental 'goods' and 'bads' research across Scotland, and work on integrating evidence and policy across the health and environment portfolios.

**12.** Government will also explore the possibility of a national portal for accessible environmental information for the public, guidelines and standards to inform a hierarchy of information, a network of environmental information providers and explicit promotion of these improvements to the public.

### Health and equity impact assessment

**13.** The Task Force has already discussed the need for a whole range of public policies to be assessed for their impact on health and to demonstrate how they are contributing to reducing health inequalities. The Better Health, Better Care action plan, published in December 2007, said that Government would support this by the development and application of an integrated process for such assessments.

**14.** Better Health, Better Care also said that local decisions about service change and investment across the NHS should be more routinely informed by health impact assessment, with a view to extending this approach to the activities of all community planning partners.

### Greenspace

**15.** Greenspace can be defined as "any vegetated land or water within or adjoining an urban area", including natural greenspaces; green corridors; amenity grasslands; parks and gardens; and countryside that people can access from their homes.

**16.** It is widely recognised that there is an association between health and access to greenspaces. Not only is the presence of greenspace believed to be conducive to good health, but the absence of greenspace is understood to be bad for health, in terms of both physical and mental health outcomes. So significant health inequalities may be associated with lack of access to greenspace, particularly in conditions such as cardio-vascular disease, obesity, diabetes and mental health. Where people at risk of these health conditions do not have access to greenspace, they are at a disadvantage. Evidence in Scotland indicates that it is the most deprived areas that enjoy least access (and least use of) high quality greenspace nearby.

**17.** While it is widely recognised that there is an association between health and access to high quality greenspaces, the role of such spaces in addressing Scotland's health inequalities is less explicitly mapped. This is an area of significant current research activity; evidence of causal links is not yet well scientifically established, but such links are strongly anticipated to exist among health and environment scientists. This emerging field is currently assessing the level of evidence available in relation to greenspace, and there is a strong argument that 'the precautionary principle' should be exercised to protect, maintain and encourage the creation of urban greenspaces.

**18.** The Scottish Government recognises the importance of greenspace and has a commitment to the provision of an environment which contributes towards well-designed, sustainable places with access to amenities and services, recognising the importance of the quality of the environment, nature and greenspace in promoting mental health and wellbeing.

**19.** Children who have better access to safe green and open places are more likely to be more physically active and less likely to be overweight, than those living in neighbourhoods with reduced access to such facilities. Therefore, children at risk of health inequalities require accessible greenspace as part of their pathway to good health.

**20.** Access to greenspace is also associated with greater longevity in older people.

**21.** Recent research suggests that health differences between urban and rural residents can be partly explained by the amount of 'green' in their direct living environments. It is not principally the quantity of greenspace available, but the quality of greenspace that makes a difference in encouraging use of such spaces. Active promotion of greenspace use is also required, especially in areas where there is lower use of accessible greenspace, and where other health inequalities prevail.

**22.** Policies that promote local creation of greenspaces offer opportunities to build social (and health) capital through local involvement, volunteering and physical activities embodied in the greenspace (such as gardening, landscaping). The Forestry Commission's *Wood In and Around Towns* initiative is already successful in reaching areas of multiple deprivation.

**23.** The Task Force can use its emerging understanding of the links between deprivation, stress and health inequalities to suggest that how future policies aim to improve provision of greenspace is as important as the policies themselves. There needs to be full engagement of individuals, families and communities most at risk of poor health in services and decisions and clear ownership of the issues involved, as set out in the Task Force's November principles. We also need to evaluate progress and success more carefully, paying particular attention to whether action really serves to reduce inequalities in health in specific communities and areas.

## Transport

**24.** A recent briefing paper by the Glasgow Centre for Population Health considered how transport could reduce health inequalities and concluded that "transport strategies have a vital role to play in improving social inclusion and accessibility through investment in good public transport systems and instituting measures that encourage walking and cycling".

**25.** The Scottish National Transport Strategy (2006) includes action in some areas where transport could contribute to health improvement, for example, to improve the quality, accessibility and affordability of public transport.

**26.** Inactivity is a major risk factor in cardio-vascular disease and cancer. Encouraging a shift from car travel to public transport, cycling and walking is a key aspect of increasing rates of daily physical activity. Public transport users are more active than car drivers/passengers as they walk/cycle to and from transit points. Both the National Transport Strategy and the Government's Physical Activity Strategy aim to increase the proportion of short journeys made on foot and on bikes to improve individual health and also to reduce carbon emissions and improve air quality.

**27.** Research undertaken in 2006, *Promoting Active Lifestyles – Good Ideas for Transport and Health Practitioners* is aimed primarily at NHS Health Promotion teams, local transport planning officers, community planning partnerships and outdoor access officers. It includes examples of the type of work that is going on around Scotland to promote active lifestyles. For example, Active Referral in Linlithgow was set up to find out whether health-related travel awareness material would be more effective if it was delivered to the public via a reliable third party such as a GP, rather than through the traditional transport sector. Government is also looking more generally at how physical activity can be promoted effectively through primary care, including 'exercise on referral' approaches.

**28.** Increasing the accessibility of services can improve people's life chances and reduce social exclusion. Having reliable, safe and affordable public transport can often be critical, for example for those with limited employment options. This means considering transport implications when re-designing services or planning/building new facilities. The Bus Action Plan, which follows through on one aspect of the National Transport Strategy, highlights the need for a more holistic and partnership approach to integrating land use planning and transport planning. Better integration and planning frameworks will help ensure that the links are made between walking and pathways and the bus network when building new houses, hospitals, shopping centres or schools.

**29.** Other specific actions which are being taken forward include: completing the National Cycle Network and associated 'short links' that encourage commuting to work and travel to school by bike or on foot; supporting travel planning to ensure that all local authorities, major hospitals and health facilities have operational travel plans by April 2008; and working to increase the number of children and adults cycling to school and more generally. The challenge here is to scale up and replicate small projects that seem to work well in deprived communities: for example, Try-cycling run after-school bike clubs in Craigmillar, Edinburgh; and the Bike Station in Edinburgh are taking forward a small project that teaches young people in deprived areas how to build their own bikes.

**30.** There are links between the neighbourhood people live in and the rate of road accident casualties. People of all age groups experiencing social exclusion generally suffer higher casualty rates. Accident rates are higher in areas where there are higher levels of lone parents and pensioners, fewer economically active adults and lower levels of car ownership. Death in road accidents is related to socio-economic background. Children in the lowest socio-economic groups are as much as four times as likely to be killed and up to six times more likely to be injured, than those from more affluent areas.

**31.** Road Safety Scotland (RSS) supplies road safety educational resources to every school in Scotland, while the Children's Traffic Club in Scotland (CTCS) offers free road safety training to all 3 year old children. RSS has also supported local campaigns to try and increase uptake of CTCS in deprived areas.

**32.** Good Practice Guidance on developing community based road safety initiatives was published in 2002. The guidance provides practical advice on what local communities and public agencies can do to address some of the main threats to personal safety from traffic and road user behaviour. Most importantly, it targets those areas and people most at risk.

**33.** The National Transport Strategy states that the Scottish Government will support action targeting children from disadvantaged areas who are at greater risk of injury in road accidents.

## Whole Community Approaches

**34.** The Government is planning a number of whole community developments and demonstration projects in the near future. For example, sustainable travel demonstration towns, in partnership with COSLA, which will focus on active travel, building in health outcomes from the outset. There are also plans for a whole community approach, mirroring successful developments in France to reduce childhood obesity. Other developments will support the creation of sustainable places as exemplars of good practice in planning and building, to help drive up the quality of new developments in the future. Work is underway within the Sustainable Places aspect of the Government's Greener Scotland theme, to make sure that the objectives of these local demonstrations are consistent and integrated, so far as possible. From the Task Force's perspective, it will be particularly helpful if these whole community approaches explore whether it is possible to reduce or avert the development of health inequalities. That will require health and health inequalities outcomes to be evaluated from the start.

## Air Quality

**35.** There is a proven clear link between air pollutants and human health. This is primarily for particulate matter (PM) smaller than 10 µm which is able to enter the respiratory system. Cardio-vascular disease and asthma have been linked to high levels of PM10 in the air, hence an EU Air Quality Directive which sets limits for a range of air pollutants across member States and an air quality strategy for the UK which sets objectives for the same set of pollutants local authorities have a responsibility to meet these objectives. In Scotland there are tighter objectives than the rest of the UK for PM10 and benzene, as generally air quality is better here.

**36.** Scotland has particularly high rates of the population affected by cardiovascular disease and asthma. Given that PM10 is linked to both these diseases it would be beneficial to explore the contribution that air quality has on health outcomes.

**37.** Research conducted by SNIFFER (2006) into social deprivation and air quality did not find a relationship between the two for Scotland. Both the most deprived and least deprived areas experienced the same levels of air quality. The explanation lies in the distribution of different communities in city centres. Air quality is closely related to traffic, and certain city-centre areas of affluence also experience high traffic pollution. A reduction in traffic, and particularly in car use would improve air quality considerably and be likely to deliver health benefits.

**38.** The Scottish Government is funding a Scottish air quality database which will (by 2009) have almost all the air quality data monitored across Scotland in one website and produce both national and regional trend data. This will help support studies into human health impacts of air pollution.

## Housing

**39.** Officials have reviewed evidence on the links between housing quality improvements and health inequalities. There are consistent correlations between poor housing and ill health, especially mental health and wellbeing. It is more difficult, however, to prove that poor housing actually causes ill health. In addition, neighbourhood characteristics, e.g. crime in the local area may be a further contributory factor to housing conditions having a negative impact on health.

**40.** Studies evaluating area regeneration housing improvements report both beneficial and adverse health effects. There may be improvements in mental health. When people are relocated, a different social environment can provide educational and employment opportunities that are beneficial to health. There may also, however, be adverse effects such as loss of social networks and stress.

**41.** It is clear that there are complex interactions between factors such as poverty and lifestyle characteristics that determine the relationship between housing and health. It is very difficult to untangle causal relationships between housing conditions and incidence of health problems. This therefore makes it hard to see what specific action, over and above current policies and programmes in the housing field, would help reduce health inequalities.

**42.** We can say, nevertheless, that more general action on poverty, employment and physical and social environments will interact with housing improvement positively and should serve to improve people's health and reduce health inequalities, if action on housing is sufficiently targeted.

**43.** COSLA's paper for the Task Force on the role of local authorities in reducing health inequalities sets out some of the general housing and environmental policies through which local government can contribute to positive impacts on health, within this complex overall picture.

**44.** More will be learnt about the impact of moves to better quality social housing and neighbourhood transformation from two current Scottish research studies. SHARP (Scottish Health, Housing and Regeneration Project) is a longitudinal study of the health and wellbeing impacts of moving into new, general purpose social housing provided by Registered Social Landlords (housing associations) across Scotland. The project is scheduled to be completed this year. It reports slight improvements in people's health after a move and some positive wellbeing and lifestyle changes, eg smoking cessation, improved diet. However, the overall scale of the improvements is very small. The Go Well project in Glasgow is a longitudinal study running for 10 years from 2006. It is investigating the effects on individuals and families of neighbourhood transformation and of people's moves within or beyond the city. The baseline survey indicated that the physical, social and service environments to be provided in transformation areas should be capable of enhancing the psycho-social benefits people derive from their homes and the neighbourhoods where they live. Both these studies should give significant insights into the ways in which housing and neighbourhood change could bring about improvements in health and wellbeing.

**45.** The Task Force's emerging thinking about design of public services will apply to the provision of housing services as it does to many other services. For staff, this is likely to mean:

- understanding is required of the interaction between stress, deprivation and people's specific housing needs and the way in which they present those needs.
- staff require to respond effectively to people with complex problems that span the responsibilities of many organisations.
- management should support cross-agency working to help clients to deal with the whole spectrum of problems, including housing issues.
- all housing services need to engage clients fully in decisions that affect them.

## Conclusions

**46.** This paper has addressed some of the most significant factors in the physical environment that seem likely to have an impact on health inequalities. Other aspects such as drinking water quality and soils and health have also been examined briefly. However, it is difficult to map health consequences, and inequalities in particular and to identify action that will have any significant impacts on health inequalities other than in small local populations. These areas have not, therefore, been covered in detail here.

**47.** In general, there is disappointingly little evidence for specific effective action on physical environments that would achieve measurable reductions in health inequalities in Scotland. There is, however, understanding of complex interactions between individual health and physical and social environment characteristics. This should be useful in informing joined up national and local activity.

**March 2008**

# 8. SAFER SCOTLAND

## ALCOHOL USE AND ASSOCIATED HARMS

### Introduction

1. This paper sets out some of the key health inequalities in relation to alcohol use and associated harms in Scotland.
2. There is now a greater awareness of the problems caused by alcohol misuse, from the short and long-term physical and mental health harms to anti-social and offending behaviour, and the negative impact this has on Scotland. As a result, the negative effects of excessive alcohol consumption continue to dominate the debate on health improvement.
3. Although many people in Scotland do drink sensibly, alcohol misuse is responsible for significant levels of harm to individuals' health, to families and to our communities. For example, in 2005-06, there were over 40,000 alcohol-related discharges from Scottish hospitals and currently one Scot dies every six hours as a direct result of alcohol misuse. The problems associated with the misuse of alcohol are particularly acute in Scotland compared to the rest of the UK and can often disproportionately affect those living in our poorest communities (see Annex A). This is why Ministers have recognised the need for a long-term strategic approach to tackle alcohol misuse in Scotland.

### Health inequalities in alcohol-related health harms

4. The relationship between excessive drinking and socio-economic factors is not straightforward. However, while statistics show that consumption levels probably vary little across socio-economic groups, alcohol-related harms are strongly correlated with deprivation.<sup>16</sup> These include health harms as well as wider social harms, for instance:
  - In 2005-06, people resident in the most deprived areas (as measured by the Scottish Index of Multiple Deprivation) were six times more likely to be admitted to a general hospital and almost eight times more likely to be admitted to a psychiatric unit with an alcohol-related diagnosis than those in the least deprived areas.
  - The alcohol-related death rate in Scotland among the most deprived members of society is six times higher than among the most affluent (see figure in Annex A). This pattern holds for both men and women.

<sup>16</sup> A fuller description of alcohol-related inequalities is included in the Ministerial Task Force on Health Inequalities paper: *An overview of the statistics relating to health inequalities.*

- Following adjustments for socio-economic circumstances, male mortality from chronic liver disease is significantly higher in West Central Scotland than the rest of Scotland. The increase in liver cirrhosis rates in Scotland over the last 10-15 years are amongst the highest in the world.
- At least 70% of all assaults presenting to A&E may be alcohol-related, with the vast majority involving young men.
- Leyland et al. Report (2007) found that relative inequalities in mortality are increasing and are greatest at younger ages for particular causes, such as alcohol, drugs and suicide, in the most deprived neighbourhoods (although absolute numbers for younger age groups are small).
- Homicide in Scotland 2006-07 shows that nearly half (47%) of the total of 167 persons accused in homicide cases in 2006-07 were reported to have been drunk or under the influence of drugs at the time. Of these, 30% were drunk, 8% were on drugs and 9% were both drunk and on drugs. In 41% of homicide cases it was not known if the accused was drunk or under the influence of drugs.
- 11,257 drink driving offences were recorded by the police in Scotland in 2005-06. There were a total of 990 casualties in Scotland as a result of accidents involving illegal alcohol levels. Of those casualties, an estimated 30 people were killed and 170 seriously injured. This suggests that around 1 in 9 road deaths in Scotland occur in an alcohol related incident. "Drinking and Driving 2007: Prevalence, Decision Making and Attitudes", published by the Scottish Executive, shows that the prevalence of driving after drinking is higher in social grades AB than in lower grades.

### Statement of current policy and action in this area (with an impact on health inequalities)

**5.** A large a proportion of adults are drinking too much, across all sections of Scottish society. For instance, the Scottish Health Survey (SHeS) 2003 reported that 63% of men and 57% of women who drank alcohol in the previous 7 days exceeded daily recommended limits (and these figures are considered an under-estimate). Alcohol misuse (in terms of consumption levels) cannot, therefore, be regarded as a minority issue.

**6.** Given that harmful and hazardous drinking are prevalent across the population, Scottish Ministers have confirmed that they wish to develop a long term strategic approach to tackle alcohol misuse, appropriate to the scale of the problem in Scotland and focusing on the long term objectives of reducing harm and achieving sustainable change. This approach, currently under development, is likely to take as its starting point a series of interventions which will impact on the whole population. There is considerable evidence to show that policies which affect the whole population can have a protective effect on deprived populations and reduce the overall level of alcohol problems.

**7.** However, a balance will require to be struck, as current trends and policy drivers also suggest that there are some groups (for instance, offenders and dependent drinkers) who will still require more targeted interventions. In addition, communication work currently under way around population segmentation will help support our understanding of the issues of particular concern to specific segments of the population enabling us to be more effective in our social marketing activity.

## Resources devoted in this area directly or indirectly to reducing health inequalities

**8.** A key outcome of the Spending Review is the commitment of an additional £85.3 million over three years to tackle alcohol misuse in Scotland. This is in addition to the current annual alcohol misuse budget of £12.3 million, and to the larger sums from mainstream budgets spent by the NHS and other bodies in preventing and dealing with the consequences of alcohol misuse.

**9.** The additional £85.3 million is by far the single largest increase ever provided for tackling alcohol misuse in Scotland. As announced to Parliament, the main focus for this additional funding will be to ensure increased access to early intervention and treatment, and for prevention activity, which will form a key component of our long-term strategic approach. Given that harms from alcohol misuse correlate closely with levels of deprivation and inequality, the majority of this funding (which will identify and respond to harm) will therefore by definition be targeting inequalities. This will be particularly true of the delivery of brief interventions in acute, ante-natal and Keep Well settings.

**10.** The majority of the additional funding has been allocated directly to NHS Boards. The allocation formula takes into account levels of deprivation as well as the prevalence of excessive drinking. While strategic priorities will be set nationally, service commissioning decisions will be for NHS Boards and ADATs in line with locally identified need. We have asked Boards to consider health inequalities when determining local priorities.

## What is known to work in reducing health inequalities

**11.** Although there is little specific evidence available on what works in reducing alcohol-related health inequalities, more generally, it is known that regulatory or structural interventions (e.g. seat belt legislation, banning smoking in public places) appear to reduce health inequalities more than information based approaches (e.g. nutrition labelling, drink drive campaigns). This is because more advantaged groups in society find it easier to avail themselves of, and therefore benefit from, health promotion advice.

**12.** Analysis of the effectiveness of brief interventions, of various forms and delivered in a variety of settings, show that interventions lead to a reduction in alcohol consumption among harmful and hazardous drinkers. A recent Cochrane Review found that brief interventions in primary care lead to a reduction in consumption by an average of four standard drinks. The Review found that the effect of the brief intervention was clear in men at one year follow up, although less clear for women. Little analysis on the effectiveness of brief interventions across socio-economic groups has been carried but it is assumed brief interventions are equally successfully across all groups.

## What current action may the Task Force endorse or seek to extend

**13.** The work on developing a strategic approach for alcohol misuse recognises that the current updated Plan for Action on Alcohol Problems does not meet the scale of the problem in Scotland. The final strategy will be cross-government and bring all elements of alcohol policy into a coherent framework. The interventions proposed will contribute towards achieving the overall Purpose of the Scottish Government and its strategic objectives of a Healthier, Wealthier and Fairer, Safer and Stronger and Smarter Scotland. The interventions are likely to be a mixture of whole population and targeted measures. Work is currently ongoing and proposals for action on alcohol misuse are scheduled to be published for full public consultation before Summer 2008. An equality impact assessment of proposed outcomes and interventions will be carried out.

**14.** A new HEAT target on alcohol screening and brief interventions is being introduced in 2008-09. NHS Boards will be expected to monitor activity on delivering brief interventions in line with Sign Guideline 74, establish delivery arrangements, build capacity and develop monitoring systems. NHS Boards will be required to demonstrate how they will target efforts in A&E, primary care and ante-natal care, and amongst deprived populations. As noted in para 9 above, the new funding package will support Health Boards to roll out screening and brief interventions and to build workforce capacity.

**15.** The longer-term aim is for SIGN 74 to become part of the routine offer of the NHS. Given the strong relationship between alcohol-related harm and deprivation, the roll out of brief interventions may be expected to have the greatest impact on groups experiencing higher levels of harm.

**16.** Funding is being provided to support the Coal Industry Social Welfare Organisation (CISWO) tackle smoking, alcohol misuse and associated health issues in the traditional coalfield communities across Central Scotland. The project will target some of the most disadvantaged communities in Scotland who suffer most from health inequality and social privation. The project will enable the local communities to develop their own networks of support via "Buddy Systems" and similar mechanisms so that the key objectives of smoking cessation and alcohol consumption moderation become embedded in the local culture as core values.

**17.** A Social Marketing review in Health Improvement has developed an over-arching strategy for Health Improvement consumer communications. This strategy aims to join up messages and targeting across a range of health topics, including alcohol, and recognises the need to address health inequalities by focusing on lower socio-economic groups as target audiences. The key target group will therefore be adults aged 25-50 and primarily C1C2DE.

**18.** Measures are already in place and planned under the Licensing (Scotland) Act 2005 to tackle under-age sales and irresponsible promotions, including removal of incentives to bulk buy.

**19.** The *Scottish Alcohol Research Framework*, compiled by NHS Health Scotland and the Scottish Government with advice from the Alcohol Evidence Group, sets out existing and planned work, together with priority areas for new research. The Framework identifies a number of studies that will help us better understand drinking patterns across population sub-groups, as well as, for example, links between patterns of alcohol consumption, serious alcohol-attributable disease and deprivation.

**20.** In addition, the Chief Scientist Office (CSO) is currently funding a project (being delivered by Health Scotland and the Information Services Division) looking at the relationship between a) alcohol deaths and b) alcohol hospitalisations to risk factors such as age and deprivation. While the project is still at an exploratory stage, the analysis plan includes deprivation based analysis for a range of alcohol related and alcohol attributable conditions.

### **What gaps in action should be filled and what new activities put in place**

**21.** Given the scale of the problem of alcohol misuse across the whole population, it is argued that tackling health inequalities should be mainstreamed throughout the long term strategic approach to alcohol misuse. As a result, there will be a need to ensure that there is appropriate (and where necessary enhanced) access to information and services in order to tackle health inequalities. In addition, as noted above, targeted interventions for particular groups (e.g. offenders and dependent drinkers) will be necessary together with measures affecting the whole population. Consideration will also be given to possible measures around supporting children affected by parental alcohol misuse.

### What measures of success are or could be available

**22.** Progress in tackling Scotland's alcohol misuse problems will primarily be monitored through existing indicators, including alcohol-related hospital admissions and deaths (both of which allow from analysis by deprivation category, Health Board, gender, age, etc). A recording and monitoring system will be put in place as part of the proposed HEAT brief interventions target. Survey data will be used to monitor 'softer' measures of success (such as perceptions of alcohol misuse in communities).

### Workforce implications, e.g. training and skills required

**23.** There may be a substantial training need for GP practice teams (and staff in acute settings) in developing skills both in screening patients for harmful and hazardous drinking and in delivering brief interventions. This is likely to be procured via NHS National Education Scotland and/or NHS Health Scotland. Training needs will be informed by research currently being undertaken by Health Scotland to consider barriers to implementation of the SIGN 74 guideline.

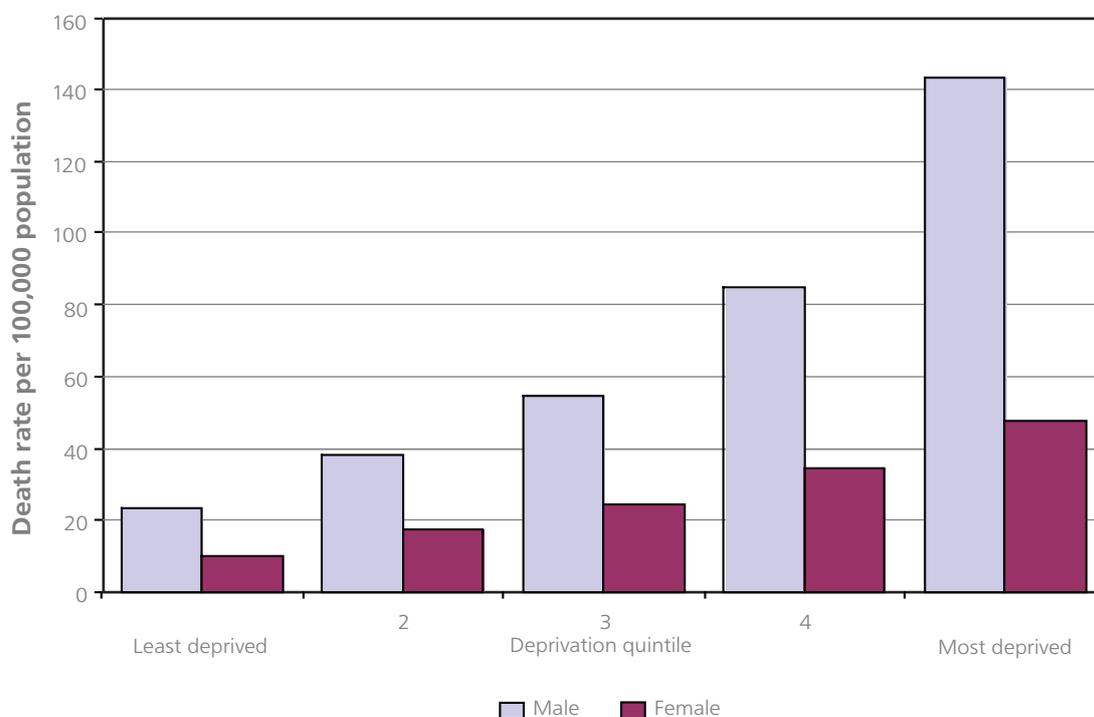
### What relevant external experts, interests and reference groups say

**24.** The expert group of stakeholders (which included a range of interests such as public health, medical, voluntary and industry), convened to consider what the desirable outcomes of a new strategic approach to alcohol might be, was clear in its view that whilst tackling health inequalities should not be seen as an outcome in itself, it is a vital component in ensuring delivery of our long-term outcomes.

January 2008

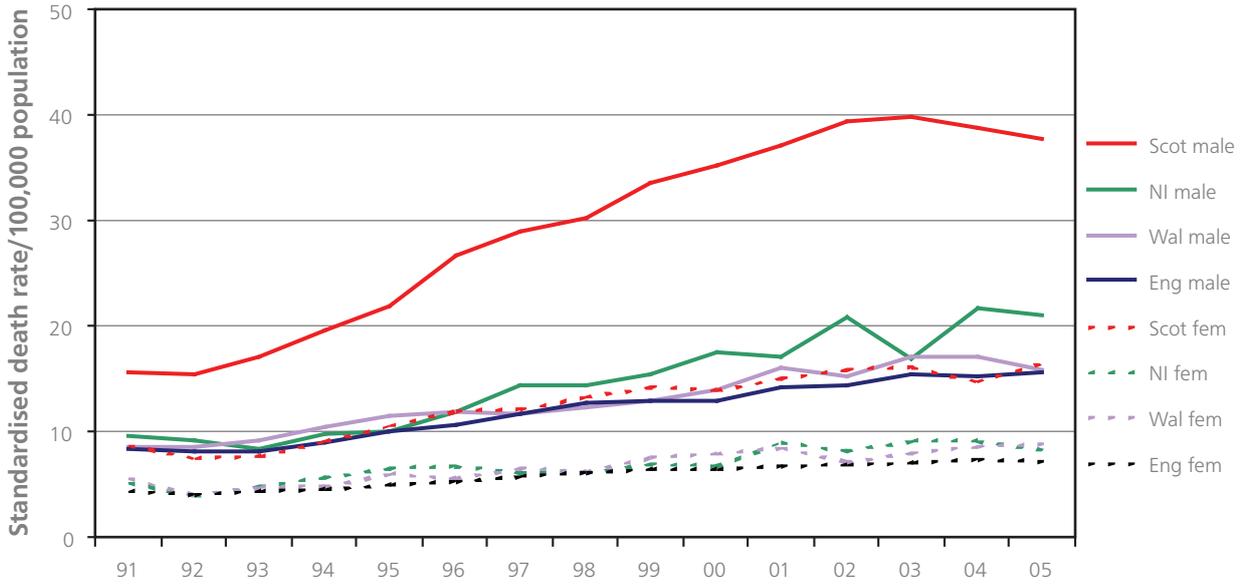
## ANNEX A

**Figure 1: Alcohol-related death rate by Scottish Index of Multiple Deprivation, 2005**

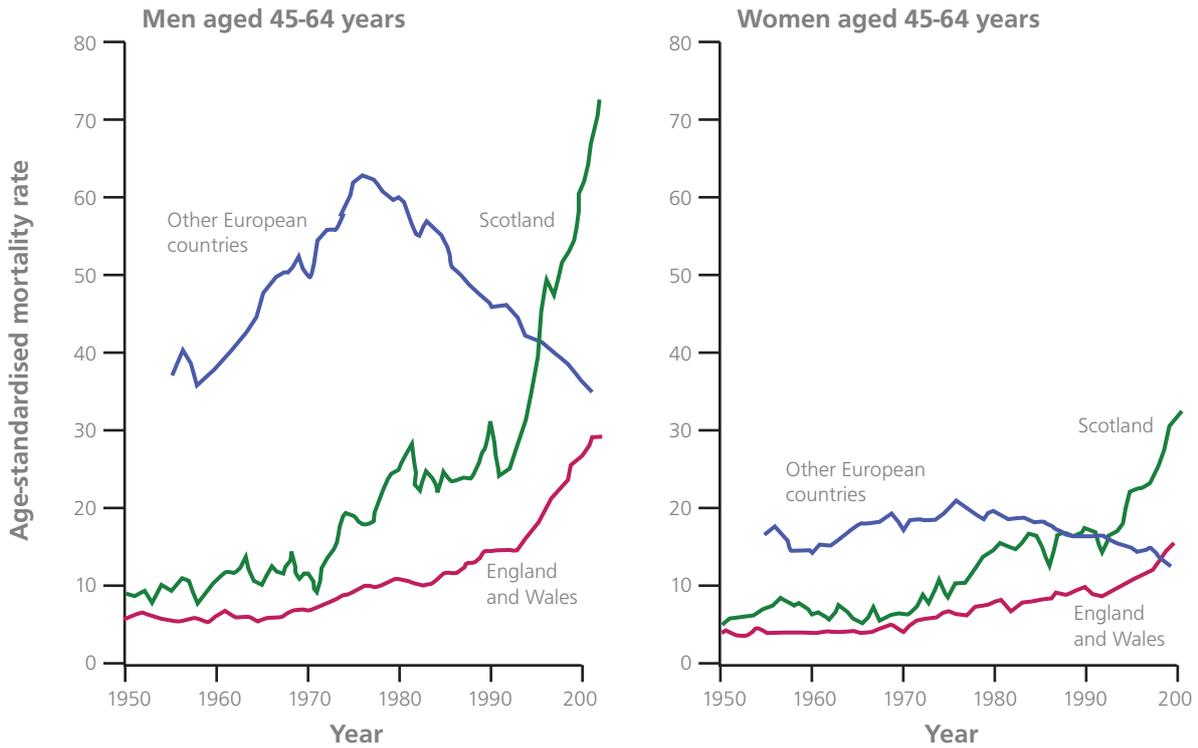


Source: ISD Scotland based on GROS data

**Figure 2: Alcohol-related mortality, UK countries, 1991-2005**



**Figure 3: Deaths from liver cirrhosis (rate per 100,000) in 45-64 year olds, 1950 to 2002**



## ACTION PROGRAMME FOR TACKLING DRUGS MISUSE

### Introduction

1. This paper:

- describes the health inequalities dimension to Scotland's drug misuse problem.
- describes current action to develop the Scottish Government's new Programme of Action for tackling drug misuse.
- identifies the key aspects of that developing strategy that could specifically address health inequalities.

### The health inequalities dimension to Scotland's drug misuse problem

2. According to the latest research, an estimated 51,582 people in Scotland were misusing opiates and/or benzodiazepines in 2003. This corresponds to 1.84% of the population aged between 15 and 54. It represents a decline in the number of problematic drug misusers since 2000.

3. There are strong and very clear links between poverty, deprivation, inequalities and problematic drug use; but the situation is complex. Not all marginalised people will develop a drug problem, but those at the margins of society, such as the homeless and those in care, are most at risk. The pattern of who develops a drug problem and encounters other problems shows a close link with aspects of social exclusion.

4. A study by Dr Laurence Gruer of some 3,715 drug related emergency hospital admissions in Greater Glasgow from 1991 to 1996 plotted them by postcode using a standard index of deprivation. **The admission rate from the most deprived areas exceeded that from the least deprived areas by a factor of 30.** In other words, if the admission rate for the least deprived area had applied across the city, the number of admissions would have been only 8% of that which actually obtained. It was noted in this study that the relationship between deprivation and drug misuse was higher than any other health variable they had studied.

5. In a recent Scottish population based study Leyland and colleagues (2007) examined age, sex, and cause specific mortality rates for social groups to understand the patterning of inequalities and the causes contributing to these inequalities. Using a comprehensive assessment of deprivation, they illustrate that there have been general reductions in mortality in the major causes of death (ischaemic heart disease, malignant neoplasms), however such reductions have been socially patterned. Relative inequalities in mortality have increased and are greatest among younger adults where deaths are attributable to increases in suicides and deaths related to the use of alcohol and drugs.

6. Indeed, Professor Neil McKeganey and colleagues have gone as far as to suggest that just a single risk factor – problem drug use – may be responsible for a large part of the observed, deprivation-adjusted, cross-national differences in mortality rates between England and Scotland. The findings are far from conclusive – nearly half of the sample cited is drawn from the prison population for example – and there has not yet been independent data to cross-check it.

7. Changing housing markets and policies have had a clustering effect resulting in a concentration of multiple social problems including drug markets within deprived areas. Drug markets occur in fragmented local areas, but also within highly deprived areas with strong networks. Drug users face a range of employability barriers including a fear of drug relapse linked to having to renegotiate welfare benefits, and restrictive pharmacy dispensing of prescription drugs.

**8.** Problematic drug users come from all sections of society, all parts of the country and all socio-economic classes. However, the statistics suggest that they are twice as likely to be men and more likely to be out of work than in a job – **in 2006-07 67% of new clients in drug treatment services reported that they were unemployed.** For both males and females accessing treatment, 25-29 was the most common age group for new clients reporting to the Scottish Drug Misuse Database in 2007 closely followed by 30-34.

**9.** In 2005-06, **45% of treatment clients reported that they had previously been to prison** and studies estimate that a high number (as much as 80-90%) of all Scottish prisoners taken into custody have been misusing drugs and/or alcohol (Scottish Consortium on Crime and Criminal Justice (SCCCJ) 2002) and that significantly high rates of prisoners come from the most deprived council ward areas (Houchin, 2005).

**10.** There is no suggestion that ethnic minorities are more likely to be affected – in 2006-07, 96% of new clients in treatment services reported their ethnicity as white. There is, however, some evidence that ethnic minorities are less likely to access health services (and therefore to be included in the statistics). Drug addicts can face many barriers to service, born out of others' moral condemnation, a chaotic lifestyle that acts as an impediment to, for example, keeping appointments, or inadequacies of local service provision (as evidenced, for example, by excessive waiting times for assessment in certain local authorities).

**11.** Among women drug users, there is a 'fear' that professionals working with them will view drug use as an 'automatic indicator of their unfitness as a mother'. This is one of the most important barriers to drug-using mothers seeking help and treatment. In addition, many abused women who are drug users lack access to social and economic resources which would help get them out of abusive and chaotic situations.

**12.** There is also an expanding population of individuals who have used drugs in the past, who are maintained on long-term substitute prescriptions (such as methadone) or are using drugs at a later stage in their lives than ever before. Studies are showing that the problematic drug using population has an ageing profile and that such drug use is associated with poor physical and psychological health and longer hospital stays. Some commentators suggest that the characteristics and health needs of older people need further investigation as the future cost of ageing drug users may be considerable.

### **The development of the Scottish Government's new Action Programme for Tackling Drugs Misuse**

**13.** The high levels of problematic drug misuse in Scotland are not acceptable. The economic and social costs are estimated at £2.3bn a year, making drugs misuse an obstacle to achieving the Government's Purpose of achieving higher sustainable economic growth. There are also wider health and social costs that potentially undermine our capacity to deliver other national outcomes. The Government is determined to address this and, as a first step, is to publish a new Programme of Action for tackling drugs misuse before the Summer of 2008.

**14.** It is intended that the Action Programme will be a high-level, ambitious document. It aims to present a snapshot of the drug misuse problem in Scotland in 2008 and set out a set of priorities for tackling it in the context of the Government's overarching objectives and the reforms of governance, including the Concordat and introduction of outcomes. It will feature a clear programme of activity and reform – for Government and local partners – that will be drawn up in partnership with the Government's advisory committees on drugs (SACDM) and alcohol (SMACAP). It will be underpinned by the best available evidence, drawing on national and international research and practice. It will, however, also concede that there are gaps in that evidence, and commit the Government to setting up a National Evidence Group to ensure future policy remains evidence-based. The Programme will also highlight the major contribution of work to tackle drugs in tackling health inequalities. It will stress the importance of local delivery partners in providing access to services for hard to reach groups, and signal a review of the methodology for funding allocations that takes this more into account as part of wider reform of delivery.

15. A key theme of the Programme will be to promote recovery. This reflects the fact that too many people on opiate substitute prescriptions do not have access to the integrated, "wrap-around" services in housing, training or education that would allow them to recover from their addiction. Put another way, services and treatment need to deliver sustainable outcomes with an impact on health inequalities that endures. It also reflects the Government's view that it is important to get beyond some of the sterile debates of the past – in particular, about whether an approach based on abstinence or aiming at harm reduction is the most likely to yield results. Our aim is to build a new approach on consensus and evidence, with an objective of "recovery" seeking to unite practitioners and academics in the field.

**16.** The Strategy is also likely to cover:

- the crucial importance of **prevention** – widely defined – including policies to grow the economy, reduce poverty, and deliver better outcomes for children in their early years and later teenage years.
- **better outcomes for children affected by substance misuse** by focusing on prevention, early intervention and support for families and highlighting the moral obligation of the local communities in identifying children at risk.
- **better enforcement** to reduce the available of drugs by continuing to support the police and Scottish Crime and Drug Enforcement Agency.
- importantly, more effective delivery structures, so that **Alcohol and Drug Action Teams** (or, possibly, successor partnerships) deliver the services that are needed and can account for the money that they spend and the quality of the services they commission.

**17.** To complement the new Programme, the Spending Review proposes a 14% increase in the funding provided to Health Boards for drug treatment services over the next 3 years. In addition, local authorities also provide funding for services which, in the past, has been at least comparable to that provided through the ring-fenced funding, and the NHS also provides funding from its unified budget. Together these resources will provide funding for local partnerships to plan and commission services at the local level.

## Addressing health inequalities through the Programme for Action

### 18. Key implications for the Task Force:

- the high degree of inequality associated with problematic drug misuse means that **realising the drugs programme outcomes would in and of itself have a significant impact on health inequalities in Scotland** – albeit that the degree of impact is difficult to quantify precisely.
- the programme will reflect actions to reform delivery of services at the local level. **These should address the need for services to be capable of reaching the hardest to reach groups;** and to provide equitable provision across the country; between men and women; and for ethnic minority groups.
- the programme will cite the potential contributions to tackling drug misuse of a range of other Government initiatives, including on early years, children affected by parental substance misuse, youth, curriculum reform, and the provision of “More Choices, More Chances” for potentially vulnerable young people. The more these strategies can contribute to reducing drug misuse in Scotland, the greater their contribution will be to reducing health inequalities. **Tackling drug misuse should continue to be recognised as being an objective of these developing policy initiatives.**

January 2008

## VIOLENCE AND HEALTH INEQUALITIES

### Introduction

1. Detective Chief Superintendent John Carnochan, head of the Violence Reduction Unit (VRU), and Professor Peter Donnelly, Deputy Chief Medical Officer, will lead a discussion on the problem of violence in Scotland.
2. The Leyland et al. Report (2007) identifies violence as a serious source of health inequalities in Scotland in particular amongst young men. This assessment is supported by the World Health Organization (WHO) which has identified Scotland as bucking the trend of Western European countries which typically have low rates of youth homicide. The WHO assessment is that young men (between 10-29 years of age) in Scotland are 7 times more likely to be the victim of homicide than their counterparts in France and 5 times more likely than even their counterparts in England and Wales.
3. The WHO data are historical. Current data, however, do not suggest significant improvement. The Scottish homicide statistics for 2006-07 were published on 18 December 2007. The statistics show a 27% increase in the number of victims of homicide. Homicide itself is rare – 119 victims equating to 23 victims per million – though the factors that contribute to it are not. The analysis of the statistics show the continued disproportionate impact on **young men** (62% of offenders; 42% of victims), the prevalence of **knives** (responsible for 3 times as many homicides as any other form of killing), the associated use of **alcohol** and **drugs** (47% of perpetrators reported to be on drink or drugs at the time of the offence), and a geographical focus in the **West of Scotland** (64% in Strathclyde Police force area with the homicide rate in Glasgow twice that of London and more than just about every other European city). The causal and associative factors in relation to violence – alcohol, drugs, deprivation – are all sources of significant health inequality.

4. The presentation to the Task Force will outline a case study involving a serious act of violence. The intention is to use this case to illuminate a much wider and deeper set of issues: profound levels of inequality across society, families with multiple and complex needs, the vulnerability of young people. Violence is perhaps the most serious symptom of these deeper issues, and discussing this symptom and its causes will in turn expose implications for a whole range of policy areas and agencies. The problem of violence and our response to it exemplifies much wider aspirations than just those for a Safer and Stronger Scotland; it gets to the heart of what we should mean by a Healthier, Smarter, Wealthier and Fairer, and even Greener Scotland.

### The extent of the problem

5. Scotland has an unenviable international reputation as a violent country. The World Health Organization (WHO) *World report on violence and health* (2002) highlighted the fact that the homicide rate in young men between 10 and 29 is **5.3** per 100,000; the equivalent rate in England and Wales is **1.0** per 100,000. On this very limited measure, Scotland is one of the most violent countries in Western Europe.

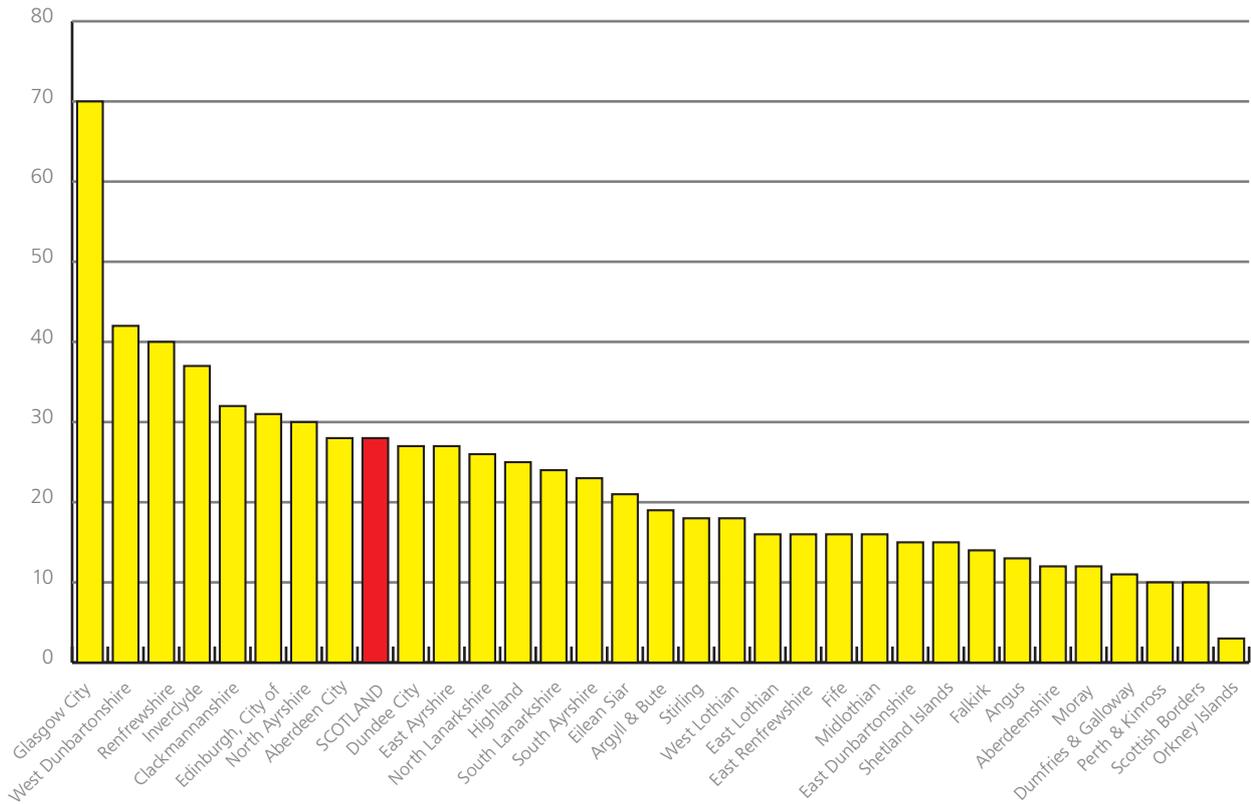
6. International comparisons are not always reliable. Domestic data, however, offer little comfort. Statistics on the Scottish homicide rate covering the most serious form of violence are set out above. In relation to violence more generally, the Scottish Crime and Victimisation Survey (SCVS) 2006 indicates an estimated **4%** of the adult population was the victim of an assault in 2005/06. Of all crime, violence can have the most pervasive and profound impact not only in relation to the victims and their families but also fear of violent attack and disorder can destabilise a much wider set of communities where violence is less of an issue. The SCVS 2006 indicates that **23%** of respondents across Scotland thought assault was common in their area, with **37%** of respondents indicating they were worried about being assaulted. DCS Carnochan will talk in his presentation of the “normalisation” of violence in certain communities, typically communities with high levels of deprivation – of different values and norms of what is and what is not acceptable, tolerable. In those communities the concept of “fear of crime” can have a deeper, more complex meaning.

7. The cost to Scotland of violence and the inequalities that underlie it goes beyond mere reputation. A Home Office analysis of the total cost to society of crime in England and Wales indicates that the total cost of violence against the person in 1999/2000 was **£16.8 billion**. (The equivalent cost in relation to Scotland would be between **£1.5-£2 billion**.) Within this there is the cost to public services. Traditional assessments in relation to violence focus on the cost to the police service and the wider criminal justice system; with violence accounting for **26%** of all crime and **40%** of the prison population, the “traditional” costs are considerable.

8. However, the impact is much wider. In his Annual Report 2006, the Chief Medical Officer for Scotland states that violence alone costs the NHS between **3-6%** of its total budget, which equates to approximately **£400 million** per annum. The impact of violence, therefore, goes beyond our aspirations for a Safer and Stronger Scotland; as Dr Harry Burns puts it, “violence poses a significant threat to Scotland’s health – and wealth”.

9. Violence affects all of Scotland but it does not do so equally. The chart below indicates distribution of non-sexual crimes of violence recorded by the police across local authority areas.

**Figure 4: Number of non-sexual crimes of violence per 10,000 population 2006-07**



**10.** The situation in Glasgow appears extreme, with a level of recorded violence 2.5 times that of the Scottish average. A relevant factor which helps explain the issue for Glasgow is deprivation. 30% of the Scottish Index of Multiple Deprivation (SIMD) data zones in Glasgow City are in the 15% most deprived areas. The Leyland et al. Report (2007) into inequalities in mortality makes clear, violence is a significant source of health inequalities, stating (p.102): *“Assault stands out as a cause of death that particularly affects those living in the most deprived areas; the death rate from assault in men under 65 was higher in 2001 than the Scottish mortality rate from cerebrovascular disease in this age group.”*

**11.** The table below sets out death rates per 100,000 for a range of causes of death. While overall the figures for assault are relatively low, the gradient between the least and most deprived is, along with drugs, the steepest of any of the causes. The death rate from assault in the most deprived communities is nearly four times that of even the Scottish average, and over ten times that of the least deprived communities. This confirms that in relation to violence where you live matters.

### Age standardised mortality (per 100,000 population) from selected causes within each SIMD deprivation quintile. Men aged 0-64, Scotland 2000-02.

SIMD quintile	Chronic lower respiratory disease	Chronic liver disease	Accidents	Intentional self-harm etc.	Mental and behavioural disorders due to drugs	Mental and behavioural disorders due to alcohol	Assault
5 (least deprived)	3	6	11	11	2	2	<b>0</b>
4	5	11	17	18	4	5	<b>1</b>
3	7	16	17	24	5	8	<b>1</b>
2	12	29	21	31	11	11	<b>4</b>
1 (most deprived)	18	61	27	48	29	20	<b>11</b>
All Scotland	9	23	18	26	10	9	<b>3</b>

12. The point of this assessment, however, is not to single out violence. Violence sits within a well-defined but complex context of risk factors, influences, causes etc., many of which have been highlighted to the Task Force previously. In relation to the discussion at the last Task Force meeting, the complex links between low educational attainment and poor health outcomes were recognised as was the potential for educational interventions to have a protective effect. There are equally strong (and complex) links to offending, reoffending, victimisation, viz., poor justice outcomes; and no doubt effective justice interventions can have a protective effect, contributing to that of health and education.

### The response to the problem

#### Background

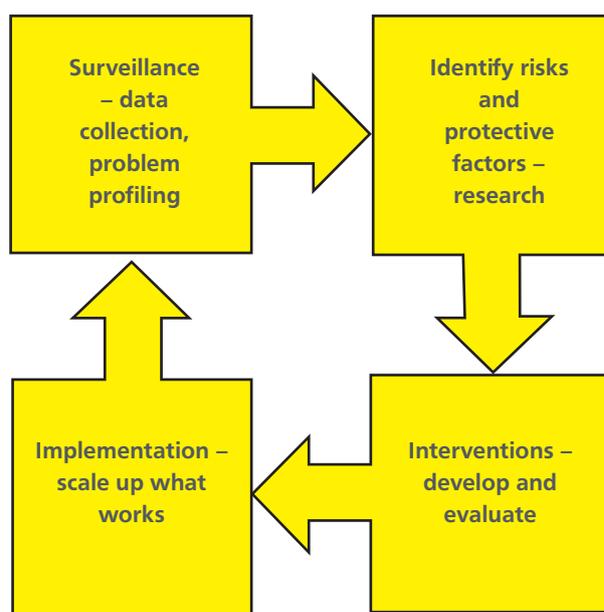
13. In 1996 the 49th World Health Assembly declared violence to be a global public health issue. In 2002 the WHO published its *World report on violence and health*, which was the first systematic articulation of how governments and other agencies can use a public health model to understand and respond to the problem of violence.

14. The Scottish Government's response to this report and the endorsement of its approach is captured in the Strategy Unit's paper *Violence in Scotland: trends and issues* published in December 2003. Separately, Strathclyde Police established the VRU in 2005 explicitly to develop a public health approach to reducing the serious levels of violence in their area. The need to coordinate a national response meant that in April 2006, with the Scottish Government's support, the VRU became the national centre of expertise on violence reduction.

15. The primary focus for collaborative work since 2006 has been on building a consensus not only around the need for change but around the specific approach to change recommended by the WHO. The achievements of the VRU in establishing consensus on the implementation of the WHO's public health approach was recognised by the WHO at their Violence Prevention Global Milestones conference at Tulliallan in July.

#### The public health approach

16. The public health approach is interdisciplinary and evidence based, while not ignoring individuals its primary focus is on whole-population solutions, and, above all, it focuses on prevention rather than reaction. The basic model is set out below.



**17.** Work to address gaps and inadequacies in relation to each of the four stages is ongoing. In relation to surveillance, data collected by hospital emergency departments (EDs) indicates that only about 30% of even serious violence is reported to the police. Before we can tackle the problem we need to understand what the problem is, where it is and who it affects – data collected by EDs can be used to assess levels of violence locally and when data on location of incident etc. is shared with partners this can be used to target resources much more effectively. Key to this is analysis and use of intelligence along with effective information sharing between agencies.

**18.** In relation to research, there is a considerable body of evidence from international and UK sources to enhance our understanding of causes, risks and what can mitigate those risks (i.e., practice). Through events such as the WHO Milestones conference and best practice seminars, the VRU and Government officials are working to ensure that this research is available to practitioners in Scotland. New research focused on some of the distinctive aspects of the Scottish context – on knives, gangs and alcohol – has been commissioned.

**19.** The work of colleagues such as Professor Jonathan Shepherd of the Wales College of Medicine show the clear benefits of leadership in relation to research in particular in translating scientific findings into effective practice. Prof. Shepherd is not only a leading maxillofacial surgeon with a recognised expertise in injury prevention but is also Chair of his local Community Safety Partnership. His efforts to implement his and colleagues’ research findings in Cardiff have resulted in a 40% reduction in violence-related A&E admissions since 2002. There is leadership in Scotland in health and, separately, in community safety; there is very little leadership in the health/community safety interface.

**20.** In relation to developing interventions, the strategy has been based on two pillars:

- The need for increasingly effective and innovative **enforcement** practice primarily by the police, local authority and other criminal justice partners. The best example of this is in relation to knife crime where the police, prosecutors and judiciary have worked together to establish a much tougher regime built on the foundation of tougher legislation.
- The need to approach violence in terms of **prevention** and anticipatory action. This is beginning to show results in terms of new innovative work with partners in education and health.

**21.** The prevention pillar of any public health approach is vital and this is where a great deal of energy has gone in Scotland so as to ensure a comprehensive response to the problem. The prevention pillar of the approach is divided into 3 related strands, which can be understood (loosely) in terms of age groups:

- **Primary prevention** – preventing violence or other antisocial behaviour from occurring in the first place. Focused on children from pre-birth through to high school age and their parents. Activity may include parenting initiatives, intensive pre- and post- natal support, early years enrichment etc.
- **Secondary prevention** – preventing the escalation of violence and antisocial behaviour toward serious criminality. Focused on children of high school age (11-18). Activity may include diversion and positive opportunities for young people through to more formal youth justice and anti-social behaviour measures.
- **Tertiary prevention** – preventing violent offenders re-offending, which typically means adults within the criminal justice system. Activity includes offender programmes within prison and in the community coordinated by Criminal Justice Authorities.

**22.** It is in the clear focus on prevention that the implications for a wider agenda – health inequalities, multiple and complex needs, etc. – become clear. In relation to criminal behaviour and offending, the traditional focus for police and criminal justice interventions has been after the “point of impact”, viz., the criminal act. Better criminal procedure, adequate prison provision both in terms of physical capacity and programmes, more effective community sentences etc. Earlier intervention has traditionally (though not exclusively) fallen to other agencies, in particular those in the health and education sectors. Police and criminal justice partners, led by the VRU, are seeing the benefits and indeed the necessity of engagement with these other agencies to reduce supply. Whether it is brief interventions to victims of alcohol fuelled violence in maxillofacial clinics or the work of school-based community police officers, new cross-agency relationships and practices are emerging.

**23.** It is early days for much of this and perhaps the most significant challenge faced in introducing the public health approach has been in relation to the fourth stage, “implementation”: our inability to scale up small scale evaluated interventions to impact on the wider population. While there is an issue about inadequate evaluation in relation to many local initiatives, there are clearly recognised evaluated interventions currently being delivered in Scotland on a small scale that could be helping achieve the Government’s priorities if they were being delivered on a bigger scale. The challenge of lack of resources is no doubt a major factor but so is lack of leadership and the associated lack of understanding of the potential benefits of better, closer cross-agency, cross-sector working.

### Implementation – challenges and opportunities

**24.** The WHO conference in July both the Cabinet Secretary for Justice and Cabinet Secretary for Health and Wellbeing confirmed that the vision for a new approach to violence reduction is now well established in Scotland and they committed the new Administration to this approach. The clear message was that the priority for the next phase is **delivery** – we need to realise the vision.

**25.** As mentioned above, there is a great deal going on at a local level. There are a significant number of local initiatives along with some regional and national programmes which are helping reduce and prevent violence, and which are addressing the wider problem of inequalities. The landscape is, however, fragmented with few of the potential benefits of a more systematic approach being realised. Government has a key role in addressing this and that is why our objectives are:

- **Joining up** – establishing, developing and enhancing primarily partnership delivery structures to ensure action on violence etc. is systematic, holistic and looks beyond the point of impact.
- **Scaling up** – ensuring that when good practice is recognised that the government directly and indirectly (through the VRU and others) supports local and regional efforts to widen and deepen that practice to cover more individuals or provide even more effective interventions for those already receiving them.

**26.** What is particularly hopeful at this time is that the Scottish Government is taking a fundamental look at its strategic aims in a way that fully supports the approach being outlined here. We see this in many of the underlying principles of the new strategic objective framework not just as part of Safer and Stronger but also Healthier, Smarter and even Greener and Wealthier and Fairer. These principles include:

- Earlier intervention.
- Recognising the value of early years support.
- “Prevention is better than treatment”.
- Promoting positive opportunities for young people.

**27.** There are a number of specific strategies and initiatives emerging that should help this agenda; these include:

- New early years strategy.
- New approach to tackling health inequalities, overseen by the Ministerial Task Force.
- Revised youth justice strategy.
- Revised victims strategy.
- Revised alcohol strategy.
- New drugs strategy.
- Actions emerging from the National Domestic Abuse Delivery Group.
- New youth strategy incorporating work on promoting positive opportunities for young people including Inspiring Scotland and use of Proceeds of Crime Act (POCA) funds.

**28.** One of the internal challenges is to ensure that the links to the violence agenda are recognised across these and the many other relevant strategies. This will help ensure that the agenda benefits appropriately – as it has not really done previously - from the delivery of more mainstream services. There is however a wider issue which is to identify and articulate the common threads between these approaches. In many cases the primary “client groups” in particular in relation to the “at risk” groups are the same: those most susceptible to poor health, education and justice outcomes. Are we satisfied that they rest on a consistent conceptual framework and that the practice being recommended is consistent? Are we maximising potential benefits from closer integration?

**29.** There is an external challenge, which is that with the loss of ring-fenced funding in many areas including community safety and antisocial behaviour, responsibility for delivery lies more clearly with local government and partners. There may be more of a challenge with both “joining up” and “scaling up” when decision making is more thoroughly devolved. This makes the task identified above of ensuring consistency across strategies all the more important.

### The way ahead

**30. The Task Force is asked to consider the following possible ways forward.** These are framed in terms of the four stages of the public health model and build directly on the comments of the Chief Medical Officer in his 2006 Annual Report.

#### *Surveillance, data collection, information sharing*

**31.** Acknowledge the intention to establish an electronic injury surveillance pilot in three hospitals in NHS Lanarkshire and, subject to appropriate evaluation, consider the value of introducing this approach across Scotland. In particular note that the data collected from emergency departments – on time, location, cause of injury – will be shared with local partners to ensure more effective enforcement and prevention action. This is a proven tool in efforts to reduce levels of violence and will have an impact in reducing health inequalities.

**32.** In relation to John Carnochan and Peter Donnelly’s presentation, note the problems highlighted in relation to information sharing between agencies. Inadequate information sharing is leading directly to poor health and justice outcomes. Steps have been taken to improve information sharing between agencies – an example includes the work undertaken recently by ACPOS and the NHS to agree information sharing protocols – but further action may be required.

#### *Identify risk and protective factors - research*

**33.** Ministers may wish to consider whether the evidence base on risk and protective factors is adequate. It may well be that the research etc. on individual strands – alcohol, violence, deprivation – is considered adequate (although this is not the case in relation to violence) so that what matters more is the interrelations between the strands and also the lack of leadership in translating the scientific findings into effective practice. Consider the example of Professor Shepherd in Cardiff and the impact he has made locally and regionally and whether similar leadership in Scotland would deliver similar benefits.

#### *Interventions*

**34.** Reflect on the current lack of effective interventions for young men who are already engaged in damaging behaviour such as violence, and who are thus susceptible to aggravating their already poor health outcomes. The Government has already committed to developing a programme of positive activities for young people, including activities funded through POCA. Some of this activity will impact on the “at risk” group we are referring to but not consistently and not perhaps enough to change behaviour. In addition the most serious young offenders receive “treatment” as part of custodial sentences and are provided with other forms of support in relation to drug and alcohol misuse etc. In particular consider whether there is a gap in provision in relation to higher volume, low tariff “offenders” – those involved in gang fighting, knife carrying, low level offending – who are a high risk in relation to later high tariff offending. In addition Ministers may wish to consider whether there is sufficient provision in relation to tackling victimisation among young people. Given that in many circumstances victims and perpetrators of crime are the same individuals, there may be merit in considering whether effort would be better focused on reducing levels of victimisation among young people rather than offending.

## Implementation

**35.** Given the point made above about the importance of local government, NHS and other partners in delivering on this agenda, consider the value of facilitating early discussions with those partners on the actions they propose to take to address the issues identified in the presentation. John Carnochan and Peter Donnelly could be invited to help in this process and report back to the Task Force with any further insights or recommendations.

**January 2008**

Additional briefing provided by the Violence Reduction Unit:

## VIOLENCE REDUCTION

### Purpose

To provide further information on the way ahead in relation to violence reduction as requested at the Task Force meeting on 9 January 2008.

### Introduction

Violence in Scotland is a chronic and pervasive problem that directly or indirectly affects everyone. The economic and social costs are a substantial drain on resources and significantly inhibit individuals and communities. This paper will not rehearse in any further detail the need for action to reduce violence but rather assume that the case for action has been made.

The recognition in Scotland of violence as a public health challenge and the application of public health models to develop sustainable strategies to reduce violence is a significant advance. Understanding of this shared agenda allows the development of cohesive cross sectoral policy development. It allows policy makers to consider long, medium and short term actions framed within a collaborative and inclusive national strategy.

In addition, the use of a common model to frame different problems and challenges allows the possibility of identifying solutions that will have a positive impact across several disparate problem areas this in turn removes or at least weakens the silo effect often cited as a barrier to co-ordinated and effective delivery of services.

At the heart of sustainable solutions will be the dedicated, robust and determined coordination of service delivery across the entire breadth of providers, public, private and voluntary sectors. There are several key National policies in place or intended that enhance the possibilities for success. Principal among these are The Curriculum for Excellence, The Early Years Framework, Getting It Right for Every Child and Better Health, Better Care.

**Annex A provides prevention actions which could be adopted to address violence within the primary, secondary and tertiary approaches** as detailed in the World Health Organisation Report recommendation, "Analysis to Action". The main high level recommendations are shown in bold text. It also categorises these approaches within the ecological public health model in relation to individual, relationship, community and society.

**Annex B shows how actions will lead to improved outcomes in the medium and long-term, and how they will contribute to better health and reduced health inequalities.**

Alcohol is the single largest driver of interpersonal violence in Scotland and as such any action that will limit supply or access will have a positive effect on reducing the levels of violence and the number of victims. The decision not to include actions relating to alcohol in this paper was made in the knowledge and understanding of the ongoing work in relation to alcohol being carried out by the Government. The VRU are fully supportive of this work.

**Violence Reduction Unit  
March 2008**

## Violence Reduction Unit

PRIMARY PREVENTION				KEY
Individual (a)	Relationship (b)	Community (c)	Society (d)	
<p>1. Assessment of risk in the ante-natal setting, identification of parents who require additional support and intervention.</p> <p>2. Scoping and reinforcing the role of the family GP and health professionals in identifying at risk families and those headed for crisis.</p> <p>3. Promotion of healthy eating, including omega 3 and omega X.</p> <p>4. Selected interventions for those considered at heightened risk in committing or being a victim of violence e.g. young men and looked after children.</p> <p>5. Promotion of healthy attitudes and behaviour within children and young people. Changing the attitudes of childhood being the “problem years” to the “golden years”.</p>	<p>1. Normalisation and introduction of universal parenting class in ante-natal stages, which addresses not only physical care, but also emotional care and the parent’s role in child development.</p> <p>2. Develop policies and actions aimed at promoting the positive role of the father in a child’s life, including those fathers not living within the family home.</p> <p>3. Promotion of the home learning environment and importance of play.</p> <p><b>4. Scoping of parenting programmes which show effective results such as PALS (Parents altogether Dundee) and Triple P.</b></p>	<p>1. Establish and promote community parenting groups.</p> <p>2. Pilot “Sing and Sign” approach in promoting communication between parents and 6month old children and upwards.</p> <p>3. Establish and promote community groups for young men.</p> <p><b>4. Increase in diversional activities, including access to public buildings and PFI schools out of hours.</b></p> <p>5. Ensure policies continue to promote life long learning, including the “soft skills”.</p> <p>6. Community wide media campaigns on normalising parenting support and “what is good parenting”, techniques which can be utilised in addressing behavioural issues.</p>	<p>1. Promotion of organisations that promote the ethos of good parenting, acknowledge and act on their responsibility, empower their staff and provide adequate support for their staff e.g. schools</p> <p>2. Alcohol Green Paper and possible follow on legislation.</p> <p>3. Violence Reduction Unit’s provision of support to local authorities, and their partners, in addressing violence which is specific to their areas of responsibility.</p> <p><b>4. Roll out of National Injury Surveillance Model currently being piloted in NHS Lanarkshire area.</b></p> <p><b>5. Development of counselling programmes for victims of violence in particular repeat victims.</b></p>	<p><b>Safer and Stronger</b></p> <p><b>Wealthier and Fairer</b></p> <p><b>Healthier</b></p> <p><b>Greener</b></p>

**Violence Reduction Unit – continued**

PRIMARY PREVENTION				
Individual (a)	Relationship (b)	Community (c)	Society (d)	Comments (e)
<p>6. Ensure that there is adequate provision of vocational training for underprivileged youths and young adults.</p> <p>7. Continuing education on substance misuse.</p>	<p><b>5. Development of mentoring programmes, which match an at risk youngster with a caring adult from out with the family that can act as a good role model. This should include Scandinavian “pedagogue” model.</b></p> <p>6. Development and implementation of accessible relationship skill programmes.</p>	<p>7. Development and implementation of anti-bullying programmes.</p> <p><b>8. Implementation of universal social programmes, that emphasise competency and social skills delivered to pre-school and primary school pupils. Adolescent programmes which addresses anger management, conflict resolution, responsibility for their actions and morals.</b></p> <p>9. Promotion of community groups for both men and women and empowering them.</p> <p><b>10. Promotion and continuation of the Nite Zones/City Centre policing plans and roll out throughout Scotland.</b></p>	<p>6. Behavioural therapy for depression and psychiatric disorders associated with suicide.</p> <p>7. Improvement to urban infrastructure; both physical and socio-economic.</p> <p>8. Promotion of utilising police in community planning and housing at initial stages.</p> <p>9. Continue to monitor and review firearm and knife legislation to ensure effectiveness.</p> <p>10. Tackling of inequality, poverty and employment opportunities.</p> <p>11. Social marketing and media campaigns on promoting pro-social behaviour.</p>	

## Violence Reduction Unit – continued

SECONDARY PREVENTION				
Individual (a)	Relationship (b)	Community (c)	Society (d)	Comments (e)
<p><b>1. Commitment to therapeutic programmes including counselling for victims of violence.</b></p> <p>2. Promotion and additional support for varying support groups.</p> <p>3. Availability of behavioural therapy for depression and other psychiatric disorders associated with suicide.</p> <p>4. Capitalising on the 'teachable moment' in police, education and healthcare environments – what public services do to promote prevention etc. when people are accessing services.</p>	<p>1. Availability of behavioural programmes in schools when initial stages of behavioural problems are displayed.</p> <p><b>2. Effective family interventions which are implemented in any initial signs of risk.</b></p> <p><b>3. Increased availability of anger management programmes and cognitive behaviour programmes.</b></p> <p>4. Family therapy programmes aimed at improving communication and interactions between the family members, as well as problem solving skills to assist parents.</p>	<p><b>1. Roll out of campus officers throughout Scotland with an extended peripatetic role.</b></p> <p><b>2. Promotion and sustainment of the Nite Zones/City Centre Policing Plans, and their partnership working and their roll out throughout Scotland.</b></p> <p>3. Training for police, health and education professionals and employers to make them better able to identify and respond to the different types of violence.</p> <p>4. Removal of "pollutants" which may affect child development.</p> <p>5. Teaching of Children's Rights that addresses violent free environments, bullying, strangers and sexual abuse.</p>	<p>1. Challenge society's attitudes towards all types of violence.</p> <p><b>2. Increased involvement of all sectors and multi-partnership working in addressing violence, including religious leaders, magistrates, social work, local authority and voluntary organisations.</b></p> <p><b>3. Increased information sharing, expertises, problem identification across sectors.</b></p>	

Violence Reduction Unit – continued

SECONDARY PREVENTION				
Individual (a)	Relationship (b)	Community (c)	Society (d)	Comments (e)
		<p><b>6. Development and implementation of a gang intervention scheme in area of highest need.</b></p> <p>7. Modifications to the physical environment, including safe routes for children and youths to and from school and improved street lighting, where required particularly in city centres and areas of entertainment.</p> <p>8. Promotion of community awareness and involvement in addressing local issues.</p>		

## Violence Reduction Unit – continued

TERTIARY PREVENTION				
Individual (a)	Relationship (b)	Community (c)	Society (d)	Comments (e)
<p>1. Recognition of signs of violent incidents or ongoing violent situations, and referral to appropriate agencies, within education, health, employers and police.</p> <p>2. Additional support for children in substance misusing households.</p> <p>3. Ongoing support for victims of violence.</p> <p>4. Support for children in violent domestic circumstances.</p> <p><b>5. Increased use of brief motivational interviewing including GP surgeries, dental surgeries and police environments. Including consideration of national roll out of "COVAID" as piloted in Glasgow Dental Hospital.</b></p>	<p>1. Additional support to families within domestic violent situations.</p> <p>2. Training in relationship skills which bring together mixed groups of men and women to explore gender and relationship issues that may play a part in violence.</p> <p>3. Counselling programmes for men who abuse their partners.</p> <p>4. Relationship and family counselling.</p> <p><b>5. Parenting support programmes.</b></p> <p>6. Parenting programmes for prisoners.</p>	<p>1. Additional training for offenders in "soft skills" and increase employment opportunities and routes into employment.</p> <p>2. Continued support for appropriate community learning and development.</p> <p><b>3. Development of "Routes out of gangs" programmes and implementation of a comprehensive multi-agency gang intervention scheme in area of need.</b></p> <p>4. Pilot "safe zones"/places of safety in addressing vulnerable individuals under the influence of alcohol.</p>	<p>1. Legislation which calls for mandatory reporting of child abuse, sexual abuse and elderly abuse.</p> <p>2. Legislative and judicial remedies against physical punishment within the home.</p> <p>3. Prison reform, including CBT and anger management, educational and skill development for all prisoners.</p>	

Violence Reduction Unit – continued

TERTIARY PREVENTION				
Individual (a)	Relationship (b)	Community (c)	Society (d)	Comments (e)
			<p>4. Development of new court disposal schemes which provide programmes on violence/treatment programmes for those convicted and stages e.g.</p> <ul style="list-style-type: none"> <li>• First stage - First offence - attend programme = no record</li> <li>• Second stage – Re-offend = criminal record and attend enhanced programme</li> <li>• Third Stage – Re-offend = Prison</li> </ul> <p><b>For Domestic abusers incentives such as if you attend programme you can have child access, if not no access.</b></p> <p>5. Introduction of intervention card given to accused/suspect by police on where to get help for anger management/violence, on release from interview and/or bail.</p>	

Note: Main high level recommendations are shown in bold text.

# 9. HEALTHIER SCOTLAND

## ACTION TO REDUCE HEALTH INEQUALITIES

### Introduction

1. This paper sets out information to enable the Task Force to contribute to the Scottish Government's action plan on health and wellbeing, Better Health, Better Care.

### Better Health, Better Care

2. The Better Health, Better Care discussion document published in August 2007 invited views, from the NHS and wider interests, on priorities for health and wellbeing in Scotland. Ministers are committed to publishing an action plan by the end of the year. This included a timetable for action for NHSScotland at national, regional and local level, as well as a series of commitments from key delivery partners.

3. Better Health, Better Care set out the themes required to deliver the Government's strategic vision for health and wellbeing:

- Improving patients' experience of care.
- Securing best value.
- Encouraging people to take responsibility for their own health and wellbeing and prevent health problems arising wherever possible.
- Focussing on tackling health inequalities.
- Providing anticipatory care and improving services for long term conditions.
- Giving children the best possible start in life.
- Ensuring continuous improvement in services.

### Current health action

4. This may be identified as:

- Improving access to NHS services.
- Improving health and preventing illness.
- Contributing to improvements in the wider factors underlying health inequalities.

**5.** Action to improve access to NHS services currently includes:

**5.1** Targeting of health care support to families with very young children through Hall 4 changes.

**5.2** Increasing the number of dental students graduating in Scotland, providing the students with bursaries on the understanding that they continue practising in the NHS in Scotland after qualification, providing incentives to encourage practitioners to set up practices in Scotland and to encourage existing practitioners to extend practices. There has also been increased numbers of dental therapists being trained and in October 2008 the new Aberdeen dental school is due to open

**5.3** Some targeting of resources and other specific initiatives in primary care: details at Annex A.

**5.4** Keep Well programme of health checks for people aged 45-64 living in the most deprived areas and at risk of cardiovascular disease.

**5.5** A number of equality and diversity activities including the Fair for All approaches. Background at Annex B.

**5.6** Unmet needs pilot projects in Greater Glasgow and Clyde and Tayside. The aim of the pilots was to provide evidence as to whether supplying increased resources to Health Boards with deprived areas would lead to an improvement in access to NHS services in these areas.

**6.** Action to improve health and prevent illness is often shared between the NHS and other organisations. In particular, many local authorities have health improvement staff and there is joint working under community planning arrangements to produce structured joint health improvement plans. Preventive activity to reduce health inequalities includes:

**6.1** Targeted improvements to children's dental health by extending the *Childsmile* programme and by introducing a preventative based school dental service.

Extensive tooth brushing programmes in nursery and primary schools.

**6.2** Smoking cessation targeted at specific groups such as pregnant women, people with mental health problems and minority ethnic communities.

**6.3** Following the smoking ban, new action to prevent young people smoking, e.g. restrictions on sales.

**6.4** Strengthening community-led health initiatives through building their capacity to operate effectively and for funders and services to work better together towards shared outcomes.

**6.5** In the food and health fields specifically, promoting access to and availability of healthy food in deprived communities through the umbrella body Community Food and Health Scotland.

**6.6** Activities of the current National Programme for Improving Mental Health and Wellbeing.

**6.7** Other targeted approaches within national and local health improvement strategies, e.g. for young people's sexual health.

**6.8** Rolling out the new Healthy Start scheme, formerly the Welfare Foods programme. This now includes providing fruit and vegetables to low income families, as well as milk and vitamins.

**6.9** Action to improve the health of particularly vulnerable groups of people, such as looked after children, people at risk of homelessness, prisoners and ex-offenders.

**7.** The NHS contributes indirectly to improvements in the wider factors determining health inequalities through:

**7.1** Support for families, including 1:1 parenting and peer group support as well as structured parenting programmes such as Triple P in Glasgow.

**7.2** Providing vocational rehabilitation and condition management programmes to improve people's health with a view to retaining or re-entering employment.

**7.3** As a local investor in deprived communities, through employing people from marginalised groups and potentially through local purchasing of goods and services.

**7.4** Investment in Patient Focus and Public Involvement in the NHS, as well as in voluntary and community sector services, all of which help to build the capacity of individuals and communities to make changes in their lives.

### What is effective in reducing health inequalities?

**8.** Sustained and targeted support for parents in children's very early years has been shown to be effective in the medium and long term in improving health and other outcomes for children.

**9.** Sally Macintyre's paper for the Task Force identified that health promotion and social marketing aimed at the whole population have in the past widened health inequalities. To be effective, these activities need to focus much more specifically and intensively on the needs of individuals and on their wellbeing and life circumstances. There are examples of effective health improvement activities in deprived communities eg the Royston Stress Centre in Glasgow, which uses a holistic approach to smoking cessation. Statutory and regulatory approaches can also be effective, in improving the whole population's health and ensuring people most at risk of poor health outcomes are included.

**10.** Anticipatory care, aimed at preventable deterioration of health, has been shown to work in primary care. It is too soon to tell, however, whether the Keep Well programme will be able to engage people most at risk, support them to sustain improvement and result in better health outcomes. Introducing health checks for everyone at age 40 (a manifesto commitment) will need to be managed carefully, so as not to widen inequalities, through reaching only the better off.

**11.** The Fair for All approach has been effective in embedding equalities across policy and planning in NHSScotland. There are now tailored guidance, support and lead officer networks to drive programmes of work forward. Specific programmes include equality impact assessment, translation and interpretation, training and education and community engagement. Leadership has been vital in prioritising this agenda. The proposed 'single system' approach (Annex B) will assess the effectiveness of these approaches across the design, development and delivery of Cancer services across NHSScotland. Further work is needed on equality impact assessment, patient monitoring and evidencing impact.

### Gaps and recommendations for further action

**12.1** The NHS should make a key contribution to children's early years, through working with other agencies and communities to deliver intensive and highly targeted interventions. Critically, these activities should support families with aspects of positive parenting such as good maternal and infant nutrition. [Support should follow through in implementing the manifesto commitments on school nursing, starting with the most deprived areas]. There will be an opportunity to discuss in more detail at the Task Force's 5 December 2007 meeting on the Smarter theme.

**12.2** There should be more emphasis on addressing inequalities in health through primary care. One possible route is Government funding for enhanced services over and above the main General Medical Services (GMS) allocations. NHS Boards should be allowed to tailor enhanced services to local needs, but where approaches are found to be particularly effective, they should be scaled up and replicated more widely. Boards already have, as part of their GMS allocation, funds to invest in enhanced services, some national and mandatory but many locally developed according to local need. The Scottish Enhanced Services Programme (SESP) currently being rolled out adds to this funding and allows Boards, with the help of Community Health Partnerships (CHP) to select services from a national list of priority areas in order to best address local needs. Boards should ensure their use of these sources of funding reflects the need to reduce health inequalities.

**12.3** Other contractual mechanisms to target available primary care resources towards areas of greater need should be maximised, avoiding duplication and inefficiency. For example, there are opportunities to further enhance the new community pharmacy contract, in particular the Public Health Service element, to address health inequality issues and provide a wider range of services such as supporting Healthy Start and providing smoking cessation support. Aspects of GMS funding which may inadvertently reinforce rather than reduce inequalities should be identified and addressed to minimise these effects.

**12.4** The Keep Well programme should be maintained, with particular emphasis on engaging the hardest to reach people and finding out what works to sustain their involvement in activities reducing their risks of preventable ill health eg healthy weight management, improving mental wellbeing. The commitment to health checks for all at age 40 should be implemented in such a way that it avoids widening health inequalities.

**12.5** New anticipatory care approaches should be sought, for example to reduce risks from alcohol to the health of young people, to improve the physical health of people with mental illness or a learning disability, and to support early intervention and rehabilitation for those with disabilities, multiple long term conditions and complex needs.

**12.6** Effective approaches to reaching and engaging the most vulnerable groups of people in improving their health should be identified and scaled up. For example, the current multiple and complex needs projects (see Annex B), adult literacy projects in the NHS and assessments of the health of looked after children.

**12.7** The Government should invest in improving the capacity of the voluntary and community sector to reduce health inequalities, most importantly, encouraging commissioners and funders and the sector to work better together, based on an understanding of shared priorities and outcomes to be achieved.

**12.8** National and local action to follow the current National Programme for Improving Mental Health and Wellbeing should focus particularly on effective action to reduce inequalities in wellbeing and support recovery from mental illness. For example, improving "mental health literacy" of staff in the NHS and other key agencies involved in people's lives eg education, housing.

**12.9** There should be more effective replication and scaling up of effective health improvement action, e.g. in smoking cessation. Current encouragement eg via learning networks is not sufficient to ensure that good practice happens everywhere. Techniques such as the collaborative approach and benchmarking good practice should be introduced to health improvement, to drive and manage change.

**12.10** New health improvement activities, such as implementing the manifesto commitment to provide free fruit and vegetables for pregnant women and pre-school children, should focus primarily on reaching the most vulnerable groups in the population, without implying stigma or a judgmental approach.

**12.11** All NHS Boards should operate pre-employment programmes to encourage the recruitment of people from hard to reach groups into the NHS, building on the current Work Foundation Study to establish the business case for such programmes. There should be more consistent action by Boards to maintain and improve the health of their own staff.

**12.12** NHS Boards should implement fully the recommendations of the Framework for Adult Rehabilitation, including for vocational rehabilitation. They should also adopt existing good practice amongst NHS Boards and CHPs in working with employability services to enable people to retain or return to work.

**12.13** NHS Boards, through CHPs in particular, need to contribute more systematically to joint activity across community planning partners, to reduce health inequalities.

**12.14** There should be a systematic process for assessing the impact on health inequalities of new (and also existing) health policies and programmes, at both national and Health Board level.

**12.15** Similarly, there should be more systematic assessment of the impact of other public policies and programmes, e.g. transport, planning, on health and on reducing health inequalities.

**12.16** Resources targeting health inequalities and the most deprived areas should be protected at national and local levels. Resources should be scaled up where a business case can be made. There should be proper impact assessment and studies of the cost-effectiveness of current and new prevention and health improvement activity aimed at reducing inequalities.

**12.17** Extension of *childsmile* programmes to areas not already covered and special provision for people with special needs.

### Measuring success

**13.** Targets have been set for some time for the NHS to reduce health inequalities. These relate to improving the health of the most deprived communities by 2008 in relation to coronary heart disease, cancer, adult smoking, smoking during pregnancy, teenage pregnancy and suicides in young people.

**14.** These NHS targets are criticised, because achieving them does not depend only, or even mainly, on activity by the NHS. Public Health and Wellbeing Directorate and NHS Health Scotland are currently reviewing how performance is managed across the whole system of agencies involved in improving health and reducing health inequalities. This includes identifying shared priority outcomes and subsequently indicators of success appropriate to the activities of the NHS and its delivery partners. The review provides more detailed back-up to the Government's aim to identify national outcomes and strengthen public reporting on progress towards these.

### Delivery and Workforce implications

**15.** The recommendations above for action have clear implications for deployment, roles and skills of NHS staff: GPs, nursing staff and others.

**16.** Recommendations also require a step change in health promotion and prevention. NHS Health Scotland and NHS Education Scotland have some programmes in place to support the public health workforce engaged in this. NHS Health Scotland is also setting up a new Directorate of Equalities and Planning by 2008 and this will help to integrate Fair for All activity into health improvement efforts to reduce inequalities.

**17.** Progress will be reported to the Task Force on improving workforce capacity and also on possible reform of the way the public health effort is managed, in order to make a greater impact on improving health and reducing inequalities.

**18.** A more concerted effort is required to make reducing health inequalities central to NHS Boards' planning and priorities. Achieving this centrality is patchy at the moment. The accountability process, including Boards' Annual Reviews, needs to focus more on whether Boards are successfully reducing inequalities in their area.

**November 2007**

## ANNEX A

### PRIMARY CARE ACTIVITIES TARGETING HEALTH INEQUALITIES

#### Primary Medical Services

- Funding that is allocated to Boards to support the GMS contract, is calculated by a range of factors including age of population; rurality; deprivation; and gender. The Scottish Enhanced Services Programme is further weighted to reflect the age and levels of deprivation within the local community.
- GP practices are encouraged to provide the highest possible quality of services to their local community. The Quality Outcome Framework (QOF) (focusing on clinical, organisational and patient experience targets) was introduced with the new GMS contract. The QOF rewards GP practices where quality of care is high. Recent data suggest that GPs across Scotland have achieved very high standards in all areas of the QOF, including such important areas such as mental health and coronary heart disease.
- Boards are still able to issue one off Golden Hello payments to GPs who decide to take up their first post in Scotland. The standard payment for a full time GP is £5000. Additional payments are also made to those individuals who take up this post in a remote, rural or the most deprived areas (an additional £5000 for remote and rural areas; and up to £7,500 for the most deprived areas).
- The Scottish Enhanced Services Programme for Primary and Community Care (SESP) currently being rolled out allows Boards to select services from a national list of priority areas in order to best address local needs. These priorities include services for adults with learning disabilities and for carers, addressing unmet need for instance in hazardous and harmful drinking patterns and preventing falls, better community services for patients with diabetes and COPD, and flexible appointment systems to improve access.

#### NHS Dental Services

- Free NHS dental examinations for all.
- Grants available under the Scottish Dental Access Initiative for those dentists wishing to establish new or expand existing NHS dental practices in areas of high oral health need.
- The Childsmile West Programme promotes oral health from birth and targets families with young children who live in the more deprived communities across the West of Scotland.
- Those in receipt of certain DWP benefits/credits or on low income receive free NHS dental treatment and NHS optical vouchers towards the cost of glasses/contact lenses. Others may be entitled to help with the cost under the NHS Low Income Scheme.
- A deprived areas allowance for those dentists providing NHS general dental services in disadvantaged areas. There is also an enhanced capitation fee, patient registration fee, on a sliding scale depending on the area of deprivation.
- A remote areas allowance to recognise those dentists who provide NHS general dental services in sparsely populated areas.
- The Community Dental Service provides NHS dentistry to special needs patients.

### Community Pharmacy

- Introduction of a new community pharmacy contract which consists of four core services provided by all community pharmacy contractors which ensures equitable access, including in areas of greater need. In particular:
  - A Public Health Service through which pharmacists and their staff support self care and promote healthy life styles.
  - A Minor Ailment Service which allows patients exempt from prescription charges to register with the community pharmacy of their choice and have any presenting common conditions or minor ailments, where appropriate, treated by their pharmacist on the NHS without the need for them to visit their GP.
  - A Chronic Medication Service which engages community pharmacists in the management of individual patients with long term conditions through improving their understanding of their medicines and working with them to maximise the clinical outcomes from their therapy as well as promoting greater joint working between pharmacists and GPs.
- Community pharmacists currently provide a range of additional (locally negotiated) services which can include substance misuse services, smoking cessation and sexual health services such as Chlamydia testing and treatment and access to emergency hormonal contraception. Work is ongoing to standardise these services and to ensure that they are available in every NHS Board to reflect the needs of that area.
- The introduction of pharmacist prescribing is improving access to services for patients across a wide range of clinical areas. To date there are around 500 qualified pharmacist prescribers and around 100 pharmacist prescribing clinics are funded.
- NHS Boards are working to develop pharmaceutical care services plans which will identify gaps and future service provision needs.

### Eyecare

- Free NHS eye examination for all, which allows patients to receive, free of charge, an appropriate health assessment of their whole visual system.
- Those in receipt of certain DWP benefits/credits or on low income receive NHS optical vouchers towards the cost of glasses/contact lenses. Others may be entitled to help with the cost under the NHS Low Income Scheme.
- Review of eyecare services in the community in Scotland the aim of which was to encourage the development of integrated eyecare services to ensure patients receive a good quality and efficient service, in a convenient setting without undue wait. This also covered a review of certification and registration of the blind and partially sighted in Scotland.

### Nursing in the Community

- Development of a generic community health nurse model based on preventative and anticipatory care that identifies the needs of the most vulnerable and deprived people in our communities. Model is being tested in four NHS Boards until 2009.
- Development of a strategy for nurse and AHP prescribing which promotes the benefits of non medical prescribing to patients, e.g. better access to medicine when required.

### Out of Hours Primary Care Services

- The Out of Hours Strategy Group – made up of representatives from NHS Boards, NHS QIS, NES, and NHS 24 – is developing a strategy for future sustainable models of out of hours primary care services. A key objective of this strategy is to address issues of equity that can be a particular issue for rural areas. The Group is expected to report before the end of the year and to provide guidance on how to redesign services to reflect a multi-disciplinary approach with extended role development for nursing staff and other health care professionals. The guidance is also expected to promote existing good practice in rural locations, models that are both sustainable and cost effective in the long-term, but continue to set high standards of patient care and which are measurable.

## ANNEX B

### EQUALITY, DIVERSITY AND HEALTH INEQUALITIES

- Sources of inequality in health are broad ranging, but it is clear that a holistic description would include; **life circumstances**, e.g. socio-economic status; access issues, e.g. physical access, literacy, and; **diversity** (including the impact of prejudice and discrimination), e.g. race, sexual orientation.
- A growing raft of **equalities legislation** puts the responsibility firmly on institutions to demonstrate that they are tackling discrimination and promoting equity of access and opportunity for all. A major focus of recent investigations by the existing equality Commissions has been the NHS, given the very personal nature of health services. A recent formal investigation by the Disability Rights Commission for example, identified institutional barriers to essential health screening for people with learning difficulties and people with mental health problems.
- Part of SEHD's Patient Focus Public Involvement, the **Fair for All** agenda aims to ensure that 'whatever the individual circumstances of people's lives, including age, gender, ethnicity, disability, religion, sexual orientation, mental health, economic or other circumstances, they have access to the right health services for their needs'. Fair for All initiatives on Age, Disability, Race, Gender, Sexual Orientation & Religion / Belief have produced a range of tools and guidance to help tackle health inequalities. Such examples include: Achieving Fair, Gender Health Guidance, Good LGBT practice in the NHS and Checking for Change.
- The **Multiple and Complex Needs** initiative (Social Inclusion / Equality Unit) aims to improve public services for those with multiple and complex needs who may find it particularly difficult to access services and/or to maximise their own benefit from them. £4 million is being made available over two years from the Executive's Closing the Opportunity Gap Fund to a range of projects, many in the NHS, to improve the way in which they engage with service users and attract them to use their services, how they assess and deal with their particular set of service needs/problems and how they improve service outcomes for them.
- SE Patients & Quality are developing a "single system" approach which will assess all stages of the delivery of a clinical service from the policy and workforce stages in SE Health and Wellbeing to the primary, secondary and tertiary services that provide the direct patient care. This programme will start in 2007 with '**Delivering Cancer Services that are Fair for All**' and will link closely with the new national **Patient Experience** programme.

- SE Patients & Quality have developed 'the **Equality and Diversity Impact Assessment Toolkit**' to assist managers within the Scottish Executive Health Directorates and Scotland's NHS Boards systematically review their policies and functions in order to meet the needs of all communities.
- The **Equality & Diversity Information Project** (NHS NSS) has now been in place for 3 years and aims to collect standard routine dataset information for patients, to enable us to record progress on equalities.
- A **Diversity Task Force** (DTF), chaired by a NHS CEO aims to provide the internal assurance that NHS Boards are delivering on their legal and policy requirements and reports on progress to the Chief Executive of NHSScotland.
- The **National Strategy and Action Plan on Race Equality** is being re-drafted at present, and will be issued for consultation in the autumn. It will then be re-drafted again in the light of the consultation and a final version should be ready for publication early in the New Year.

## ACTIONS TO IMPROVE OFFENDERS' HEALTH

### Purpose

1. To provide information for the Task Force on the health and other needs of prisoners.

### Background

2. The Government is committed to a cross-cutting approach to reduce health inequalities, both as an important public health end in itself, and as a route towards creating a more successful country with opportunities for all of Scotland to flourish. Consideration to the health of offenders and ex-offenders has an important place in the delivery of a fairer, more equitable society.
3. The key inequalities identified for (and accepted by) the Task Force are:
  - early years.
  - mental illness and wellbeing.
  - drugs/alcohol/violence.
  - the 'big three' killers and their associated risk factors.
4. The approaches to be implemented will involve:
  - Redesign of public services.
  - Focus on very early years and support for families.
  - Building resilience and promoting wellbeing.
  - Reducing the prevalence of, and exposure to, environments (physical and social) that perpetuate health inequalities.
  - Attention to delivery (includes leadership, workforce development, continuous improvement methodologies, strong partnerships).

**5.** Improving the health of offenders has been identified as an area in which the Task Force would like to consider specific actions. This is a population group in which the inequalities identified above are particularly prevalent – 80% being cigarette smokers; a similar % having a drug problem; two thirds reportedly having personality disorders and 70% or more having a mental health issue sufficient to require clinical support. It is also a group for which all of the approaches just mentioned are not only relevant but particularly appropriate.

**6.** In addition, the needs of two particular sub-groups should be highlighted. First, women prisoners, who comprise only 5% of the prison population but have exceptionally high levels of health need. Recent figures show, for example, that 98% of the women in Cornton Vale have addiction problems, 80% have mental health problems, 70% have been abused and around 50% self harm. The range of offences and sentences is wide – in February 2008 28% of current sentenced Cornton Vale inmates were in for 4 years or more, 74% in for 1 year or more, and only 28 prisoners had sentences of under 6 months. But many women do not pose a risk to the public and overwhelmingly these women are in need of protection themselves, as well as requiring treatment for mental illness, abuse and/or addictions. Many are carers, and their imprisonment may increase the vulnerability of those for whom they have a caring responsibility. In short, this is a highly vulnerable group in need of care, support and protection.

**7.** The second sub-group are those with learning difficulties, who comprise about a quarter of the prison population and an unknown percentage of those receiving community penalties. Their learning difficulties are often both at the root of their offending, and create a barrier to receiving effective support and service responses. Proposals for actions to support both of these sub-groups are included in the recommendations that follow.

### General approach and potential benefits

**8.** The links between offending behaviour and poor health (addictions and mental health problems in particular) are well documented, and are recognised as being multi-factorial and multi-directional. Actions therefore need to assume no ‘magic bullet’ but instead recognise that there is a complex system at play. Offenders are not a homogenous group and recognition also needs to be made of the fact that in recent years a greater number of offenders have received a community sentence rather than custodial term.

**9.** A linked point is that neither offending behaviour nor poor health/health-related behaviour is simply an individual choice. Both reflect family circumstances, social, economic, cultural and environmental factors, and are concentrated within the same communities in Scotland. Efforts to improve health and reduce offending should include attention to these family, community and circumstantial factors as well as to individuals’ motivations, lifeskills and health.

**10.** A related point is that investment made successfully in improving the health of offenders will bring benefits to their families and communities (who will also often have a high level of health need). Approximately 15,500 children in Scotland lose a parent to prison per year; 51% of men and women in prisons have dependent children. The health, social and educational prospects of these children are affected in turn by their parent’s health. More widely, investment in continuity of care brings particular benefits to the local community from which an offender comes and to which – in most circumstance – he or she will return. Fear of crime is a major factor in undermining local residents’ confidence in their community as a safe place to live. Reducing victimisation rates and perceptions of crime, and building up confidence in one’s local community as a good place to live, are all further high level indicators for the Scottish Government success.

**11.** A great deal of work with offenders focuses on those who are furthest away from success and stability – people with compound problems and “chaotic lifestyles”. We invest significant effort to improve their outcomes, and must do so if we are to ensure that economic growth – the Government’s prime aim – is not divisive. A key goal for the Government is increasing active and positive participation in building the economy and work with offenders focuses on making it more likely that they will be able to contribute positively in future. That improves both solidarity and cohesion -two characteristics of economic growth that the Government wants to see

**12.** The health inequalities within Scotland are partly a consequence of the services currently being provided. As a minimum, we have to accept that our services are not currently effectively reducing the burdens of ill-health and vulnerability experienced by offenders, and concentrated within our poorer communities. This is not only an issue for the health services, but more widely across the public sector. It has implications for service redesign and improvement (draft Task Force report includes sections on these), and also for better “bridging” mechanisms between the more excluded members of society and mainstream services.

**13. Service-redesign:** It needs to be emphasised that the impacts of offending on Scottish society will not be turned around solely through criminogenic interventions. The securing of improvements to the care and wellbeing of offenders is a core strategy for the achievement of a safer, as well as a healthier, Scotland. A number of important developments are already being progressed to enhance the health impact of existing services. The prison health service is linked in to government funded initiatives on alcohol problems, Hepatitis C, the refreshed Drugs Strategy for Scotland, and strategies on sexual health, food and others. The existing six Offender Outcomes identified in the Performance Framework for Community Justice Authorities include a number that relate to improved circumstances in terms of housing and health interventions, as well as individual resilience and life skills. Proposals are currently being developed to pilot approaches to improve the condition of people with personality disorder. Furthermore, *Better Health Better Care* commits to reviewing NHS Scotland’s approach to the health and healthcare of offenders and ex-offenders. This review is a key route to improving, and enhancing the reach, of health services for offenders. But it will be important to embed it in a wider programme of changes which secure long term improvement in the health of offenders by ensuring continuity of care through a custodial sentence and following discharge.

**14.** In this context the work of this Task Force will relate closely to the proposals in the emerging strategies on drugs and alcohol for vulnerable people, including offenders. Continuity of care for offenders, as the key to long term improvement, should be a key focus for us. We already fund the Throughcare Addiction Service (TAS), which signposts those being treated for addiction problems in prison to addiction/health services available in the community, draws up a pre-release action plan and retains contact with the ex-prisoner following release. TAS does not, however, increase the volume of drug treatment services available and the time that it takes ex prisoners to access the services identified in their plans varies widely across Scotland. There is a resultant risk that the ex-prisoner will withdraw from contact with service providers or relapse into drug misuse. The situation across the health board areas has been assessed, and those with a particular problem identified.

**15.** Similar considerations apply to those serving community sentences in ensuring that there is ongoing access to services for those who need it at the end of the criminal justice intervention. For example, it is vital that those who successfully complete a Drug Treatment and Testing Order are able at the end of the sentence to make a seamless transition to mainstream service provision in ensuring that the offender’s addiction issues continue to be addressed if the benefits gained during the order are not to be lost.

**16.** In relation to complementary approaches, there are some insights and positive findings emerging at a project level, for example from the Routes out of Prison project funded by the Multiple and Complex Needs pilots and the link worker pilot to support women offenders on community penalties, developed in light of the review of community penalties. Components of these projects that appear to be important include buddying/mentoring by people who have had experiences similar to those of the offenders; and the value of multi-professional outreach workers who are able to work across different sectors and act as an advocate for offenders and their families.

**17.** It is recommended that these emerging findings form the basis for an specific *Inspiring Scotland* funded programme. Particular foci for which there would be a sound basis would be a project to ensure that every women offender coming out of prison/on a community sentence was offered peer support starting during the sentence and continuing thereafter to aid integration. As noted above, women offenders have exceptionally high health needs and a high level of need for support in a non-institutional setting.

**18.** Another possible element of investment through the *Inspiring Scotland* fund would be to support Transition to Accommodation projects; providing a housing advice and assessment support service to prisoners – a model currently being developed with full stakeholder support will be available for deployment from the summer. Projects would provide better information to offenders and their families, help to increase the number of offenders leaving custody with suitable accommodation arranged, and help in the maintenance of tenancies despite custody.

**19.** There is, however, an almost total lack of knowledge of interventions designed to and demonstrably succeeding in narrowing the health gap between offenders and the rest of the population. Scotland is well placed to develop a programme of research that could meet health inequalities and re-offending aims simultaneously.

## Gaps and Challenges

**20.** We have identified a number of further gaps/challenges for consideration by the Task Force:

- (i) **Support for offenders with learning difficulties or disabilities.** The Prison Reform Trust's *No One Knows* programme runs to October 2008 and is building up an understanding of the experiences of people with learning difficulties and disabilities who come into contact with the criminal justice system. A number of early recommendations are already available and respond to the fact that people with learning difficulties are not identified routinely prior to arriving in custody and, once in prison, face a number of difficulties (including victimisation and exclusion from opportunities). Political leadership for action to implement these recommendations would make an important contribution to reducing the health deficit experienced by these individuals.
- (ii) **Support for mental health and wellbeing.** The Scottish Prison Service had made considerable progress in relation to the prevention of suicide and self-harm. Most people report feeling better about themselves on leaving prison than they did on entry. However, there are a proportion of offenders (and particularly women offenders) who even seek to return to prison, as a place of safety and care. Despite current levels of over-crowding, Scottish prisons are at present relatively peaceful places and there are a proportion of offenders (particularly women offenders) who even seek to return to prison, as a place of safety and care. This has been achieved through a concerted effort to put in place positive, respectful environments and through introduction of specific mental health programmes such as mental health first aid and choose life. It is recommended that the Task Force seeks the extension of such approaches across all criminal justice settings, and includes them within its recommendations on service redesign and continuous improvement.

- (iii) **Work to ensure (ex-) offenders have good access to health and other public services and benefit from the same quality of service as the rest of the population.** Proposals to move all health services for prisoners into the NHS will present an opportunity, and also a major challenge, in this regard. It is recommended that achievement of the HEAT targets on access be explicitly applied to care for (ex-) offenders as well as the population as a whole. In addition, it is recommended that in each community planning partnership and Community Health Partnership area, work is carried out with CJAs to ensure joint priorities and that projects are in place to supporting (ex-) offenders to use these services more effectively. This is about integrating a population group with a high level of need into mainstream services.
- (iv) As highlighted earlier, the effects of imprisonment impact on offenders' families and wider social environments as well as on the offenders themselves. The SPS is developing a family and relationships policy, which aims to alleviate those wider impacts, and to support the formation and sustaining of stronger social relationships by and with offenders. The potential gains of this approach for Scotland's health are significant. The majority of people in prisons are parents and/or young people, with whom there is scope to support a new start in life not only for themselves but also for their children.
- (v) **The Task Force might consider flexibility to incorporate health-related programmes as part of community sentences.** The report of the review of community penalties commits to allowing community service to include an element of activity other than unpaid work. This scope should be developed for women offenders as a priority, to include the development of health and care services in the community for this group. This already occurs with the 218 Centre in Glasgow for female offenders which offers both residential and day programmes with a significant focus on improving the health and well being of those being worked with. It is proposed that the lessons to be learned from the 218 approach and the opportunity presented by the more flexible approach to community service could offer a more effective route to good health, free of addictions and free of crime than that which is currently offered.
- (vi) Courts in imposing a probation order are able to add additional specific conditions of the order to address a variety of issues the offender may need to address. These conditions are applied most regularly with those offenders facing serious addictions issues but a significant number are also made with those presenting with medical/psychiatric/psychological problems. However, the extent to which courts are willing to impose such conditions is often a reflection of actual or perceived levels of local service provision and the availability of more consistent treatment services which offenders might access continues to be a key issue.
- (vii) There is a need to better link research on desistance/resilience with the research agenda in health (and particularly health inequalities). Much could be gained by securing a more integrated set of objectives.

## MENTAL HEALTH AND WELLBEING

### Definitions: *Mental Wellbeing, Mental Health, Mental Illness*

1. Mental wellbeing is a construct in general usage that describes the emotional, social and psychological functioning of the individual. It includes the ability to cope with life's problems and normal stresses, realise abilities, make the most of opportunities and make a contribution to the community. It can include elements such as optimism, mastery, confidence, the feeling of flow, strength of relationships, resilience, contentedness and happiness. Individual experience of mental wellbeing can be presented as occupying a position on a continuum that runs from flourishing to languishing. Mental wellbeing is being measured annually in Scotland through the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS). In Scotland in 2006, 14% of the population were classified as having good mental wellbeing, 73% average mental wellbeing and 14% poor mental wellbeing.
2. Confidence, self-esteem, positive affect (e.g. hopefulness, optimism), resilience and (mental) health literacy are individual level factors that underpin mental wellbeing and quality of life. In terms of social and environmental factors, having close and supportive friends and family, social interaction, social participation and engagement within local communities and the extent to which people are satisfied with their residential neighbourhood are all strong positive influences on mental wellbeing. Insecure and inadequate income and working conditions characterised by high demand/low control, low support and effort-reward imbalance are the most commonly cited negative influences on mental wellbeing.
3. Mental wellbeing is associated with the idea of good mental health but separate from the idea of mental illness (which is concerned with the cognitive functioning of the individual and with physical illnesses of the brain). Both people with physical and mental illnesses can have a good sense of mental wellbeing. This suggests that it is helpful to see mental wellbeing and mental illness (or its absence) as two continua for assessing an individual's experience.
4. Where people experience common mental health problems such as depression and anxiety or are subject to stress at a significantly high level, the two continua of mental wellbeing and mental health/illness intersect as the absence of mental wellbeing may also be seen as indicative of poor mental health. Depression is strongly co-related with languishing, but in time may also manifest as an acute or long term mental illness.

### Links Between Mental Health and Health Outcomes

5. Those who are flourishing and in good mental health are more likely to engage in activity that promotes and protects their health. They are more likely to be socially engaged and to participate in networks that offer access to opportunities such as employment and social support. They are more likely to take responsibility for their own health outcomes. By contrast, those who are languishing are less likely to manage their own health and that of others close to them, and more likely to be disengaged, sedentary, eat poorly and abuse alcohol. They are less likely to respond positively to health improvement and mental health promotion activity. Action on health improvement needs to therefore address the underlying reasons and understand cultural and behavioural issues as to why some people do not engage positively with health improvement social marketing and promotional activity.
6. Depression is highly correlated with other chronic diseases and failure to treat depression leads to poorer general health outcomes. The current GP contract recognises this in rewarding GPs for case-finding of depression for those with CHD and cancer. Improvements in positive mental wellbeing will help reduce the prevalence of common mental health problems, such as depressions and anxiety, substance use, anti-social behaviour, as well as improving health, recovery and social outcomes in clinical populations. While the best outcomes are associated with the absence of mental illness, the presence of positive mental wellbeing brings additional benefits, especially for those with common and longer term health conditions who are limited by their condition and/or disabled.

- 7.** There is a clear social gradient for most physical and mental health problems as well as for mental wellbeing. Poor mental and physical health is both a cause and consequence of social, economic and environmental inequalities; the uneven distribution of health problems in the population both reflects inequalities and contributes to them. Moreover, the mental and physical dimensions of health inequalities are intertwined. For example, CHD risk is directly related to the severity of depression with a 1–2-fold increase in CHD for minor depression and 3–5-fold increase for major depression. For young people, psychosocial functioning (self determination, closeness to others and school integration) is closely correlated with behaviour problems (arrests, truancy, alcohol, tobacco and marijuana use).
- 8.** In terms of the burden of disease, mental illness (including suicide) accounts for 20% of the total burden of disease in the UK, compared with 17.2% for cardiovascular diseases and 15.5% for cancer (WHO figures, 2006).

### Current and Future Action: Part I: Depression, Anxiety and Stress

- 9.** Commitments have been made under the Government's *Delivering for Mental Health* programme to increase the availability of psychological therapies and offer stepped care for those with depression, anxiety and depression and those with depression as a co-occurring condition with CHD and cancer. This builds on Scotland's work under the Doing Well by People with Depression. The commitments are supported by the HEAT target of levelling off the increase in anti-depressant prescribing and over time moving to a reduction.
- 10.** Work is place to develop the *Living Life to the Full* resource (web, books, DVD, and a range of supported self-help) as a national resource and programme of work from 2008 onwards. LLTTF promotes self-help and cognitive behavioural therapy based approaches for those with depression, anxiety, suffering high levels of stress, low mood, sleep disorders and related problems. The work will focus on promoting a range of tools and resources (the work conforms to NICE guidelines and is internationally recognised as best practice) and training staff both to signpost people to it and to collaborate with individuals and groups in supporting improved self help in addressing common mental health problems in a positive and effective way.
- 11.** The Mental Health Delivery Collaborative (which supports local service change) will focus on the implementation of stepped care approaches and embedding psychological therapies, learning from best practice experience in Clyde and elsewhere under the Doing Well by People with Depression initiative. In addition work will also focus on the contributions that Community Health Partnerships can make and through the use of community and social referrals. In each case, establishing easy to use, clear referral pathways that make systems work more easily and efficiently are key to the work.
- 12.** Further targeting of this work on deprived areas, while recognising the often more complex issues involved that follow from multiple disadvantage is likely to produce better health and other outcomes. There are already a number of local champions for this work in deprived areas and we should them as a resource more (as well as developing more local champions). LLTTF has already been delivered through further education colleges and we can do more of that as well as examining other locations where the programme might be delivered and promoted; the work on depression, anxiety and stress and also wellbeing is well suited to inclusion within Well Centres and we will develop options for this quickly. Other programmes, such as Keep Well, should pay more attention to mental wellbeing and mental health as underpinning the response to health improvement activity.

## **Better Outcomes: Part II: Towards a Mentally Flourishing Scotland**

**13.** *Towards a Mentally Flourishing Scotland* was published in October 2007 by the Scottish Government and focuses on Promotion, Prevention and Support in respect of mental health improvement. It is intended to support discussions with public, voluntary and third sector organisations focused on the identification of tangible, deliverable commitments for action which will form the basis of the next stage of work for the National Programme for Improving Mental Health and Wellbeing.

**14.** A series of national and local events are taking place to facilitate the discussions, with events being hosted by a range of mental health and non-mental health organisations. External and internal reference groups are in the process of being set up. An event will be held at the end of January 2008 to focus on how the programme can contribute to addressing health inequalities.

**15.** A group is being established to co-ordinate Scottish Government engagement in the process and identify how this work can make appropriate connections with work on early years, justice, social inclusion, equalities, employability, the wellbeing of children and young people and other key cross-cutting programme areas.

**January 2008**

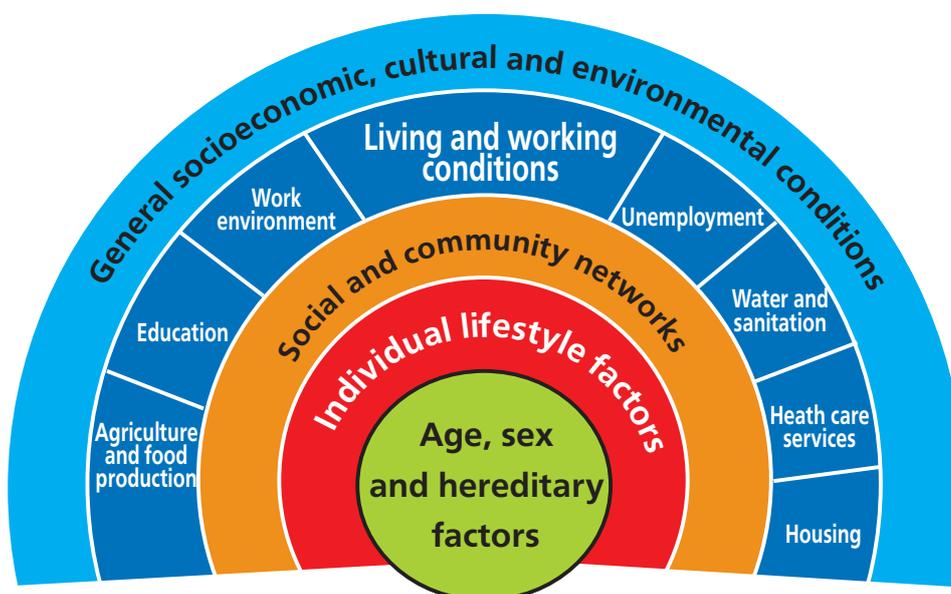
# 10. EQUALITIES AND DIVERSITY

## Introduction

1. Diversity (age, disability, gender, race, religion or belief, sexual orientation) can lead to unequal health outcomes for people with particular characteristics, compared to the rest of the population. We need to respond to diversity in a range of ways including: making services more culturally sensitive and accessible; providing a bridge for people to access mainstream services, for example translation and interpreting; providing a different level or type of service for example to address South Asian people's propensity to harm from diabetes, or tackling the societal discrimination and disadvantage some groups face that cause their unequal health outcomes.

2. The Task Force has mainly been looking at health inequalities that relate to life circumstances such as poverty and deprivation. Members expressed a wish at the extended meeting on 21 November to explore health system responses to some of the other determinants of health, including diversity characteristics, which are demonstrated in the Dahlgren & Whitehead model previously considered by the Task Force. (Figure 1). This paper responds to that request.

**Figure 1 Determinants of health are multi-layered and range from societal to individual factors**



**3.** Sometimes diversity and life circumstances interact and pose increased and interlinked risks to health. People do not just live in poverty, they may also be a lone parent, may have a long term disability that affects the work they can do, or live with discrimination that impacts on their mental health. Gender, and masculinity in particular, contributes to problems of violence, to the reluctance of men to seek help for problems and may make men more likely to resort to alcohol and drugs than to seek help for a mental health problem.

**4.** While the Task Force has been primarily interested in health inequalities that result from socioeconomic circumstances, recognising and responding to these multiple and complex determinants of health is important when considering health service responses to health inequalities and identifying gaps in current action where health outcomes for individuals could be improved. This includes action to support people with learning disabilities and people with long term conditions. It also includes encouragement of community-led approaches which address some of the institutional and societal discrimination and resulting sense of alienation experienced by some groups.

The Equality and Human Rights Commission endorses the case made in this paper that the Task Force should consider all the factors that influence unequal health outcomes. The Commission agrees that plans for improvement should take account of the diverse needs of the population, and the multiple discrimination and disadvantage that affect outcomes for many people. Effective equalities impact assessment will be one of the key tools in addressing this. The Commission looks forward to seeing the conclusions of the Task Force and will continue to work with the health service to support its equalities agenda.

## The Evidence

**5.** Inequalities due to some aspects of diversity are well understood, for example coronary heart disease (CHD) admission rates in Scotland among men are nearly double those of women,<sup>17</sup> diabetes prevalence is 4 times higher among Pakistani people in Scotland than the general population (NRCEMH 2004). While data exist on health inequalities by gender and age there are fewer systematic data available in Scotland for health inequalities by ethnicity, disability, sexual orientation, transgender, and religion or belief.

**6.** Even where we do have data they are either incomplete or are not used. For example while there are good trend data on life expectancy by gender, there is little systematic analysis of variations in clinical outcomes between men and women. This is despite evidence of differences in the symptoms and prognosis of a wide range of diseases and conditions that affect men and women. This is very evident in the case of CHD, for example, which affects more men than women at younger ages.<sup>18</sup>

**7.** And, although there is very little research on the health of lesbian, gay, bisexual or transgender (LGBT) people, there is research that suggests the LGBT communities experience lower self esteem and higher rates of mental health problems than in general population,<sup>19</sup> that impact on health behaviours including higher reported rates of smoking, alcohol and drug use.<sup>20</sup>

17 [http://www.isdscotland.org/isd/servlet/FileBuffer?namedFile=CHD\\_incidence\\_Board\\_IC1.xls](http://www.isdscotland.org/isd/servlet/FileBuffer?namedFile=CHD_incidence_Board_IC1.xls)

18 Doyal, L., Payne, S., Cameron, A., (2003) *Promoting gender equality in health* Equal Opportunities Commission, [http://www.eoc.org.uk/pdf/promoting\\_gender\\_equality\\_in\\_health.pdf](http://www.eoc.org.uk/pdf/promoting_gender_equality_in_health.pdf)

19 Warner, J., McKeown, E., Griffin, M., Johnson, K., Ramsey, A., Cort, C. and King, M. (2004), Rates and predictors of mental illness in gay men, lesbians and bisexual men and women, *British Journal of Psychiatry*, 185, pp. 479-485.

20 Stonewall, Scottish Executive (2003) *Towards a Healthier LGBT Scotland*.

The **mental health and wellbeing** of particular groups appears to be worse amongst some specific groups. For example:

- Mental health problems affect more women than men. Specifically, women experience higher rates of depressive disorders than men. However, men are more likely to complete suicide and experience earlier onset of schizophrenia with poorer clinical outcomes than women
- Comparison of teenage and older mothers showed that teenage mothers suffer from poorer mental health in the first three years after their child's birth
- Rates of attempted suicide and self harm have consistently been shown to be higher amongst young and adult LGBT people

**8.** Where evidence exists it shows that there are important variations in health by ethnic group. Chinese people have better self-reported health and people born in HK/China but living in Scotland have low all-cause mortality. Differences in health between different ethnic groups are at least as large as those between the wealthy and the poor. Compared with the non-South Asian population, the incidence of heart attacks in Scottish South Asians is 45% higher in men and 80% higher in women.<sup>21</sup> All cause mortality among people living in Scotland but born in India, Pakistan, Bangladesh and China is lower than those born in Scotland.<sup>22</sup> On the other hand, mortality from cardiovascular disease is higher among South Asian born than Scottish born (Fischbacher et al) and the prevalence of diabetes is much higher (NRCEMH 2004). As is the case for all groups, the likelihood of ethnic minorities reporting poor health is strongly associated with ageing and deprivation.

**9.** Evidence highlights the impact of culture on health, the excess of ill health in some minority ethnic communities and the many barriers to access, including the impact of racism on mental health and wellbeing.

### Factors Affecting Health and Wellbeing

**10.** As demonstrated in Figure 1 determinants of health are multi-layered. Particularly important amongst these and a focus for action are *social and community influences*. Discrimination and prejudice are formed from attitudes and norms in society. Additionally the way people are brought up impacts on their health and health behaviours. An example is the role of gender, and masculinity in particular, in contributing to public health and criminal justice problems. Across the entire spectrum of male violence there are key questions that need to be addressed:

- Why is it predominantly men who engage in this behaviour? There are just as many females growing up in similar circumstances who do not behave in this way.
- What is it about being male – gender expectations of being 'hard'; conforming to perceived notions about being a man etc – that supports and normalises aggression for boys and men?

**11.** The same processes, for example, contribute to the reluctance of men to access health services or seek help for problems at an early stage for fear of appearing 'weak'; make men more likely to self-medicate with drink and drugs than accept they have a mental health problem etc. Similarly there are disproportionate levels of disengagement by boys compared to girls from the educational system. The gender difference in relation to violence and abuse is often attributed to 'natural aggression' for males, yet this argument fails to explain the capacity of most men to lead non-violent lives.

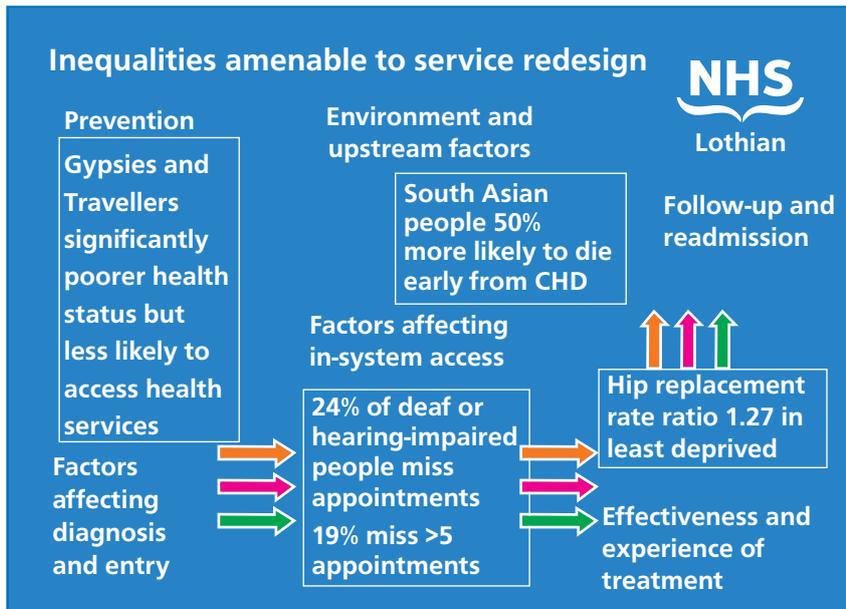
<sup>21</sup> Fischbacher et al. BMC Public Health 2007; 7:142.

<sup>22</sup> Fischbacher et al. Scottish Medical Journal 2007; 52:5-10.

12. The impact of prejudice and discrimination on self esteem and the possible impacts on health including mental health, alcohol and drug use are also related to social and community influences as well as more general *environmental factors*, and indeed living and working conditions.

### Diversity Issues and Health Services

13. It is useful to consider these issues from a service redesign perspective of **getting in, through and out** of services. This is usefully portrayed in Dr Alison McCallum and Professor Mats Brommel’s model (fig. 2). This highlights the role of the patient, community and wider factors at all stages of the healthcare pathway.



### Getting In

*“I can remember going to see a consultant who just told me that I’d be dead by the time I was sixteen – because I had both epilepsy and a learning disability. That stuck with me, that did. I’ve never forgotten him saying that to me – when I was just young. And you know, I invited that consultant to my 40th birthday party last year – and he came!”*

14. In 2006 the Disability Rights Commission (DRC) conducted a formal investigation into the health of people with mental health problems or learning disabilities in England & Wales. An analysis of more than eight million patient records was backed up by written and oral evidence. The investigation found that people with learning disabilities and people with mental health problems are much more likely than other citizens to have significant health risks and major health problems. For people with learning disabilities, these particularly include obesity and respiratory disease; for people with mental health problems, risks and problems include obesity, smoking, heart disease, high blood pressure, respiratory disease, diabetes and stroke.

15. The DRC investigation also found that these high risk groups were actually less likely to receive some of the expected, evidence-based checks and treatments than other patients and efforts to target their needs specifically were ad hoc. For people with mental health problems some standard treatments and tests, for example cholesterol checks and statins for people with heart disease, and spirometry for respiratory illness, were received less often than for others with heart disease or respiratory illness. For people with learning disabilities, some checks were given less often. People with learning disabilities who have diabetes had fewer measurements of their body mass index than others with diabetes and those with stroke had fewer blood pressure checks than others with a stroke. They also had very low cervical and breast cancer screening rates.

**16.** Some people face difficulties in accessing services or reporting health problems because they fear discrimination, lack experience, or have low confidence. This includes people whose first language is not English and people who have difficulty accessing information. For example homeless people and people with low literacy levels do not have the same access to information about health risks, signs and symptoms or accessible information on health services.

### Getting Through

- 87% of GPs felt they could communicate effectively with deaf people using their service.
- 52% of them could not name any resources they had for communicating with deaf and hard of hearing people.
- 23% of deaf and hard of hearing people had left an appointment unsure of what was wrong with them.
- 1 in 6 avoided going to the doctors because of communication problems.

#### **RNID (2000) Can You Hear Us? Deaf people's experience of social exclusion, isolation and prejudice in Breaking the Sound Barrier**

*"Mrs B has been living in Scotland for over 20 years, she is in her late 50s. About 5 years ago, she suffered from severe stomach pains so she went to see her GP. Both the GP and the practice nurse were not able to understand Mrs B as she speaks very little English. No interpreter was sought for to assist Mrs B. The pain persisted and Mrs B was treated by the GP for about 2 years as a form of stomach illness. At no time was she referred to the local hospital for further investigations. One day Mrs B found external bleeding and she was rushed to the A&E department immediately. After a thorough investigation, the consultant confirmed that Mrs B was suffering from cancer of the intestine and required an operation at once."*

**17.** The Scottish Government's Multiple and Complex Needs initiative was established in 2006 to investigate effective approaches to understanding and responding to the needs of people with multiple identity or complex needs, recognising that people do not just live in poverty, but may also live with a range of other circumstances that are important to their service needs. The initiative was discussed in Paper 15 for the Task Force on anti-poverty action. Much of the work done to date across the 14 projects funded by this initiative has been on changing NHS staff awareness, attitudes and behaviour towards certain groups and changing staff attitudes towards role 'boundaries', for example more comprehensive needs assessments or making sure domestic abuse victims feel comfortable bringing up substance abuse issues. A number of the projects are experimenting with actual changes in the structure of delivery or support services, in particular through the introduction of peer support workers or Patient Champions.

### Getting On

*"The nurse just took time to talk to me. She spoke to me, not to the people with me, and told me what was happening, what was wrong. She told me what was to happen to me, every step. I felt safe, I went home knowing that I was going to get better."*

**18.** Better Health, Better Care affirms the Scottish Government's focus on people as partners in their health and health care. Supporting and empowering those who are traditionally excluded or disadvantaged and ensuring they have accessible and appropriate information about their health and wellbeing is central to ensuring everyone can accept their rights as partners in their own health. By tackling societal factors that impact negatively on health, for example prejudice and discrimination; or the negative effects of masculinity, including violence, we can create safer, supportive communities where people can sustain good health and thrive. The Equalities Review<sup>23</sup> clearly states the role public policy has to play:

<sup>23</sup> Crown Publications (2007) Fairness and Freedom: The Final Report of the Equalities Review.

*“No-one, in the final analysis, can compel anyone in a free society to be more motivated or to have higher aspirations. Public policy can help in two ways. First, policy can make it easier for people who suffer disadvantage to find paths out of that disadvantage. Here the role of mentors, role models and good practice can be crucial ... But the second and crucial role of public policy is to remove barriers to such aspirations.”*

### Effectiveness of Approaches to Date

**19.** There are some Government health policies and strategies to tackle the issues highlighted above, in particular Fair for All, as outlined in Paper 6 for the Task Force on Healthier Scotland action. Much of this has been in response to legal requirements, in particular relating to the public sector duties on race (2002), disability (2005) and gender (2006). These duties require public services to involve communities in setting equality objectives, publish equality schemes and assess the likely impact of all policies and functions on these groups. However there is little evidence to date of improved health outcomes or a change in patient experience resulting from effective implementation of these strategies.

**20.** A national programme of service improvement work, focusing on patient experience and equalities in the design, development and delivery of cancer services has been established with a specific focus on measuring outcomes. This initiative is closely linked to the recently launched *Better Together* patient experience initiative, which will survey a quarter of a million patients per year, disaggregated by equality ‘strand’. It will improve or redesign services in areas such as chemotherapy, screening services and different tumour pathways based on patients’ experiences and existing evidence of the barriers different communities face. Effective practice will be rolled out across all NHS cancer services. This approach will then be developed across CHD and mental health services, thereby tackling the main areas of NHS activity, which correspond to significant Task Force priorities.

**21.** Of particular importance is improved data collection. Over 90% of healthcare is provided in primary care. Yet almost no data are available about primary care services for particular groups, with the result that it is not possible to assess whether primary care services are adequately meeting the specific needs of different populations, a requirement of equalities legislation. The situation is little better in secondary care. As a result it is not possible to use routine data to identify variations or trends in health and health care or to guide quality improvement initiatives.

**22.** NHS National Services Scotland has developed a range of initiatives, e.g. new datasets, training programmes and communications advice to support data collection by NHS Boards across equality strands. However, there are few incentives for NHS Boards to collect these data and no targets have been set for equality data collection.

#### Using information to promote equality

Mrs Singh has received an audiotape and letter in Punjabi inviting her to attend for Breast Screening. Both tell Mrs Singh that a Punjabi interpreter trained in Breast Screening will be present to help her.

**Action** The clinic arrange for a Punjabi interpreter to meet Mrs Singh when she arrives for her appointment and stay with her throughout her screening.

**Outcome** Mrs Singh feels less anxious about the examination and confident in asking questions in Punjabi knowing that she is understood.

**23.** A new e-Health Strategy is being developed in Scotland. It is crucial that any new systems include, along with date of birth and gender, the requirement to record ethnicity and disability. The Government also needs to consider how best to collect data on sexual orientation and religion and belief. Better data collection is essential to inform strategies to improve health across all the diversity groups.

### Tools for the Job

**24.** A range of tools and approaches are available to support the implementation of equalities sensitive design, development and delivery of services. Many of these are complementary to those being considered to tackle other aspects of health inequalities, including:

**24.1 Equality Impact Assessment (EQIA)** has been a requirement on NHS Boards since 2005 and if implemented effectively, will promote equality and tackle the adverse impacts many people experience in our health services.

**24.2 *Fair for All* Guidance** has been developed for NHS Scotland covering all equality strands, this now needs to be implemented effectively.

**24.3 HEAT**, the Government's performance framework for NHS Boards provides a focused set of performance targets for NHS Boards that could be disaggregated by age, disability and other diversity factors.

**24.4 Patient Focus Public Involvement (PFPI)** frameworks exist across all NHS Boards and the Scottish Health Council was established in 2005 to assess Boards' progress against agreed PFPI targets.

**24.5** The recently launched ***Better Together Patient Experience*** programme will survey 250,000 patients' experiences per year, disaggregated by age, disability, gender, race, sexual orientation and religion or belief and will use these experiences to develop a national service improvements.

**25.** Additionally the merging of the 3 previous Equality Commissions (Disability, Equal Opportunities and Race) into a new integrated Commission for Equality and Human Rights will work to encourage, enable and (as a last resort) enforce public services to promote equality and tackle discrimination. The integration of Human Rights into the work of the Commission is significant and something that will need to be considered further.

### Conclusion

**26.** While NHSScotland has been complimented by the 3 previous Equality Commissions for being at the leading edge of public sector responses to issues of equality and diversity. But there are still significant challenges ahead. By encompassing an equalities dimension to their considerations and recommendations the Task Force can provide a significant lever for health service responses to the needs of discriminated and disadvantaged communities in Scotland.

**April 2008**

# 11. CONSULTATION

## **TACKLING HEALTH INEQUALITIES AND POVERTY – CONSULTATION WITH SCOTLAND’S THIRD SECTOR**

### **Summary**

Established in October 2007, The Ministerial Task Force on Health Inequalities undertook to agree priorities for cross-cutting government action to reduce health inequalities in Scotland, through a cross-cutting, cross-sectoral approach.

The Task Force priorities of supporting children’s early years, enhancing mental health and wellbeing, increasing education and learning opportunities and employability, all through a multi-sector approach will contribute to current Government economic and health strategies. The Task Force is due to report in June 2008.

Voluntary Health Scotland (VHS) was asked by the Government Public Health and Wellbeing Directorate to scope the views of the third sector on current Government approaches to combating poverty and health inequalities, identify actions that should be taken by the different sectors and provide examples of effective third sector initiatives.

In a two-phase approach, VHS conducted an online survey of third sector organisations, using their 123 responses to facilitate a ministerial roundtable discussion.

Third sector participants were broadly in support of Government priorities for tackling poverty and its effects on health, adding other issues and groups with whom the sector works best as meriting policies and action. While supporting the need for early intervention, participants gave equal weight to addressing the structural causes of poverty.

Participants emphasised their strengths in working with many marginalised groups, complementing Government approaches to reducing the impact of poverty on the early years. These included skills in supporting individuals and groups to lift themselves out of poverty through raising self-esteem and confidence alongside structural measures to remove barriers to income enhancement and employment.

Despite some reservations about the success of recent ‘closing the gap’ initiatives, respondents believed that targeting extra efforts at the poorest groups were essential, citing many examples of their own successful initiatives.

Recommendations for action included making explicit the urgency of explaining and tackling poverty in Scotland, establishing the primary importance of partnership working, making better use of new planning structure to do this, aligning resources more closely through joint budgeting and shared outcomes, thus maximising returns on investment. Finally, performance management of programmes which allow the added value brought by the third sector to the alleviation of poverty and reducing health inequalities was seen as essential.

## Introduction

Living longer healthier lives and combating the significant inequalities in society are key Government objectives for a better Scotland. Reducing inequalities in health is therefore crucial to this purpose. The Ministerial Task Force on Health Inequalities was set up in October 2007, with the aim of:

- Agreeing priorities for cross-cutting government activity that will achieve measurable outcomes in reducing health inequalities.
- Identifying practical measures to reduce the most significant and widening health inequalities.
- Ensuring key sectors and organisations that are involved in delivering action on health inequalities work alongside the Task Force in order to build commitment and support.

*The specific objectives of the Task Force are:*

- To reduce factors in the physical and social environments in Scotland that perpetuate health inequalities.
- To build the resilience and capacity of individuals, families and communities to improve their health.
- To enhance the contribution that public services make to reducing health inequalities.

*And its priorities are:*

- Maintaining an emphasis on supporting families and children in the very early years.
- Enhancing mental health, wellbeing and resilience.
- Strengthening the importance of education and skills, income and employment status as factors which can combat inequalities in health.
- Taking a multi-agency approach in which public, private and third sectors work together, with strong Government leadership.

The Task Force is due to report in June 2008.

The Task Force priorities are made explicit in the *Better Health, Better Care: Action Plan* (December 2007), in which there is commitment to:

- Increase healthy life expectancy in Scotland.
- Break the link between early life adversity and adult disease.
- Reduce health inequalities, particularly in the most deprived communities.
- Reduce smoking, excessive alcohol consumption and other risk factors which compromise a healthier life.

The Ministerial Task Force has also been informed by the Government's approach to tackling poverty through the development of a new delivery framework for reducing income inequality – *Taking forward the Government Economic Strategy: a discussion paper on tackling poverty, inequality and deprivation in Scotland* (January 2008). In this, the Government sets out its fresh approach for delivering sustainable economic growth through adherence to the Government's three 'golden rules' of Solidarity, Cohesion and Sustainability. Within the Purpose Targets, the objective of ensuring that greater equity underpins the delivery of sustainable economic growth is reflected in the Solidarity Target:

- To increase overall income and the proportion of income earned by the lowest three income deciles as a group by 2017
  - this is predicted to have a positive effect on tackling poverty and contribute to the achievement of the UK-wide target to eradicate child poverty by 2020.

The framework for reducing income inequality will be focused on delivery of the Solidarity target, but to achieve this it will also be important to attain the Cohesion target:

- To narrow the gap in participation between Scotland's best and worst performing regions by 2017
  - narrowing the gap in economic activity between Scotland's best and worst performing regions is key to promoting equity and tackling the challenges of multiple deprivation.

These objectives are considered to be the conditions of economic and therefore societal sustainability in Scotland.

Against this background, the Government is developing its strategic approach to improving health, combating health inequalities and tackling poverty through the involvement of all sectors, identifying effective approaches and initiatives that will shape ongoing action. The role of the voluntary or third sector is seen as increasingly important in strategic approaches to addressing these issues and in identifying through its stakeholders the approaches which work best.

## The consultation

As part of the strategic approach to tackling poverty and its impact on health inequalities, Voluntary Health Scotland was asked by the Government Public Health and Wellbeing Directorate to ascertain the views of a selected range of stakeholders in third sector networks on current Government approaches to combating poverty and health inequalities and what kind of additional efforts which should be made by the different sectors. Respondents were also asked to provide examples of effective initiatives from within the third sector.

The consultation consisted of two phases. The first phase took the form of an on-line enquiry, which was carried out in February 2008 through the use of an on-line enquiry tool, Survey Monkey. The link to the enquiry is:

[http://www.surveymonkey.com/s.aspx?sm=4tXdngZ8o\\_2fztPlpxLRiRdg\\_3d\\_3d](http://www.surveymonkey.com/s.aspx?sm=4tXdngZ8o_2fztPlpxLRiRdg_3d_3d)

The enquiry yielded 123 responses in just over two weeks. The resultant material was analysed by Rock Solid Social Research and used as the basis for the second phase, a roundtable discussion event for an invited third sector audience held on 17th March, at which the Minister for Public Health, the Director for Public Health and Wellbeing and the Deputy Director for Social Inclusion were present.

## Phase One – on-line enquiry

Analysis of the on-line phase of the consultation is presented below.

## Findings

### 1 Supporting government priorities for tackling poverty and health inequalities

Government priorities for tackling poverty and addressing health inequalities identified thus far are: protecting and supporting the early years; improving mental health and wellbeing; maximising income; improving employment opportunities; creating opportunities for and take-up of education, learning and skills development

When asked if they agreed with these priorities as key areas for action on poverty and health inequalities, respondents were almost unanimously in support. However, they added a number of other areas for action which were felt to be crucial. Most salient of these were fuel poverty, homelessness and environmental conditions affecting elderly people. Respondents also prioritised working with marginalised groups which included young people and young adults in transition – those leaving care and leaving home, those becoming unemployed or affected by family break up – as directly meriting policies and action.

One respondent said: *“Fuel poverty has clear links to health inequalities. While the Scottish Government recognises the impact of damp homes on health, the promotion of affordable warmth must be prioritised and supported by Health Boards”* (environmental charity); and another added: *“I would like to see work supporting the elderly population as many of them live in poverty and isolation, this contributing to poor quality of life and ill-health”* (community food project).

And: *“Young people leaving school and leaving care having to manage their lives as they try to get into the job market are among the most vulnerable.”* (youth support agency)

Specific approaches were highlighted: improving access to existing services; supporting the acquisition of financial skills and eating well on a low income; structural action on the benefits and taxation system (although this is a reserved issue, it was felt that the Scottish Government was in a good position to influence Westminster on this); and increasing learning and recreational opportunities for young people.

### 2 Prioritising prevention and early intervention

Respondents were asked to rank three preventive measures and early interventions according to their effectiveness in breaking the cycle of disadvantage and its effects on health inequalities. The measures and interventions were: a) increasing educational opportunities; b) enhancing skills development; and c) improving employability. All were considered important, although there was a slight weighting towards improving early learning opportunities – seen as a prerequisite for improving skills and employability.

Additional themes which featured strongly were providing as much support as possible to families and interventions to improve mental health, wellbeing and self-confidence. While most of these preventive measures and early interventions focused on working directly with individuals, families and communities, there was still strong support for addressing what were seen as the real root causes of poverty – structural inequalities – *“These [above] interventions address the effects of the structural organisation of institutions, systems and decision-making – we would include better provision of good standard housing, affordable good quality food, more opportunities for leisure and recreation and participation in local decision making.”* (community health projects network)

### 3 Alleviating the impact of poverty on health

Turning to the impact which poverty has on ill-health, respondents were asked which of a number of measures for lessening the impact of poverty on health they most favoured. The measures were: a) targeting support for young mothers prior to the birth of their baby; b) targeting direct support towards lone parents; c) increasing childcare opportunities for lone parents; and d) providing general support for families with very young children.

Again, these measures were seen as of almost equal importance, re-emphasising the principle of acting early to prevent children from growing up with the damaging effects of living in poverty. It was also felt that there must be continuity of support, which invariably requires co-ordinated interventions at different times – it was of little use putting in extra resources to support lone parents with under fives if that support did not continue in the school context. Providing parenting programmes and engaging absent fathers in the lives of their children were given priority, too.

Respondents came out strongly in support of intervening to reduce the impact of poverty on the lives of other vulnerable groups, in particular young people requiring more chances and more choices in life, homeless people, carers and those with addiction to drugs – *“While working with families with young children is very important, we must remember that there are many other vulnerable groups of individuals with multiple needs”*, one respondent said.

#### 4 Determining the best policy avenue for poverty reduction

The Task Force is interested in hearing where the emphasis should be put in relation to poverty reduction – enhancing the internal capacity of individuals to lift themselves out of poverty, or removing external barriers to income enhancement, such as improving access to education and employment. This is a long debated issue, and the superficial impression was that respondents leaned towards enhancing internal capacity (58%) over removing external barriers (41%). However, within these categories, very few favoured a one-line approach and most respondents qualified their position by saying clearly that both approaches were necessary and mutually reinforcing. One respondent quoted evidence from the Poverty Alliance and studies by the Joseph Rowntree Foundation which suggested that: *“People’s capacity and resourcefulness are automatically increased when barriers to income enhancement are removed.”* And a housing charity added: *“People need to feel they can succeed and then they will be able to work through the barriers.”*

Respondents listed a number of ways in which internal capacity could be enhanced and external barriers removed. These included increasing self-confidence and self-esteem, raising aspirations, pursuing educational and learning opportunities (seen as enhancing internal capacity), as well as removing benefits disincentives, providing affordable child care and improving educational opportunities, transport and housing (seen as removing external barriers).

Encouraging the building of self-confidence and self-esteem, raising aspirations and helping people to overcome barriers to services are considered as areas in which the third sector excels.

#### 5 Closing the gap or lifting the poorest out of poverty?

Research shows that unequal societies, where the gap is greatest between rich and poor, experience the worst health inequalities.<sup>24</sup> We also know that improving overall economic performance does not necessarily make the poor less poor and for some years, Scottish government policy has put more emphasis on closing the gap than on lessening absolute poverty. Respondents to this enquiry, however, appeared to be marginally more in favour of lifting the poorest sections of the community out of poverty (54%) than of closing the gap (46%). As before, however, the two approaches were not seen as mutually exclusive.

Those who preferred closing the gap as the primary approach adhered to ethical principles of solidarity, egalitarianism and fairness in support of this approach – *“The wealth of rich people is as much the issue as the poverty of poor people – inequalities are unhealthy in themselves”* (national support group); and *“Inequality and the perception of inequality is corrosive to good communities and the commitment of individuals to the social good.”* (local community health initiative).

24 R. Wilkinson (1996) *Unhealthy Societies: the Affliction of Inequality*. London: Routledge.

A number of those in favour of lifting the poorest out of poverty cited the evidence for the perceived ineffectiveness of many “closing the gap” initiatives. One national support group for older people said: *“Closing the gap means there is potential for more people to enter into poverty”*; and another respondent said: *“Closing the gap might just uplift the central section and leave the top and bottom sections in very much the same position as they are now.”* (local community health project).

Respondents mentioned specific groups of vulnerable people on whom targeted efforts to reduce poverty should be concentrated – groups who are potentially at risk as well as those already living in or on the margins of poverty. These included lone parents, BME groups, refugees and asylum seekers, homeless people and, increasingly, low-paid workers and low-income home owners.

## **6 Prioritising Government action on tackling the root causes of poverty and alleviating its effects on health**

Respondents were asked to rank those actions already identified as top priorities for action by the Task Force. The actions are: a) concentrating on support for the early years; b) enhancing opportunities for increasing education and learning; c) increasing employment opportunities; and d) providing interventions to improve mental health and wellbeing.

All four priorities were seen as of more or less equal importance, and interlinked. One national support group for lone parents pointed out: *“Contradictions in government policy should be addressed: lone parents are to be pressurised into employment; part-time work leaves them vulnerable to low pay and consequent poverty, but full-time work leaves their children with little parental time.”*

Some respondents felt that it was insufficient to promote educational, learning and employment opportunities without ensuring that people had suitable conditions in which to pursue these opportunities – cramped space in a damp unheated house was a deterrent to learning, as was lack of affordable child care facilities at a training centre, or an unwelcoming reception by front-line public sector workers for clients living in poverty. Others felt that there was an over-emphasis on the early years and on getting lone parents back to work and stressed the importance of maximising benefits take-up by vulnerable groups – including young people, those with special needs or who were homeless, those with mental health needs and older people. Many implied that without approaches to improving mental health and wellbeing – approaches in which the third sector has long experience – promoting learning and employment take-up was likely to be of limited value.

Finally, a number of people pointed out that while reform of the fiscal and benefits systems was an issue reserved to the Westminster Parliament, the Scottish Government was in a good position to advise Westminster of the directions which needed to be taken, from experience of the current Scottish situation.

## **7 Determining the best contributions of other bodies and sectors to the alleviation of poverty**

Respondents were asked to identify ways in which other bodies and other sectors could best make a difference to addressing the root causes of poverty and alleviating its effects on health. There was consensus here that long-term strategic planning across all sectors was absolutely essential. Moreover, strategic planning without some measure of joint budgeting and development action was of limited value – in short, the focus must be on *“agreeing cross-sector priorities and budgets being allocated to actions rather than organisations”* (anonymous).

Additionally, partnership working on the ground could reduce red tape and thereby improve access to benefits and services for vulnerable groups by signposting people to services, providing co-ordinated information and creating single assessments of need.

The private sector was seen as having a major contribution to make on the ground, both as employers and investors in local communities and the public sector should be making more use of these opportunities. Private sector employers were considered to have a responsibility for providing living wages, training and career development, flexible working conditions, fair recruitment practices and maintenance of equality and diversity in the workplace, as well as support for vulnerable workers, including those affected by mental ill-health.

As investors, private sector companies had many means at their disposal for alleviating community poverty – providing socially-just bank lending, social housing, fair pricing of healthy foods, leisure opportunities, employee volunteering openings and sponsorship of health-promoting services.

As a national lobbying group put it, *“long-term commitment to economic activity in deprived areas, rather than focusing on profit and shareholder values over a short time; involving members of local communities in meaningful way...is key to making a difference”*.

## 8 Determining the best partnership opportunities for the Third Sector

The added value brought by the third sector to anti-poverty work and tackling health inequalities is already well known. Across Scotland, many hundreds of voluntary organisations, support groups and community development projects are working effectively in close partnership with the statutory sector.

Identifying the most positive opportunities for third sector partnerships with other sectors, the majority of respondents focused mainly on the need to open up the field at strategic planning levels. Participation in community planning and in relation to health, the Joint Health Improvement Plan, as well as in high-level working groups and in joint funding bids were all seen as key opportunities. The new Concordat and with it, requirement for local authorities to establish Single Outcome Agreements was seen as an additional route to strategic partnership working with the third sector.

At operational level, many pointed out that the third sector was uniquely placed to address the root causes of poverty in communities, in partnership with statutory agencies, and to respond sensitively to the immediate needs of the most vulnerable – *“the third sector is able to engage individuals labelled as ‘hard to reach’ and this should be taken up and harnessed by other sectors. Joined up approaches to service users would avoid a multitude of access points ...”* (environmental charity).

But respondents acknowledged the weaknesses of their own sector and the current difficulties it was facing, which were detracting from its effectiveness: *“The third sector is very disparate; it needs improved knowledge and understanding of the issues generally and of the opportunities that can open up via social enterprise, improved co-ordination and effective impact at strategic and delivery levels. The danger of large scale procurement is that instead of closeness to the community it relies on efficiency via scale ...”* (local network body).

And: *“More mechanisms are needed to bring about greater understanding between the sectors in identifying what's better for sectors to take forward individually and what's better for sectors to collaborate on, clarifying the actual benefits which are brought about for people experiencing poverty when sectors collaborate.”* (community health network).

Respondents did acknowledge the responsibilities which the third sector itself needed to take on for pointing out the value of its own approaches: *“Third sector organisations could do more to present better their ideas and ways of working. The focus on engaging with other sectors should be on the benefits to their business rather than preaching about their responsibilities.”* (national lobby group)

## 9 Bringing Third Sector skills to the alleviation of poverty and its effects on health

Respondents were asked to rank key areas to which third sector skills could make most difference. The areas for intervention were: a) measures to support children's early years; b) enhancing opportunities for increasing learning and skills development; c) increasing employment opportunities; and d) providing interventions to enhance mental health and wellbeing. Increasing employment opportunities through informal learning and formal training support to individuals, combined with enhancing mental health and wellbeing, were the most highly ranked of these areas, and again, respondents felt that the third sector was well placed in terms of the skills of its workforce to work in this context.

Many respondents emphasised that it was by means of providing extensive support for improving mental health and wellbeing that the third sector supported individuals in increasing their self-confidence and therefore their employability. The third sector was extensively seen as excelling in crisis intervention, helping people to get back on their feet and become better at taking charge of their own lives, which led eventually and in many cases, to their being able to enter or re-enter the job market.

Throughout this enquiry generally, it seemed that respondents saw Government as already providing a great deal of support for the early years and believed that third sector skills were best deployed in working with communities and with particular groups of vulnerable young people and adults in building self-worth and confidence. People said: *"Reaching out and involving the most excluded members of our communities, feeding back experiences of those most disadvantaged to influence strategy and services..."* (campaign group), and *"Supporting the participation of people experiencing poverty in engaging with public sector bodies."* (community health network).

## 10 Identifying the strengths of individual Third Sector organisations

Respondents were asked to describe the particular strengths of their own organisation in tackling the effects of poverty on ill-health. By and large, the strengths of respondent organisations mirrored those of the third sector in general.

Third sector added value attributes identified within respondents' accounts of the key strengths of their own organisation included skills in partnership working, crisis intervention and rapid response ability and providing sustained support for individuals and groups – in other words, being there for the long term.

The third sector is uniquely placed to respond rapidly and sensitively to individual need. It quickly gains trust with those who can be wary of statutory services, provides early intervention, can alleviate crisis and signposts people to statutory services. Often it is third sector organisations which provide the links between individuals or groups and a range of services in different sectors. They support and work with the most excluded and vulnerable people whom statutory services often find hard to reach and address individual and community deficit in self-esteem and confidence, encouraging positive mental health and wellbeing and making people more able to take charge of their own lives.

The sector offers volunteering opportunities and work placements, thereby increasing chances of employment, and promotes participation by individuals and communities in civic society.

All these attributes can bring much to partnership working with the statutory sector, can ease the pressure on public services and have the power to address and alleviate poverty and its effects on health.

## 11 Highlighting Third Sector work in alleviating poverty and addressing health inequalities

Many respondents to this enquiry provided vivid accounts of ways in which their work was responding directly to poverty in this unique “third sector way”. Snapshots of some of these are featured here.

*“We work closely with primary care staff, encouraging them to refer people who might benefit from learning. In this way we have been able to meet some very socially isolated people who spend most of their day simply coping with the challenges of poverty and deprivation. Getting involved in learning starts to reduce social isolation, improve self-worth and open up alternative futures.”* (health and literacy project).

*“Our energy professionals work with the public, private and third sectors. We help them to develop policies and programmes for identifying and tackling the effects of cold damp homes on service users. We use a range of approaches suitable for the group involved – giving affordable warmth advice by telephone, offering support in people’s homes, running group work sessions. Referrals to and from associated organisations enable amore holistic service, helping people get out of fuel debt and create warmer healthier homes ...”* (Third Sector energy advice agency).

*“We run a fruit and veg co-op in the nursery where mums can pre-order, pay and pick up their order when they pick up their children. We have also a breakfast club for mums – mums rarely eat in the morning and this does not provide a good role model for their children.”* (food co-operative).

*“Our volunteering towards employment project supports people volunteering in the NHS and with other partners. Our volunteers may have had mental health problems, addictions etc., and they are now better equipped for re-employment because of he skills they have developed as volunteers.”* (volunteer centre).

## 12 Aligning resources across sectors to alleviate poverty and its effects on health

Respondents were asked for their views on and experience of ways in which resource-alignment can best be achieved in the interests of preventing and alleviating poverty and its effects on health.

Respondents put the strongest emphasis on effective partnerships. They listed key ‘quality’ features of good partnership working at both planning and operational levels. Essential to the process is mutual respect and a shared vision of what needs to be achieved, jointly developed strategies and service planning, equitable allocation of resources, effective communication between all partners, shared intelligence (including the vital dimension of engaging constantly with service users and local communities), joint workforce learning and skills development and mechanisms for signposting users to services across all sectors. In effect, respondents were identifying the key principles of The Scottish Compact and where these exist, of local compact agreements for joint working.

In relation to the relief of poverty and its effects on health, early intervention was seen as “spending money now to save money later”. If needs are anticipated at an early stage and jointly managed resources put in, the need for expensive single-agency intervention can be avoided at a later stage. Examples of this include working with vulnerable older people to minimise fuel poverty and maximise household warmth, thus saving crisis-driven hospital admissions; encouraging young mothers to feed their families on a low budget, thus minimising the damaging development of poverty-related poor nutritional status and its effects on their children’s learning and wellbeing.

Resource sharing was another valued strategy. One respondent said: *“Where resources are tight, there should be scope for a group of organisations to employ staff on a shared basis to carry out targeted work. In our experience service users are initially reluctant to go outwith the [third] sector because of fears of discrimination but a single specialist post can be shared between three or four agencies.”* (addiction support service).

Better use of “social prescribing” was seen as another means of effective resource-sharing – *“If cross-referral between from healthcare services and the many local third sector organisations were better organised, people could be supported in the community, often preventing illness arising from poverty and deprivation and avoiding the need for more costly health care...”* (volunteer centre).

Financial incentives for partnership working were highlighted – a condition of funding being granted should be that there must be cross-sectoral working: *“Working partnerships between the statutory services and voluntary organisations need to be backed by government with financial incentives, otherwise the inclusion of the sector in partnerships is not meaningful.”* (mental health campaign group).

Funding should be allocated to specific objectives but restrictions on the eligibility for support of particular groups affected by poverty were seen to put unnecessary restrictions on what could be achieved at a community level through cross-sectoral local initiatives. In other words, the desired outcome – an overall increase in take-up of local employment opportunities, for example – should allow for the third sector to partner statutory services at all stages of the process, bringing its own unique strengths to the outcome.

### 13 Identifying other factors which can lessen the impact of poverty on health

Respondents were asked for their views on what other factors could make a significant difference in alleviating the impact of poverty on health. By far the greatest emphasis was put on a reiteration of the necessity for cross-sectoral working – by sharing resources, developing skills jointly and increasing employer input. A respondent described this in more detail: *“Definitely encouraging more willingness to work across sectoral boundaries. Staff in our project all have a background in adult education but are based in NHS premises. Primary care staff who work according to a psycho-social model of health value our input and value having our project as an additional resource for people who are their patients.”* (health and literacy project).

The second main focus was put on building evidence of what works and feeding this into government policy and staff training, ensuring that funding is sufficiently stable to promote and embed best practice.

Workable approaches included *“Having a ‘skills bank’ of tools, approaches and strategies which can successfully be used in tackling inequalities; having local ‘champions’ to promote services”* (smoking cessation organisation); and:

*“Ensuring that successful local anti-poverty initiatives are sustained with long-term funding; ensuring that evidence is collected from these initiatives and shared across all sectors; building capacity in ‘poverty awareness raising with managers and staff of public sector organisations.”* (community health network).

In the performance management of health improvement systems and interventions, there must be a joint determining of what outcomes translate into improvement and what intermediate stages must be gone through to achieve this improvement. The third sector need to articulate more clearly exactly what it can contribute to this process and partnerships encouraged to let third sector skills shine through where these are best positioned to make a difference. As one community food initiative said: *“Not everyone needing to make dietary changes is able to aspire to full-time employment – what is needed are indicators of the increase in self-confidence and self-esteem which clients can achieve with third sector support.”*

National intermediary bodies Voluntary Health Scotland and CHEX are currently working with NHS Health Scotland to build third sector capacity for building evidence of its own effectiveness.

## Phase Two – Roundtable Discussion

The material derived from the on-line enquiry was used as basis for the roundtable discussion held on 17 March 2008. The Minister for Public Health, the Director of Health Improvement and the Deputy Director for Social Inclusion took part in the discussion.

The Minister for Public Health, Ms Shona Robison MSP, opened the discussion with an overview of the Government's position on tackling health inequalities and the key issues that had emerged thus far from the deliberations of the Task Force.

Ms Robison emphasised that the strength of the Task Force on Health Inequalities lay in bringing together ministers from across all government directorates and key external partners, including COSLA, to address the extent of health inequalities and identify the scope for action. In the course of its work, The Task Force had agreed key concepts and ways of working. These state that:

- Action must be cross-governmental
- Work is needed to raise awareness across all sections of society of the implications of poverty and inequalities for Scotland's health and future
- Priority must be given to moving forward practical action rather than on further analysis of the problem
- Community Planning Partnerships (CPPs) could be the best context for action, but their capacity and ability to reach those most excluded requires to be strengthened
- Actions must be evidenced-based and applied in creative ways
- The key starting point for action must be families, engaging with their needs even before the birth of children
- Clear service pathways must be developed to meet anticipatory need, obviating inappropriate crisis intervention
- To make best use of the substantial investment in local government and health, service re-design must be prioritised
- Better use must be made of the skills of people on the ground, in particular frontline workers
- The measurable achievements of third sector work in partnership with other sectors must be built into models for action, using third sector skills in building trust with people most affected by health inequalities
- There must be recognition that action must be sustained over a time period much longer than four years, requiring cross-party support by the body politic for long-term success

Following reflections by Ms Robison on the progress achieved by the Task Force, input was provided by the Deputy Director for Social Inclusion, Mike Palmer, on the current Government Economic Strategy's approach to tackling poverty, inequality and deprivation in Scotland.

Participants were reminded of the clear role laid out for the third sector in tackling health inequalities in both *Better Health, Better Care* and the Government Economic Strategy, as follows:

- *We will improve the capacity of the third sector to reduce health inequalities by:*
  - *Supporting commissioners, funders and community-led services to achieve shared outcomes; and*
  - *Reviewing the way in which NHS Scotland supports third sector organisations to explore ways of enhancing the sustainability of programmes that demonstrate a clear benefit for patients and carers.*

And:

- *The third sector should be regarded as a full partner in the [economic strategy] process ...*

The roundtable discussion was framed around identification of the characteristics of interventions most likely to be effective in reducing health inequalities. These characteristics emerged from the analysis of the data yielded by the on-line enquiry.

To open the discussion, an overview of the main features and findings of the on-line enquiry was provided by Rock Solid Social Research. The full presentation is contained in Appendix 1 to this Report.

In small groups, participants were then asked to address three issues and tasks.

## 1 Identifying characteristics of successful interventions

In the on-line enquiry, Third Sector respondents identified a number of essential characteristics or defining features of interventions that are effective in reducing health inequalities. These are:

- Ensuring cross-sectoral, inter-agency delivery
- Working where people are at
- Ensuring a comprehensive approach
- Ensuring responses that are sensitive to ethnicity and culture
- Tailoring services to meet expressed individual and community need
- Working at the interface between supplier and recipient, using the strengths of both
- Working with (extended) families as a unit
- Investing in people's futures
- Maximising individual and collective participation and empowerment
- Embedding sustainable support for long-lasting outcomes

Participants were asked to comment on these and they added further characteristics of success.

**1.1** Considerable work needs to be done in communicating effectively Scottish and UK government policies and strategies for poverty reduction; participants noted that significant numbers of people – often those already disadvantaged - still do not have internet access. The use of a variety of media and communication methods is an ingredient of success.

**1.2** At the same time, further work is needed to understand and explain to an audience beyond Government the underlying economic causes of inequalities and how these impact on people's health. For people to perceive that they are part of the solution and not just creators of the problem is likely to be marker of success.

**1.3** Working with frontline health professionals and local government workers to change their perceptions of and attitudes to health inequalities can increase solidarity and reduce stigma.

**1.4** Success breeds success – maximising the visibility of initiatives and celebrating achievements are likely to be precursors of success.

**1.5** Ensuring a careful balance between individual and societal responsibility is likely to ensure sustainable results – focusing on mutuality and co-production.

**1.6** Successful interventions are likely to feature ongoing analysis of the changing picture of individual and community need – building in action research can help this process.

**1.7** Setting jointly-owned and realistic targets supported by sustainable funding are likely to gain “early wins”, in which all parties can have a stake.

**1.8** Establishing joint posts or ones that link with other local services can maximise resources and lead to jointly owned improvement.

Participants in the roundtable discussion identified many or most of these defining features of success as ones that had led to successful practice by their own organisations.

## **2 Taking forward and embedding successful interventions in strategy and practice**

Participants were asked to say how the successful features identified could be taken forward in strategy and embedded in practice. They advocated a number of key ways of working.

**2.1** Establishing a shared vision of a healthier, fairer Scotland and setting up a strategic and practice-based approach common to all sectors and agencies has real potential for the alleviation of poverty.

**2.2** Using social marketing approaches in ongoing strategies to explain absolute and relative poverty and how these impact on health inequalities in Scotland today is key to establishing a shared vision.

**2.3** Working with all frontline workers and those who are in face-to-face contact with individuals and communities is likely to de-stigmatise poverty and reduce the blame culture.

**2.4** Maximising the partnership approach to strategy and practice at all levels is the main predictor of success.

**2.5** Engaging with third sector infrastructure locally, e.g. local councils of voluntary service (CVSs) and community health projects networks is likely to result in wider, more strategic engagement with the third sector.

**2.6** Encouraging people to access under-used services through well-used services, e.g. benefits take-up advice in health centres, health screening information in post offices can maximise the one-stop shop approach.

**2.7** Relating to the above, developing the one-stop shop approach and extending local income maximisation initiatives, e.g. credit union and food-co-operative provision offers individuals and families greater resources for self-reliance

**2.8** Promoting measurement of the effectiveness of interventions through Social Return on Investment and social capital increase is to be advocated.

**2.9** Establishing identification of savings made to the NHS and other statutory services must be a part of measuring effectiveness.

Participants in the roundtable discussion believed that embedding these key ways of working in strategy and practice were crucial to the success of interventions.

### 3 Third Sector recommendations to the ministerial Task Force

Finally, participants in the roundtable discussion were asked to identify key recommendations for action at policy and practice levels. Their recommendations were clustered under four main headings.

#### 3.1 Communicating the urgency of poverty and health inequalities

Throughout the whole consultation process, respondents from the third sector expressed the view that the meaning of poverty and its impact on the health of people in Scotland required clear explanation at all levels, using as many different means of communication as possible. Accustomed as they now are to raw depictions of absolute poverty throughout the world, many people in Scotland are unaware of the devastating impact of relative poverty in communities close to where they live.

*Key Recommendations for improving communication about poverty and health inequalities in Scotland today are therefore:*

- 3.1.1** To create a greater awareness of the definitions of absolute and relative poverty and what these mean for Scotland's health today
- 3.1.2** To encourage social marketing methods for information dissemination and to include the general public, communities, the third sector and a broad range of statutory sector workers within the target audiences
- 3.1.3** To use the above approaches to de-stigmatise poverty and inculcate a philosophy of a fairer sharing of Scotland's resources

#### 3.2 Adopting a partnership approach to tackling poverty and health inequalities

In both the online enquiry and the roundtable discussion, respondents from the third sector repeatedly stated the absolute primacy of working together. This reinforces the concept of the "mutual NHS" laid out in *Better Health, Better Care*.

*Key Recommendations for taking a partnership approach to tackling poverty and health inequalities in Scotland today are therefore:*

- 3.2.1** To promote the value of Scotland's people as the greatest resource in the alleviation of poverty and co-production as the means of enhancing personal and societal resources
- 3.2.2** To maximise returns when planning interventions by using partnership approaches rather than setting up single-sector interventions
- 3.2.3** To commit meaningful resources to the third sector role in partnership and co-production of health, embedding the principles of the Scottish Compact for partnership working

#### 3.3 Maximising returns on investment for health

Third sector respondents to the online enquiry and at the roundtable discussion stressed the importance of establishing a shared vision and desired outcomes from the start and of moving towards these coherently in shared programmes.

*Key Recommendations for maximising returns on investment for health are therefore:*

- 3.3.1** To establish from the beginning a shared vision of desired outcomes and use to best advantage the strengths of public sector, private sector and third sector contributions
- 3.3.2** To ensure that the scale of investment matches the problem and ensure that initiatives are sustainably funded for long enough to make a measurable difference, while still allowing for intermediate indicators of success

**3.3.3** To balance resource allocation between addressing general need and targeting the most disadvantaged individuals and communities

**3.3.4** To balance approaches which focus on individual income maximisation, e.g. better benefits take-up with those which improve structural opportunities, e.g. childcare, learning and skills opportunities

### **3.4 Establishing evidence of effectiveness in order to replicate successful interventions**

Third sector respondents to both the online enquiry and at the roundtable discussion had much to say on evidence and were keen to see established effectiveness measures that allow the strength of third sector working to “shine through”.

They believed that in the performance management of health improvement systems and interventions, there must be a joint determining of end outcomes and an identification of the unique added value brought by the third sector to intermediate outcomes. At the same time, respondents acknowledged that the third sector needs to do more work on establishing measures of added value and translating these into “added health”.

*Key Recommendations for establishing evidence of effectiveness to replicate successful interventions are therefore:*

**3.4.1** To introduce the concept of “public value” in the setting of outcomes

**3.4.2** To include in outcome measures an identification of cost savings made, e.g. where community-based partnership interventions can reduce impact on NHS services

**3.4.3** To make better use of social return on investment and social capital as measures of effectiveness

**3.4.4** To measure the value of co-production and partnership in the interests of establishing mutuality within the NHS

**3.4.5** To promote evidence of success more effectively across Scotland and incentivise replication of workable initiatives

## **Conclusions to the Consultation**

At the end of the two phases of this consultation on the views of third sector organisations in Scotland on current Government approaches to combating poverty and health inequalities and on the additional efforts which require to be made by all sectors, Voluntary Health Scotland has been able to reach a number of conclusions on the value of the exercise. These are:

- 1.** Third Sector organisations across Scotland valued the opportunity to be included in the deliberations of the ministerial Task Force on Health Inequalities. While their experience is diverse, there was considerable consistency in their priorities for strategy and action.
- 2.** The realities of poverty and inequalities in Scotland today and their effects on health need to be better explained to the public and to the workforce across all sectors in order to reduce stigma and increase fairness and solidarity. Imaginative communication methods need to be used.
- 3.** There is room for the Scottish Government to influence Westminster thinking on new approaches to combating the underlying causes of poverty and inequality, based on the Scottish experience.
- 4.** Those participating in the consultation supported and broadly agreed with current Scottish Government priorities for action. However, they identified other additional areas where poverty can be at its most corrosive, areas in which third sector action can make a real difference.

5. It is expected that Government take the main responsibility for supporting families and children in the very early years, making best use of statutory obligations in this area and partnered by the third sector in critical areas.
6. Improving mental health, enhancing self-esteem and confidence in both individuals and communities are pre-requisites for approaches focusing on employment and employability – best use must be made of third sector skills in meeting these needs.
7. Partnership working at all stages is the single best predictor of success. The third sector must be included as strategic thinking partner, as well as partner in delivery. Better use needs to be made of planning and partnership opportunities, including those newly created through changes in local government relationships with national Government with the advent of the Concordat and Single Outcome Agreements.
8. More creative use needs to be made of the private sector in partnership working.
9. There is an ongoing need for better evidence of “what works best in partnership” and of the value of partnership working itself. Recent thinking on shared outcomes and the value of investment in the public good must be incorporated into evidence. Indicators need to be established which allow the unique added value of the third sector to shine through.

The on-line enquiry phase of this consultation was organised by Phil McAndrew and Helen Tyrrell of Voluntary Health Scotland

The analysis of the on-line data and the facilitation of the roundtable discussion were carried out by Marion Lacey of Rock Solid Social Research

**The report was written by Helen Tyrrell**

**15 April 2008**

## **'DELIVERY PROOFING EVENT'**

**Scottish Health Service Centre  
Crewe Road, Edinburgh**

**Wednesday 19 March 2008: 10:30 - 15:00**

### **1.0 Introduction**

The Scottish Government hosted a 'delivery proofing' event in Edinburgh to enable an invited audience to consider the emerging conclusions of the Ministerial Task Force on Health Inequalities.

The event was attended by over 40 participants drawn from a range of sectors and settings (a full participant list is included in Appendix 1.)

The aims of the event were:

- to check that the Task Force's emerging conclusions are practical and can be delivered by organisations working directly with individuals, families and communities.
- to seek to refine and improve on these conclusions where necessary to make them more realistic and deliverable.
- to examine both barriers to and opportunities in implementation, including possible early and visible successes.

The event opened with Ministerial addresses from both Shona Robison, MSP, Minister for Public Health and Jim Mather, MSP, Minister for Enterprise, Energy and Tourism, during which the key areas within which the Task Force is likely to make its recommendations were outlined. Participants were then asked to contribute to discussions on two of the following themes:

- Redesigning public services
- Preventing future problems
- Wellbeing and resilience
- Skills and capacity of the workforce
- Violence reduction

A summary of points from discussions on each of these themes is outlined below.

### **2.0 Redesigning public services**

Facilitator: John Howie, Health Scotland.

Note taker: Helen Hassell, Health Scotland

Participants were asked to consider the following questions:

- How can we make public services more accessible to people who need them most?
- How can they best work with people's complex needs where more than one organisation is involved?
- How can we redesign and transform the services we have, rather than working through separate projects and time limited funding?

The discussion that followed can be grouped into four areas:

## 2.1 Redesign cycle

Participants felt that complementary planning systems are required which are needs led, embrace community development approaches and are not restricted as a consequence of annual planning cycles and non-negotiable deliverables and associated spends. In addition more flexible working across financial years (through increased ability to 'carry forward') would support this.

Comments received in relation to the '4 stages of redesign' were provided as follows:

### 2.1.1 Evidence of Need to Redesign

- The system for design needs to change overall and include more focus on planning. (Planning)
- Effective and participative methodologies with all service user/citizen groups and providers to identify needs and preferred local solutions
- The involvement of service users to inform service redesign and improve access is essential. (Service Planning)
- Effective data collection is a priority
- Sufficient time and resources to ensure the accurate and impartial analysis of results, priorities identified and recommended solutions is essential
- The importance of the health impact assessment process as a vehicle for promoting wider responsibility across a range of organisations was emphasised.
- It is important to have a longer term view of impact assessment. (Planning)
- Political drivers can come above patient need, e.g. GP extended hours. There needs to be consideration of the opportunity cost of what is not done. (Planning/Evidence)
- A sound evidence base is important to inform design. (Planning)

### 2.1.2 Planning for Redesign

- The compartmentalisation of policy streams and a tendency to 'set in stone' too early can make it difficult to translate original intentions into action on the ground. (Planning)
- If populations (e.g. learning disabilities) do not fall within the remit of central targets such as HEAT, it can be difficult for frontline staff to ensure that issues relevant for these populations are considered and acted upon at a local level. (Planning)
- Action plans need teeth. (Planning)
- Engagement with communities and individuals to win their confidence is key. (Planning/Communication)
- There are tight budgets and increasing public expectations – a debate is needed. (Planning)
- There is a need to ensure that targeted approaches do not further discriminate against populations not deemed to be in greatest need, e.g. rural (Planning)
- The use of community planning needs to enable delivery and not be tokenistic. (Planning)
- Community development approaches can work well but are not happening across the board. (Planning)
- Health and social care agendas don't always dovetail. (Planning/Delivery Processes)

- Services need to be clear on their key aims, objectives and client group, and raise awareness of this. There needs to be a starting point to build on. (Planning)
- Staff 'buy in' to redesign is essential to effect change. (Planning)
- Funding constraints for councils could result in areas of most need getting least funding. Services which impact upon health, e.g. housing, are not always given a high priority. (Resource Allocation/Planning)
- It is important to build on what already works well and not redesign everything. (Planning/Review/Evidence)
- It may not always be about redesign but a 'change of focus', guidance would support this.
- Community Planning Partnerships are a good mechanism to support redesign. (Planning)

### **2.1.3 Delivering Redesigned Services – Resources and Capacity**

- The joint assessment process is a good system but the practicalities of delivery are problematic. Central policy and guidance would support development of local systems without duplication of effort. Information sharing across agencies and consent issues also need to be addressed and there needs to be technology to support this.
- The voluntary sector funding mechanism often focuses on specific groups/agenda but most individuals needs cut cross different groups/topics. (Funding Mechanisms)
- Short term pilot funding is welcome however can cause problems in terms of sustainability if alternative/extended funding is not released. This is particularly frustrating when services showing evidence of effective practice cannot be continued.
- Legislation, e.g. DDA has enabled change. (Legislation)

### **2.1.4 Monitoring and Review of Redesigned Services**

- There was view that reducing the inspection regime which is seen in some quarters as a large burden, would be beneficial but monitoring and evaluation was still seen as important. (Governance)
- Action plans and strategies are not always translated on the ground, e.g. Fair for All. (Scrutiny)
- Clarity about where the accountability lies would be helpful. (Governance)
- Information gathered from services needs to be reviewed and used to inform change. (Service Planning/Evaluation/Dissemination)
- There has been extensive redesign of mental health services but there is no knowledge as to whether services have improved for service users as a result of this. (Governance)
- Services are sometimes redesigned to 'tick boxes' not designed around service user needs. This can be the result of bureaucracy and there is a need to simplify things and free up time but ensure accountability. (Governance)

To ensure effective and efficient redesign a robust, enabling and complimentary planning environment at both national and local is essential.

## **2.2 Access**

- The importance of equity of access to services was emphasised as was the design of services to ensure this happens. Positive discrimination in allocation of resources to focus on populations who need it most, e.g. geographic areas, learning disabilities, homelessness etc. needs to be considered.

- Many people who need services do not know where to get them. (Access)
- Co-location of services would be helpful as could information sharing across organisations. (Access)
- Choice for all, not just those who are better informed is an essential value. (Access)
- Services are stretched due to lack of resources and it can be difficult to develop good relationships with service users due to lack of time during contacts. (Capacity/Access)
- Pressures and different priorities mean it is difficult to invest time in working across different organisations. (Capacity)
- There should be a shift of emphasis onto those who need it most and access services less, rather than traditional approach of treating ill people. (Access)

### 2.3 Workforce Development

- There is an assumption that an increase in knowledge will automatically result in positive change, but this does not always happen. (Workforce Development)
- Education of commissioners around target setting is needed. (Workforce Development)
- Importance of cultural values as the basis of how we plan and deliver services. (Workforce Development)

### 2.4 Leadership

- Effective leadership at all levels across the system is essential if public services are to work towards the same set of goals.

## 3.0 Preventing future problems

Facilitator: Ann Kerr, Health Scotland. Note taker: Cara Letsch, Health Scotland

Participants were asked to consider the following questions:

- How can public services prevent problems arising that are likely to lead to poor health later on?
- What can services do to focus on supporting families in children's very early years?
- What about other kinds of preventive action, e.g. to improve people's physical and social environments?

### 3.1 Preventing problems

- In addressing the first of these questions the group felt that the inequalities gap should be tackled by focussing on those most at risk. Services should not merely aim to narrow the inequalities gap, but should also be about preventing the gaps from emerging in the first place.

### 3.2 A focus on early years

- There was general agreement that 'early years' was the period from pre-conception to 3 years and that, within this, services should target groups that have been identified as vulnerable. Moreover, support needs to be sustained, so that individuals do not become at risk again when services cease, noting that families can move in and out of vulnerability.
- The need to focus on vulnerable young people who were likely to become parents, such as Looked After and Accommodated children and young people (LAACY), was recognised, however the idea of preparation for parenthood being taught in schools met with some resistance.

- It is suggested that support during pregnancy should include ways to develop and maintain the aspirations of young women (and their partners), such as pathways to employment. A key short term measure of the success of this intervention would be delaying another pregnancy.
- Families where drug use is a problem were also seen as a priority group. Key areas for action were access to treatment and sustaining support beyond quitting. (See also notes on partnership)
- **NB** Care with language is required. Interventions should be at the appropriate time, this generally means early, but there is a risk of confusion between early intervention and intervening in the early years.

### 3.3 Cultural change

- The group identified that without cultural change, intervention strategies will be ineffective. Fostering an aspirational culture is fundamental. This links to Dr Harry Burns' observation of a sense of helplessness in areas of deprivation with poor health outcomes
- To highlight cross-cultural differences, a member of the group provided the example of young women in the Netherlands whose sexual health outcomes were greatly improved because they, in contrast to the Scottish target group, had "aspirations" or the drive to make differences in their lives, which supported better health outcomes.
- Devolution and the change in government may provide an opportunity to strengthen Scottish culture and build aspirations

### 3.4 Capitalising and building upon existing strengths

- The universal, non stigmatising nature of education and health services is important in enabling trust. Although there are problems with engagement, access and inclusion, the importance of continuous therapeutic relationships is a key strength. The roles of HVs and school nurses were particularly noted. However potential threats to these services, such as the changes in GP regulation, Community Nursing Review should be recognised.
- It was noted that poverty alone should be regarded by health professionals as a risk factor, and that the evidence suggests that siting GP practices/primary care services in areas of deprivation has an impact on health outcomes.

### 3.5 Strengthening partnerships and making connections

- The importance of local partnerships and the practicalities of implementing good partnership working on the ground was a key theme throughout the workshops. Although recognised in policy, in practice they can depend on working relationship and support to embed partnership working is required.
- Partnerships are enabled/strengthened by the creation of joint workers, joint teams, joint training, improving professional networks, good referral systems, communication networks, information sharing, co-location, and local mapping.
- Barriers to collaborative working include: adaptability of systems (particularly ITC), inflexible reporting and accountability. If there are high level shared outcomes and SOAs then these must translate into funding arrangements on the ground.
- Better services do not necessarily need more financial resources. What is needed is for all sectors to think more broadly and flexibly about their role. Signing up to shared outcomes is a major step forward and requires both clarity and flexibility in terms or roles and responsibilities if they are to be achieved.

- Examples were given of services for vulnerable groups where “wraparound” services were developed that were responsive to the needs. These were often led by a keyworker, but set up on a multi-agency basis and in the best examples service users were equal partners in the design and delivery of the services.
- There are “trigger points”, such as the first ante natal visit and referral to Children’s Panel which can help identify vulnerable individuals for referral to other support services.
- Examples of good practice include: Highland GIRFEC Pathfinder, Tayside project, Lothian schools, and Glasgow Housing.
- **NB** examples of good practice were mentioned throughout the workshops, and individuals were happy to be contacted. Participants felt that use of these in the Task Force report could be valuable

### 3.6 Workforce issues

- In order to enable good referral and support from a range of services, the general workforce need to work in ways that support multi-agency working, focussing on the client needs, rather than professional/sectoral needs.
- The worker at the first point of contact needs to appreciate the influence of early years intervention on health in later years. It was recognised that developing these skills and knowledge across the general workforce in contact with families with young children was a tall order.
- The need for good assessment leading to intensive, multi-agency support for the most vulnerable groups, with skilled key workers was recognised.

### 3.7 Environment

- The need for improved home safety, opportunities for play, outdoor play and physical activity were all noted.
- Threats to the housing stock, and the cost of accessing PFI premises were noted as barriers.

### 3.8 Key Groups

#### 3.8.1 Families and drug use

- As well as the key issue for children affected by drug use, the wider issues of the parent’s health, local ‘drug economies’ and the criminal justice system all resonate negatively in communities, making this group a priority for early intervention.

#### 3.8.2 LAACYP

- This group as a whole have poor outcomes in life, not just in their health. They are particularly likely to become young and unsupported parents, creating future risk.

#### 3.8.3 Young pregnant women

- Evidence supports ensuring early access to good antenatal care and continuing support improves the life chances for themselves and their baby. Delaying future pregnancy is an early indicator of effectiveness.

### 3.9 Short-term recommendations:

The group felt that the following areas could usefully be the focus for immediate attention:

- Review implementation of GIRFEC and integrated assessment.
- Identify common key trigger points that bring pregnant women, their families and young children to any service. This has the potential to develop good referral systems or protocols and ensure the appropriate multi-agency support.

## 4.0 Wellbeing and resilience

Facilitator: Laurence Gruer, Health Scotland.

Note taker: Katie Hetherington, Health Scotland

Participants were asked to address the following questions:

- How can public services foster in their clients the qualities of resilience, coping, adaptability and a sense of control over their lives?
- How can services involve clients and local communities in service design and in decisions that affect them?

It was agreed that the focus for today's event would be essentially inequalities in socio-economic status, rather than those relating to for instance gender, ethnicity, disability, sexuality. etc. (although the importance of these in relation to health inequalities was acknowledged).

There was a consensus that wellbeing and resilience have an important bearing on health and thus, by their variable extent across individuals, families and communities, contribute to health inequalities.

The discussions mainly concentrated on how services and other factors can influence wellbeing and resilience and have greater positive impact.

### 4.1 Accessible, personalised and timely services

- As well as generally ensuring that people know about the full range of services available to them, services should be tailored to individual circumstances and made available at the right time. One example from a school perspective was the importance of a rapid response once the need for support and services to children and their families is identified (linked to early intervention below).
- There was a need for a cultural shift in how some services are provided to improve the experience of people when they access services, e.g. to avoid multiple discrimination and stigmatisation for some people once they access services.
- Broad-brush approaches will not tackle health inequalities as those isolated and excluded will remain so and this may lead to the inequalities gap widening.

### 4.2 Early intervention

- The importance of early intervention was recognised. The role of services and activities in helping build resilience and giving people (at all stages in their lives) opportunities that may prevent crisis situations and poor outcomes for them at a later stage, was seen as crucial.
- The voluntary sector play an important part but are vulnerable to funding cuts by local authorities on what can be seen as 'non-essential' services but may lead to negative impacts for people later on.

### 4.3 Building communities and societal values

- Equipping individuals to become self-sufficient and take ownership can help give a sense of empowerment and motivation to change.
- There was recognition that a lack of a sense of belonging to a community contributed to health inequalities. There was also a view that individuals need to feel valued by society and that people need to have hope in their lives. In some cases getting into work can provide this but for some people such as refugees and asylum seekers work is not an option and when it is, often skills are not recognised.

- Working with children and young people to help towards achievable aspirations and goals was discussed.

#### 4.4 Partnership working

- Building shared agendas across services so people's needs are not treated in isolation was seen as important. Government and policy can play a part in this by setting expectations about partnership working and incentives for it to work. Some partnerships could be explored further, for instance with GPs. Multi-agency working around schools can provide children and families with support tailored to their specific needs.

#### 4.5 The role of key workers

- Key workers were seen as important in building relationships with clients and ensuring that they receive the right services at the right time.

#### 4.6 Involving users in service design

- This is important but the view was expressed that currently it is being heavily driven by central government leading to a 'tick box' exercise and may not be very meaningful in practice. Are we consulting with the right people? What about those we are not talking to? Are some people over-consulted?

#### 4.7 Wealth distribution

- Several participants felt there was a need for core political decisions to be made about wealth distribution in the country and the allocation of resources to our public services if we are to make a difference to Scotland's health inequalities.

### 5.0 Skills and capacities of the workforce

Facilitator: Shirley Fraser, Health Scotland

Note takers: Emma Witney, Health Scotland and Alun Ellis, Scottish Government

Participants were asked to focus on the following questions:

- What qualities and ways of working are needed amongst staff to prevent clients' problems emerging, rather than react to crisis?
- What support do frontline staff need from their own managers and from their organisation more generally?
- What would help staff to work better with staff of other organisations with whom they are likely to share clients?

The discussions on skills and capacities of the workforce was wide ranging and many issues identified in other groups, such as the need for appropriate structures and systems to promote interagency working, appeared here too. The theme of skills and capacity building is one that will be of growing importance as the recommendations of the Task Force become more detailed and concrete and implementation considerations come to the fore. The points raised can be grouped under three headings.

#### 5.1 Ensuring individual skills and knowledge

- Creating appropriate levels of competence, autonomy and accountability within the workforce was seen as important. Participants felt that trusting professional judgement and engendering appropriate skills was the key to achieving this. If this were in place then the need for referral to specialist services could be reduced.

- Defined roles/responsibilities and accountability needs to be combined with a learning culture where there is permission to admit when things are not going to plan and then learning from mistakes.
- Specialised staff could be seen as counterproductive to delivering holistic care – is there a need to have a generalised work force that can deliver and refer to a number of services?
- Staff need to be given the knowledge and tools to refer and signpost individuals to other services which they cannot deliver. Partnership working will lead to increased staff knowledge of other services. This can help with referral to services.

## 5.2 Creating supportive service structures and networking opportunities

- Shared short- and long-term outcomes at national and local level were seen as important and useful in providing the context for developing structures and systems to promote joint working.
- Should systems be implemented that allow for individual/patient information to be shared across service including GPs, police, schools, health workers?
- By encouraging staff who deliver services to 'buy in' to the service they will, in turn, deliver a better level of service
- Mechanisms to provide continuous feedback to staff/organisations in terms of the impact of their work on people's lives/behaviours were seen as desirable. The need for expectations to be realistic and achievable was also emphasised.
- Clarity about values and goals was seen as central to developing closer collaboration between voluntary and statutory agencies. Equal status within partnerships (e.g. CPPs) was also seen as important together with a commitment to appropriate accountability and performance management systems. The importance of being realistic about what can be achieved with limited resources was also emphasised.
- Co-location was identified as a useful mechanism for promoting joint working and better information sharing. Work on specific areas of focus such as safer neighbourhoods, requires a clear consensus on priorities and goals.
- Shared and more effective IT systems can also be useful for identifying needs (particularly of at risk groups).
- Greater sharing of evaluated practice at national and local level would be useful.
- In areas where the workforce is predominantly female it is essential to ensure that there are sufficient resources to provide maternity leave cover. Plea for no more re-organisation in the near future as it disrupts effective partnership working.
- Staff and services may need to prioritise the care they provide and who they provide it to due to resource implications. Prioritisation may be aided by an evidence base for 'what is most effective'.

## 5.3 Influencing wider cultural and attitudinal values

- Implement policies that tackle long standing cultural values, e.g. acceptability of alcohol and drugs/going to work with a hangover
- Avoid blame culture around areas of deprivation through providing real tangible alternatives to risk taking behaviour (and providing staff with skills and knowledge to follow through on implementation)

## 6.0 Violence reduction

Facilitator: John Carnochan, Strathclyde Police

Note taker: Karyn McCluskey, Strathclyde Police

Participants were asked to address the following questions:

- How can public services contribute locally to reducing violence in the community?
- How can local services be coordinated more effectively to prevent violence?
- Do existing information sharing arrangements support or inhibit coordinated service delivery?
- Given the group most at risk of poor life outcomes in relation to health, education and violence is young males, what can be done to reduce the risk and/or increase protection?

At the outset participants felt that the topic of 'violence' immediately seemed to indicate it as a police issue and therefore the people who attended were in the main police officers. It is perhaps pertinent to note that the concordat provides the potential for developing action plans to tackle violence based on a local analysis of the problem. This opportunity will enable all CPP partners, including local communities to see 'violence reduction' as 'their business'.

A number of issues were seen as important by the group:

- Information Sharing – came across as one of the biggest inhibitors to progress in delivery of services at an appropriate time and to the right people. Despite huge effort it seems that the legislation confuses us and inhibits us. Where there is good information sharing, it seems to be more about personal relationships as opposed to the goal of good service delivery.
- Comprehensive analysis also came out as a key inhibitor – although it was recognised that this is improving, with the sharing of police and health data in the public health profiles.
- Early years and parenting came out as the strongest theme and the connectedness of good intervention to the outcomes of children was recognised across our two groups. Holistically approaching the needs of the child through family, housing, education etc. was seen as key – integrated case management needed to work better to achieve this.
- Mental health, wellbeing and resilience are critical to reducing violence in the long term. It was highlighted that males are our most at risk group – behind girls educationally, more at risk of becoming a victim or offender, have the worst health. Added to this the decline of the nuclear family is in decline and there is an absence of male role models as fathers, bread winners, or present in the community or media in positive roles. The result of this is that young males are creating their own social constructs of what it is to be male in 21st century Scotland; this is resulting in violence, binge drinking, risky behaviour and lack of aspiration or goals. The role of mentoring by males came up in our groups as a positive step.
- The tackling of alcohol also came through as critical in delivering 'Violence Reduction' and the consultation on alcohol is anticipated as being a way forward for Scotland.
- Communities – it was mooted that an emphasis on communities taking responsibility for their own issues was fundamental to 'Violence Reduction', instead of relying on Police mainly to deal with issues such as failures in parenting and setting boundaries. Good signposting to services to deal with own issues was required – such as Teen triple P, services for dealing with anger and violence (of which there are very few at present) both self help and programmes in the community.

- Early identification of violence and aggression problems in primary schools seem to be thwarted by a lack of interventions such as SNAP (Stop Now And Pause) which works with parents and children to address problems and deliver better outcomes.
- Tolerance – there is a high tolerance level of violence in areas of highest deprivation and normalisation of violence. Tackling this tolerance is one of our greatest challenges both within communities and organisations who perhaps don't see violence as an issue they can do much about. Through the new concordat we believe that we need to deliver a framework/plan for local authorities to tackle the issue based on the analysis of the problem in their area. Violence is such a complex issue that clear guidance and a 'what work' framework is key.

## APPENDIX 1 – PARTICIPANTS

Mrs Linda Allan, NHS Greater Glasgow & Clyde  
 Ms Martha Baillie, Waverley Care  
 Mrs Sue Barnard, Shared Care Scotland  
 Mr David Brownlee, Citizens Advice Scotland  
 Mrs Rosalind Bryson, Sensing Change Project - RCA Trust  
 Mr Graham Cairns, Strathclyde Police  
 Mrs Lynette Cousens, Lothian and Borders Police  
 Dr Andrew Cowie, Scottish General Practice Committee  
 Mr Ian Davidson, Argyll & Bute Council  
 Mr Chris Denmark, Action Team on Alcohol and Drugs in Edinburgh  
 Mr Steven Duncan, Lothian and Borders Police  
 Mrs Moira Dutton, Trinity Academy  
 Mr Mike Finlayson, Forth Sector  
 Mrs Yvonne Gallacher OBE, Money Advice Scotland  
 Ms Liz Gladstone, North Lanarkshire Council  
 Mrs Vivien Goodbrand, Falkirk Council  
 Ms Pauline Graham, Social Firms Scotland  
 Ms Carrie Ho, Project Empower Glasgow West CHCP  
 Ms Shona Honeyman, Glasgow City Council  
 Ms Jane Kellock, West Lothian CHCP  
 Ms Isobel Kelly, North Ayrshire Council  
 Ms Heather Knox, West of Scotland Regional Planning  
 Mrs Valerie Lawrie, City of Edinburgh Council  
 Ms Marion Logan, STRADA  
 Mrs Elizabeth Lumsden, RoSPA  
 Mr Andrew Macdonald, East Ayrshire Council  
 Miss Sandie Mackay, North Lanarkshire Council  
 Mr Robert Madden, Renfrewshire Council  
 Dr Rajan Madhok, Royal College of Physicians and Surgeons  
 Dr Zelda Mathewson, NHS Tayside  
 Ms Catherine McDerment, NHS Lothian  
 Mr Gilbert McGill, Mamillan/DAGCAS Cancer Benefits Team  
 Ms Agnes McGowan, NHS Greater Glasgow & Clyde  
 Ms Linda Middlemist, West Lothian CHCP

Mrs Maxine Moy, NHS Fife

Ms Suzanne Munday, Coalition of Carers in Scotland (COCIS)

Mrs Maureen O'Neill Craig, NHS Greater Glasgow & Clyde

Dr Euan Paterson, RCGP (Scotland)

Mrs Dawn Redpath, Working for Families Fund, Dumfries & Galloway

Mr Laurie Russell, The Wise Group (on behalf of SECC)

Mr Dave Simmers, Community Food Initiatives North East

Mrs Petra Staats, SUSTRANS

Mrs Mary Stewart, Fife Carers Centre

Mr Nigel Walker, East Dunbartonshire Citizens Advice Bureau

Mr Graham Watt, University of Glasgow

Mrs Helen Weir, West Dunbartonshire Council - Addiction Services

Mr Andrew White, Comhairle nan Eilean Siar (Western Isles Council)

## APPENDIX 2: PROGRAMME

Scottish Health Service Centre  
Crewe Road, Edinburgh

Wednesday 19 March 2008

10.30	Registration and Coffee Sign up for discussion sessions <i>Carrington Room</i>	
11.00	Opening Plenary: Shona Robison, MSP Minister for Public Health  Jim Mather, MSP Minister for Enterprise, Energy and Tourism <i>Fettes Suite</i>	Chair: Stephen Gallagher Deputy Director of Health Delivery
11.30	Coffee <i>Discussion Rooms</i>	
11.40	Discussion session 1	
12.30	Lunch <i>Carrington Room</i>	
13.20	Discussion session 2	
14.10	Final Plenary: Feedback from discussions and next steps <i>Fettes Suite</i>	Chair: Stephen Gallagher Deputy Director of Health Delivery
14.45	Close Refreshments available in <i>Carrington Room</i>	

## APPENDIX 3:

### Ministerial Task Force on Health Inequalities – Summary of Progress up to December 2007

The Task Force has met 4 times between October and December 2007. It has agreed its remit, which includes cross-Government activity to achieve both short and long-term outcomes, and the need to use existing evidence and have a clear and measurable impact through its recommendations.

The Task Force will draw on the Better Health, Better Care consultation. It has also agreed how to involve and communicate with external interests, including organisations that will be critical to putting its recommendations into practice. Further consultation and involvement will be carefully targeted, in order to secure commitment and buy-in.

The Task Force is considering factors that influence people's health, from individual characteristics, through people's lifestyles and behaviours, to wider influences such as education, employment, living conditions and other environmental influences. The focus is, however, on health outcomes. The most significant inequalities have been agreed as:

- Children's very early years, where inequalities first arise and may influence the rest of people's lives.
- The high economic, social and health burden imposed by mental illness, and the corresponding requirement to improve mental wellbeing.
- The "Big Killers" including cardio-vascular disease and cancer. Risk factors for these, such as smoking, are strongly linked to deprivation.
- Drug and alcohol problems and links to violence that affect younger men in particular and where inequalities are widening.

Scientific evidence is emerging of how deprivation and other forms of chronic stress lead to poor health, starting at the very early stages of life. The Task Force is basing its principles and approach on this evidence. It has set out key principles to drive its work, which include building the resilience and capacity of individuals, families and communities to improve their health and to reduce factors in the physical and social environments in Scotland that would otherwise perpetuate inequalities in health.

The Task Force's principles have been published in the Government's Better Health, Better Care action plan, December 2007. The action plan states the high priority that the Government attaches to reducing health inequalities. This is reflected in the Spending Review 2007 which prioritises spending on relevant current and new activities.

Professor Sally Macintyre has advised the Task Force about action that works in tackling inequalities in health. This includes structural changes in the environment, legislative and regulatory controls, maximising income and reducing price barriers, improving accessibility of services, prioritising disadvantaged groups, offering intensive support where people need it and starting young. The Task Force will test its recommendations for actions against this evidence.

Some NHS Chief Executives presented information to the Task Force in November, to enable it to contribute to the Better Health, Better Care action plan. As a result, the Task Force is on record in the action plan as identifying critical activity to: support particularly vulnerable children and families, realign resources and effort in primary care, extend anticipatory care approaches to preventing ill health, reach and engage with the most vulnerable groups of people to improve their physical and mental health more effectively, ensure that health is not a barrier to retaining or entering work, and improve the capacity of the third sector to reduce inequalities in health. The NHS itself plays a critical role as an employer, investor in local communities and as a community planning partner. More detailed delivery programmes are now being worked up to turn these recommendations into specific action.

The fourth meeting of the Task Force considered tackling health inequalities through action in children's early years and with young people. The Task Force's conclusions will feed into the Government's early years strategy due in 2008. This will also be taken into account in the More Choices, More Chances element of development and delivery of the new Curriculum for Excellence during 2008.

Key points for the early years strategy include the need for holistic support for children and families at risk of poor health and other outcomes, in all aspects of their lives and for sustained periods. Redesign of existing services is required, working through mainstream planning and delivery systems and joining up services effectively across statutory agencies. It should be possible to test out promising approaches from other countries quickly, to find out how to make these work in a Scottish context. A number of workforce factors will be critical, for example encouraging professions to work across organisation boundaries, fostering the key worker approach for more complex families and boosting the confidence and skills of staff to deal with issues such as sexual health and prevention of early pregnancy. The Task Force emphasised the importance of literacy and numeracy, which are vital for people's subsequent capacity to manage and improve their own health, as well as for other aspects of their lives.

The remaining Task Force meetings will address themes from the Government's Safer and Stronger, Wealthier and Fairer and Greener objectives. They will look at health inequalities that depend on gender, ethnicity, disability etc. as well as on socio-economic status. Finally, the Task Force will look at delivering and managing implementation of its recommendations, making sure that the impact of these can be measured and evaluated.

## YOUNG SCOT

### EXECUTIVE SUMMARY

This report outlines the process used in a video consultation group set up to allow young people aged 14-25 to create video diaries which addressed the questions of inequalities in health. These videos have been edited and were presented to the Ministerial Task Force on Health Inequalities on 16 April 2008 by two of the young people from the group. All edited and unedited video content was uploaded to a microsite for access by all young people in Scotland. The video consultation was cross-linked and promoted through relevant sites and publications to encourage young people to contribute.

#### Introduction

Young Scot is the national youth information agency for Scotland, providing young people aged 11–26 years with a mixture of ideas, information and incentives to:

- Allow young people to make informed decisions and choices about their lives.
- Turn their ideas into action.
- Take advantage of the opportunities available in Scotland and throughout the rest of Europe.
- Have the confidence and knowledge to become active citizens in their communities.

Young Scot achieves these aims through the provision of an integrated youth information package, offering young people access to information and services through a variety of media, including books, magazines and web-enabled services, including [www.youngscot.org](http://www.youngscot.org) – the national youth information portal.

There are currently over 340,000 Young Scot members, with young people offered the opportunity to join via our partnership local authority network Dialogue Youth.

Figures show that people living in the poorer areas of Scotland have worse health and die younger than those that live in well-off areas. There are a number of factors that could contribute to this, such as lack of education and good quality affordable food, each of which furthers the health inequalities of Scotland as a nation.

The Government's focus on the needs of people in poorer areas has led to the set up of a Ministerial Task Force on Health Inequalities, which focuses on practical actions for change, working across the Government and with partners in the public, private, and voluntary sectors to tackle the causes, and the effects of health inequalities.

Young Scot, in partnership with local authority, statutory and voluntary sector providers, has significant experience in developing consultation processes and investigatory initiatives as part of a menu of connections enabling young people to be involved in, for example, community planning structures, national decision making processes and changing services.

The Scottish Government approached Young Scot to gather the views of a representative group of young people in Scotland aged 14-25 on the topic of health inequalities. Young Scot decided to use cutting-edge new media consultation methods to engage the group and allow them to present their views in an innovative manner.

#### Outcomes

The outcomes set out for the video consultation were:

- The collation of a representative group of young people's views on the inequalities of health and their reasons behind them.

- Empowerment of the young people through full involvement in each step of the consultation process, from diary creation to presentation to the Ministerial Taskforce.
- Young people provided with the opportunity to express their views to policy makers.
- Ministers provided with the opportunity to hear directly from young people on the issues that affect them.
- The creation of an ongoing resource which can continue to provide views on the topic.
- Testing of video technology as a consultation method, with a view to future use of this method in local and national engagement with young people.

## Methodology

The consultation used digital video technology and a web interface designed to encourage visitors to the site to leave their comments on both the videos and on the topic overall. The pilot of the video consultation began in March 2008 and ran until early April 2008.

Young Scot worked with a representative group of six young people to create the video consultation. This group of young people consisted of three young people from Young Scot's Health Panel, set up to inform Young Scot and NHS Health Scotland of health issues of importance to young people aged 14-26, and to ensure young people have the opportunity to work with Young Scot and Health Scotland to improve the health information available to young people through Young Scot's information products and services. The rest of the group was made up of a volunteer who works with the Scottish Inter Faith Council, and two asylum seekers from Glasgow, who volunteer with Positive Action in Housing.

Each young person was supplied with a video camera and additional equipment such as a tripod and clip microphone. Training was provided by Young Scot for each member of the group, focusing on how to use the equipment and next steps for carrying out the consultation. This training was conducted by the Young Scot Senior Development Manager (Online), responsible for overseeing the digital media work for the organisation.

Once they completed the training, the young people were tasked with answering a series of questions through a self-filmed video diary or blog. These questions were drawn up and approved by the Scottish Government, and covered a number of themes, including 'Friends', 'Family', 'Education and Employment' and 'Smoking, Drugs and Alcohol' (see Appendix 1 for a full list of the themes and questions provided to the young people). The young people filmed themselves giving their views and answers on the themes, and were encouraged to gather the views of others in their lives, including other friends and family.

The young volunteers had two weeks to record their footage, before the videos were returned to Young Scot. During this period 12 hours worth of video footage was recorded by the young people. The videos were then edited by Young Scot, using video editing software, to provide a presentation overview of the answers provided by the young people. Young Scot then worked with two volunteers from the group to assist in preparing them to present the finished video consultation to the Ministerial Task Force on Health Inequalities on 16th April 2008. The young people who presented were Fiona Beaton (17), a member of the Young Scot Health Panel and Haroon Ahmed (19), a volunteer who works with the Scottish Inter Faith Council.

On the day, the edited video consultation was shown, with the young volunteers outlining the process carried out for the consultation, their personal views, and answering questions posed by the Task Force.

Alongside delivering the presentation to the Ministerial Task Force, both the presentation and the unedited versions of each of the video diaries were uploaded to a new online microsite for all young people to access and provide feedback on.

The microsite features the overall presentation on the homepage, and is broken down into each individual theme, and the video blogs from each of the young people on each theme are available for everyone to watch. Along with links to further information on the topic of health inequalities, each theme subsection has a feedback form to allow visitors to leave their comments on the subject, thus continuing the dialogue on health inequalities. The interface design was structured around the concept of user-generated content. This means that the user is encouraged to contribute to the content of the page by giving their views on the site itself, rather than the content being completely authored by a programmer or behind the scenes content management system.

The online microsite is supported by further Young Scot information services, including the Health information channel on [www.youngscot.org](http://www.youngscot.org), information factsheets from the Young Scot InfoLine website, and the Young Scot InfoLine, a free and confidential information enquiry service for young people.

Young Scot Health Information Channel – <http://www.youngscot.org/channels/feelinggood/>

Young Scot InfoLine website – <http://www.youngscot.org/infoline/>

Young Scot InfoLine phone line – 0808 801 0338

A short URL (web address) was also created for the online microsite at <http://www.youngscot.org/healthvideoblogs> which will be used to promote the consultation and its findings. The video consultation will be promoted and cross-linked through representative websites and publications to encourage debate and wider engagement from young people across the country.

## Summary of Findings

There were a variety of opinions expressed on each theme outlined for the video blogs. The key views which came from the consultation were:

- There is no room for health inequalities in Scotland as a modern nation.
- Services can be daunting for young people and need to be made more youth friendly.
- Alcohol is too readily available and inexpensive, causing health inequalities and also making communities less safe in the evenings.
- More should be done to make healthy food cheaper.
- More should be done to provide healthy recreation for young people, with current problems often stemming from transport issues.
- Wealth is one of the key reasons behind health inequalities.
- Young people should be involved in the continuing process of tackling health inequalities and improving services.
- Providing qualified health information for young people is one of the key elements of tackling health inequalities.

To hear all the views expressed by the group of young volunteers, visit the online microsite at <http://www.youngscot.org/healthvideoblogs>

## Next Steps

Young Scot was delighted to work with the Health Inequalities Task Force and Scottish Government on this project. The video consultation has proven in this instance to be a successful method of using modern technology to engage young people and gather their views, along with providing an ongoing dialogue with them through the feedback from the online microsite. It provides an accessible and interactive option which compliments other methods, such as depth interviews and focus groups.

## Contact

For more information about any aspect of this work, please contact:

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## **APPENDIX 1**

### **Ministerial Task Force on Health Inequalities - Young Scot Video Blog Consultation Briefing for Participants**

#### **Themes and Things to Think About**

##### **Family**

- How important is your family life to your health and wellbeing?

##### **Friends**

- How important are your friends to your health and wellbeing?

##### **Community**

- How does your local community contribute to your health and wellbeing?

##### **Education and Employment**

- What does your school/college/university do to help your health and wellbeing?
- Are there any other people that contribute to your health and wellbeing, e.g. youth workers?
- What are your educational goals?
- What skills and opportunities will you require to achieve these goals? Are there any barriers to achieving these?
- What are your career aspirations?
- Will anything prevent you from achieving these goals?

##### **Violence and Safety**

- How safe do you feel going out in your local community (during the day/at night?)
- Do you feel you have access to good services for recreation?

##### **Discrimination**

- How have you been treated by the public services you have used?
- Have you ever felt/experienced discrimination because of your age?

##### **Smoking, Drugs and Alcohol**

- Do you or your friends smoke?
- Do you or your friends regularly consume alcohol or drugs? (would the young people involved in the consultation be willing to answer this on camera)
- If you do drink/take drugs, what is the reason for this?

**Public and Private Services**

- What services do you regularly use? How would you rate them?
- Are you unable to access any services that you would like to use? What prevents you from accessing these?
- Are there any services that are not available to you but you feel would make a positive difference to you/your community?
- What difference do you and your friends think you could make in delivering/planning services?

**Finance**

- Does cost hinder your ability to access certain services? How would you make services cheaper?



**The Scottish  
Government**

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