“It is unacceptable in 21st century Scotland that some people can expect to die earlier than others, simply due to an accident of birth or circumstance.”

- FIRST MINISTER
ALEX SALMOND
HEALTH NEWS  TACKLING INEQUALITIES EDITION  FEBRUARY/MARCH 2009

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SETTING THE SCENE

AS Director of Public Health I find it disturbing, unacceptable and deeply unfair that a boy aged just 15 in a deprived area of Glasgow has only a 50% chance of reaching his 60th birthday... while his counterpart in a more affluent area has a 90% chance of living well beyond his 60th birthday.

This single stark statistic sums up the challenge we must meet to redress the current inequalities and obstacles to equality of health and wellbeing.

We all know in the West of Scotland we have some of both the best and the worst health in Europe and areas sitting side by side have very different average life expectancy and rates of illness. Areas with the poorest health also have many other problems, including higher crime rates, higher unemployment, lower voter turnout and poorer educational attainment.

This edition of Health News focuses on some of the inequalities that determine health outcomes and on how we need to do more - and do it differently - to level the playing field of life for the people of Scotland.

Socio-economic factors have a significant bearing on health outcomes – but other factors such as gender, ethnic background and disability also impact on health, wealth and well-being. We already know that being unemployed affects your chances of heart disease and even cancer. In this period of economic downturn and rising unemployment the job of improving health by helping people into work presents an even bigger and more important challenge. It’s a challenge to every sector of our community – from public sector organisations, politicians, private business and community groups to individuals themselves. Social justice must be a priority for all public organisations and political parties.

The NHS is determined to do everything in its power to remove the obstacles to health improvement and make sure that everyone has access to the best health care. We have set out our pledge on page 12 of this special edition of Health News.

THE X FACTORS

HEALTH statistics commonly show the huge gap in health and life expectancy between people from different parts of Glasgow.

The challenge that faces us is to level this playing field to give the same chances of health, happiness and self esteem to all.

Before this can be achieved we have to understand what factors are the cause of such significant pockets of population being blighted by ill-health and early death. What might these be?

● Poverty: 59% of those from less affluent areas have an annual reported income of less than £15,000 compared to only 4% from more affluent areas. More than half of those from more affluent areas have an annual income of more than £45,000 as compared to less than 3% of much less affluent areas.

● Education: more than 50% of those in less affluent areas leave school at age 15 compared to only 12% in more affluent areas. More than twice as many people from more affluent areas than less affluent go into further education.

● Employment: nearly 80% of those from more affluent areas are in employment compared to only 44% in much less affluent areas.

● Future Prospects: A feeling of hopelessness is twice as prevalent in the areas of less affluence.

● Housing: More than 97% of people in more affluent areas are owner occupiers of their place of residence, compared to 29% in less affluent areas. More than 60% of people in less affluent areas are local authority or private rented housing tenants.

By Dr Linda de Caestecker, Director of Public Health, Greater Glasgow and Clyde

PUTTING IT IN PERSPECTIVE

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Let’s put it in perspective

Imagine Glasgow as a village of 100

IMAGINE the population of Glasgow was shrunk to just 100 people... but retained the exact scales of diversity of wealth, health, race, religion, disability, age and sex.

The miniaturised city – Glasgow The Village – would give us a true picture of the many health and diversity issues that exist within our communities – at a glance.

We would see a detailed picture of just who we are, what we do and the circumstances we live in. The statistical and numerical breakdown is interesting … but what is more thought provoking is the underlying picture that emerges.

Our gender, our race, our employment status and our lifestyles are all key to determining our health outcomes … but perhaps some of the things that we know influence life expectancy and quality of health and well-being shouldn’t be making such a difference.

As we try to tackle health inequalities and create a society where everyone has the same chance of leading a healthy and fulfilling life it’s crucial to understand just who we all are and why the health status of our population is so widely varied.

Often people say: “Take a look at the big picture,” but what researchers at the Glasgow Centre for Population Health did was quite the opposite. They have created, in collaboration with the International Futures Forum, a seven minute film inspired by Miniature Earth. It paints a picture of Glasgow as a village populated by just 100 people and reflects the huge variety of circumstance, lifestyle, social and economic standing that exists in the current city population of around 600,000.

It is a fascinating insight into the make-up of our population and draws a clear picture of the issues that need to be addressed both in Glasgow and generally across the West of Scotland if we are to really create a society where people have the same opportunities to health and wellbeing.

The film shows that the Village of Glasgow with a population of 100 would have 20 adults unemployed or too ill to work;
Imagine Glasgow as a village of 100

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where 15 adults don’t even have a bank account and 25 are income deprived. Of those adults in work the 10 best paid would earn three and a half times that of the 10 worst paid.

Of the 100 who live in Village Glasgow, 29 adults have no formal qualifications and 18 have a university degree. Thirty-nine women and 24 men feel unsafe walking in their neighbourhood after dark and 57 live within 500 meters of a derelict site... yet 86 rate the area they live in as good.

The health status of the 100 villagers would show that 22 adults were obese and that 36 men and 28 women would exceed the recommended weekly drinking limits. Thirty four adults smoke and 26 have a long-term illness.

The film is thought provoking and relevant to many of the issues addressed in this special NHS Greater Glasgow and Clyde edition of Health News with the theme: “It is unacceptable in 21st century Scotland that some people can expect to die earlier than others, simply due to an accident of birth or circumstance”.

We recommend you to view the short film online by logging on to: www.miniatureglasgow.com

Glasgow has a diverse population with many new “Glaswegians.”

It has emerged from its industrial past to become a 21st century European City.

If the city of Glasgow was a village of 100 people, it would look something like this....

People

- In 1 year, 1 person is born, 1 person dies.
- 17 are children.
- 16 are adults.
- 17 are pensioners.
- 1 is from an Indian background.
- 3 are from a Pakistani, Bangladeshi or Other South Asian background.
- 1 is Chinese. 95 are from a UK European or Other Background.
- 1 is from eastern Europe.
- 1 in a hundred Glaswegians is an asylum seeker.

Life Expectancy

- A boy born today might just live past his 70th birthday.
- A boy from an affluent area will live for 14 years longer than one from a poor area.
- A girl born today might live to 77.
- A girl from an affluent area will live for 8 years longer than one from a poor area.
Huge task ahead to create a fairer society

THE Scottish task force on tackling inequalities was struck by the need to do more about children’s very early years, mental health and wellbeing and about alcohol, drugs and violence.

These are the key major contributors to the gaps in life expectancy between different communities. And it is these which became the focus for many of the Equally Well report’s 78 recommendations.

It’s no surprise that there is no single or simple answer to the question of what to do to achieve a more even distribution of good health across society, given the overwhelming evidence that the health gap results from inequalities in opportunities, circumstances and environments.

We agreed within the task force that one of the principles that would underpin our work was that of seeking 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. As a result, actions to improve physical environments, reduce poverty and its consequences, and increase healthy employment, are cornerstones of Equally Well.

The argument for making a greater investment in supporting children to have a good start in life is now widely and convincingly made. Good evidence exists about the benefits of parenting support, pre-school education and language development, and a good home-learning environment. Our challenge is to ensure that these are accessible to all – but especially to those who need them most.

It is impossible not to be struck by the huge disparity in health experience between different geographical communities – such as those seen when we compare the profiles of different parts of Glasgow. The worst health in Scotland is to be found in some of these communities, and I’m convinced that comprehensive neighbourhood regeneration remains the main route to better health in these areas.

The sad truth is that, in the past, regeneration programmes have not delivered this. We need to do better in the future. Through the GoWell programme (see GoWellonline.com) in Glasgow we have an unprecedented opportunity to evaluate the health impacts of neighbourhood change and learn as we go. The importance of placing people at the centre of these regeneration processes has been a strongly emerging message already.

Action to tackle poverty and reduce income inequality also needs to be given highest priority. I have become increasingly aware, though, that material poverty is but one dimension. Approaches that recognise and address people’s experiences associated with their place in society, and their responses (biological, behavioural and psychological) to those experiences, are also needed. All agencies and organisations have a role in this regard, and the leadership of NHS Greater Glasgow and Clyde in developing standards for all of its services is highly significant.

To achieve improvements for those with the worst health or who experience discrimination and disadvantage, services and interventions may need to be much more intensive and targeted – and much better at two-way engagement with individuals and families – than in the past.

Our work at the Glasgow Centre for Population Health supports others in highlighting that the direction of travel needs to change in two other key ways.

Alcohol is now the most serious cause of ill-health, death in some of our communities, and the major underlying cause of violence and injuries. Would this scale of preventable harm be condoned if it resulted from any other cause? The efforts being made to change the cultural acceptability of drunkenness, and to reduce the almost universal availability of alcohol, should be given much wider support and priority.

Our natural environment also requires us to take new directions: to travel more actively, to consume less, and possess less. This is a stark illustration that the sustained achievement of better health for all will require changes to be made by all sections of society.

There is no quick fix, and no room for short-termism. The task force will reconvene to review progress. I look forward to that. The ongoing commitment to hold the system to account for reducing the health gap may be one of the most important contributions of all.
THE earliest years of a child’s lives are critical.

We now have scientific evidence that stresses from poverty, neglect, violence and exposure to substances such as drugs, alcohol and smoking, in early childhood can also result in greater risk of physical illness, mental health problems and drug and alcohol addiction in later life.

If we are going to improve life expectancy amongst people disadvantaged in our communities, action is needed to break the cycle of poor health in society.

Experience has shown that waiting to treat problems once they become apparent in later life can be too late to solve them.

A new sensitive approach, involving early intervention, both through universal education and health services, and targeted services that focus of the families with greatest need, is now believed to offer the best outcomes for children – building their strength and resilience to cope with life’s stresses. This approach both seeks to address the impact of issues in society such as child poverty and to develop inequalities sensitive public services.

The following stark account is of one person’s experiences, whose ‘accident of birth’ resulted in a self-destructive and chaotic lifestyle but who now, as a result of this new approach, has hope of a healthier future for her children.

**How sensitive services helped one mum and her children**

**ANNE’S STORY**

FROM an early age, Anne witnessed her drug addict father regularly abusing her mother.

After her mother sought refuge for the family with Women’s Aid, much of Anne’s childhood was spent moving around various women’s refuges and hostels, trying to escape her father. Anne’s education suffered as a result and she left school with no qualifications.

At the age of 18, Anne was pregnant. By the time of the birth of baby Gillian - her first daughter - Anne’s relationship with her partner had broken down due to domestic violence.

Anne first experimented with drugs before falling pregnant. In February 2000, she started using heroin. She lost her job and refused support for her drug dependency.

Gillian was placed in the care of her grandmother and gradually Anne’s contact with both became minimal.

When Anne met Dan, a local...
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drug dealer, in 2003, she had been forced into prostitution to fund her drug habit. Dan encouraged her to stop prostitution and supplied her drugs through his dealing instead. Anne fell pregnant in 2004 but this time took up the offer of support for her addiction. She was stabilised on methadone, given support to establish a routine and counselling to understand the reasons for her drug misuse.

She was also referred for parenting skills and re-established contact with her mother and daughter.

Joan was born in November 2004 and experienced withdrawals. It was decided that, although both parents had made attempts to address their addictions issues, they had not done so for long enough. Joan was therefore cared for by Anne’s mother.

Working with our Children’s and Addictions Services, Anne continued to re-build her life. She managed to turn her lifestyle around and made exceptional progress in addressing her addiction issues. As a result, Joan was returned to Anne’s care full-time with a support package in place.

Joan is now four and has thrived in Anne’s care. Anne and Dan have proved themselves to be very good at parenting. They are also more involved with Gillian’s upbringing. They are determined to ensure that Joan and Gillian do not follow the same chaotic lifestyles as them.

* Names have been changed to ensure anonymity.

A RANGE of targeted services is being implemented within the Greater Glasgow and Clyde area to support vulnerable children and families in the early years.

- Dedicated link midwives have been appointed to help vulnerable women, who need particular support during pregnancy because of complex needs, including asylum seekers and refugees, homeless people and teenagers.
- The Special Needs in Pregnancy Service in Clyde provides an integrated social work and health service for pregnant women with special social or psychological needs. This award-winning service identifies potentially vulnerable babies as early as possible in pregnancy and provides focused intervention. It’s now planned to roll this model out across Greater Glasgow and Clyde and to incorporate the Women’s Reproductive Health Services, based at Princess Royal Maternity, which, for the past 20 years, has provided an important service to women with a range of social and addiction problems.
- Peer supporters are working with women from deprived areas to encourage more to breastfeed.
- Parents and Children Together (PACT) teams have been set up across the Glasgow City area to provide an intensive service to families with young children who face multiple health and social problems. PACT teams are made up of Social Workers, Health Visitors, Nursery Nurses, Family Support and Money Advice Workers.
- Gender-based violence link midwives provide professional and practical support for midwives and nurses caring for victims of domestic and other gender-based abuse.
- Maternity Services and the PACT services have recently been assessed as part of a major two-year initiative to improve services for patients with multiple and complex needs. The learning from the Inequalities Sensitive Practice Initiative will be used to improve practice not only in these services, but across all NHSGGC.

Getting our teeth into child poverty

A SHOCKING 29 percent of three-year-olds in Greater Glasgow and Clyde have decayed, missing or filled baby teeth.

- Dental disease is strongly associated with poverty. Children in the most disadvantaged communities have the highest level of decay.

- Despite its high prevalence, dental decay is an entirely preventable disease. Dental disease in childhood causes significant ill-health. Dental decay continues to be the most common single reason for admission to hospital and provision of general anaesthetic in childhood. The most needy children do not need to suffer dental decay and its unfortunate consequences.

Our staff are working hard to prevent the onset of dental decay in the youngest age groups. Toothpaste and toothbrushes are distributed to children from the time that their first teeth appear and throughout their pre-school years.

Regular toothbrushing at home is not enough. A programme of toothbrushing in nurseries continues and will be intensified in coming months across the entire NHSGGC area. We have also introduced the Childsmile Programme into General Dental Practices in areas of relative deprivation - one of the first areas to do so.
VIOLENCE is a major contributor to Scotland’s health inequalities. It causes premature death, not only from the injuries inflicted but also from the long-term effects of depression, trauma, anxiety and other mental health problems.

Indirectly it shortens life expectancy by limiting opportunities for employment and trapping its victims in poverty. Many victims of domestic abuse have to leave their homes and jobs to find safety, affecting future job prospects. Scars caused by knives and other weapons affect every part of a victim’s life, not least their chances of finding work.

Tackling violence within our communities is primarily the responsibility of our police authorities, the Criminal Justice system and the Scottish Government … but the NHS also has a crucial role to play.

On a daily basis, we deal with the aftermath of violence. Each year, an estimated £517million is spent in Scotland on dealing with the consequences of attacks. Equally importantly, we play a major role in tackling alcohol problems which are a significant cause of violence.

Over the next few pages we set out how we’re contributing to making our communities, streets and homes safer.

DOMESTIC abuse is a significant problem in Scotland - affecting one in four women at some point in their lives.

Along with rape and sexual assault, child sexual abuse, prostitution and forced marriage, it is one example of the different sorts of violence some men use to control women, children and sometimes other men.

Such violence is often referred to as gender-based violence and it affects people of all ages, backgrounds, languages and abilities.

Some people don’t survive this violence. On average, two women per week are murdered by their partners as a result of domestic abuse.

For those who do survive, it has a significant impact on the long-term health of its victims, not only as a result of the physical injuries that are inflicted, but also because it can cause depression, anxiety, trauma and other mental health problems.

Whilst women from all walks of life are affected, some have fewer opportunities to escape it because of poverty, caring responsibilities, cultural issues, language barriers or disability.

In recent years there has been an increase in the number of incidents of domestic abuse, rape and sexual assault reported to the police. It’s generally believed that actual levels of abuse in some areas are much higher than reported levels.

Even those who do report the crime can suffer for a long time before doing so. On average, women experience 35 episodes of abuse before reporting this to the police.

Now a new scheme is being rolled out in Greater Glasgow and Clyde to train key staff to sensitively ask patients about their experiences of domestic abuse and other forms of gender-based violence.
Lending an ear and a voice to the victims

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Through these routine enquiries, an assessment of the situation can be made and support offered to protect the individual, and children, if needed.

This early intervention represents a shift in thinking about how the NHS should treat victims of gender-based violence.

NHS Greater Glasgow and Clyde’s gender-based violence lead Kath Gallagher explains: “For many years we took the approach that adults who have had control over their lives removed by an abuser, got strength from choosing if and when to tell others about their experiences.

“We now know that survivors feel a sense of relief when the issue is raised by their GP or other health service worker. It tells them that this violence is not acceptable and sends out a signal that the health service understands the health and social problems that arise from abuse. The overwhelming majority of women we speak to are comfortable with being asked the questions.”

Routine enquiries are already underway in ante-natal services where women are spoken to separately from their partners. The scheme is also being piloted in additions services where sensitive enquiries are made to find out if service users are involved in prostitution. And, as Kath explains, it helps to get this out in the open.

“If a service user discloses that he or she is a prostitute, we can ensure they get a wide range of support, including sexual health checks, access to money advice and a sympathetic ear to listen to their problems. We can ensure that they feel able to access services with no stigma attached. Once the issue is out in the open, we hope clients will be more willing to talk about other violence they have experienced within prostitution and arrangements can be made to provide support for these issues too.”

Over the next three years it is planned to widen out the scheme to GP services, health visitors, mental health services, emergency care, homeless services, addictions and learning disabilities.

For more information on how NHS Greater Glasgow and Clyde is tackling gender-based violence, log on to www.equality.scot.nhs.uk

Support at the Archway for city rape sufferers

SCOTLAND’S first dedicated round-the-clock support service for people who have recently suffered rape or sexual assault opened in Glasgow in 2007.

The first service of its kind in Scotland, Archway Glasgow is available to anyone over the age of 13 who has been raped or sexually assaulted within the previous seven days.

After an initial clinical assessment, Archway Glasgow can offer:

- Counselling
- Onward referral to other agencies
- Forensic examinations
- Forensic sample storage – to offer clients time to decide whether or not to involve the police
- Testing for sexually transmitted diseases
- Support and advocacy.

Archway Glasgow can be contacted on 0141 211 8175 or online at www.archwayglasgow.com

“Lending an ear and a voice to the victims”

Support at the Archway for city rape sufferers

Archway Glasgow is staffed by medics, nurses and admin support. The core team is supported by a bank of specialist forensic examiners, and on-call doctors and nurses. Clients have access to female forensic medical examiners and language interpreters if they so choose.

The service is open to both women and men.

Dr Tamsin Groom, Archway’s lead clinician, said: “Rape and sexual assault can happen to anyone, irrespective of age, disability, gender, age, ethnicity, religion, faith or sexual orientation. Our services are there for anyone aged 13 or over living in the Glasgow area who has been raped or sexually assaulted within the last seven days.

“We stipulate seven days because collecting and storing forensic evidence is an important way in which we can help. This lets us gather evidence for any potential criminal prosecution.”

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ON a typical Saturday night in Glasgow, the city’s problems with excessive drinking are plain to see. Scenes of young people, drunk and incapable, getting into arguments and fights, are all too common. And it’s a blight that’s repeated in towns throughout the Greater Glasgow and Clyde area.

A health service study into masculinity and alcohol concluded that using alcohol was central to young men’s understanding of what it means to be a man in Glasgow.

It’s maybe not surprising then, that almost half of prisoners questioned in 2007 said they were drunk at the time of their crime. In murder cases, this figure is even higher – with two-thirds of those accused either drunk or on drink and drugs at the time of the alleged offence. If our alcohol problems are addressed, it seems clear that our streets will become safer too.

Violence is also significantly linked to poverty. The death rate from assault in our most deprived communities is more than ten times that in the most affluent communities. The major gap in life expectancy between our most and least deprived areas is due in significant part to this grim statistic.

For those victims who survive an assault, the long-term health effects can be considerable. High rates of self-harm, as well as illness, are closely related to assaults. The injuries that are inflicted, particularly facial scars from knife attacks, can also impact on prospects of getting work.

The Government has therefore made it a top priority to tackle the high death rate in deprived communities caused by alcohol-fuelled violence.

Greater Glasgow and Clyde’s health services are doing their part to fulfill this ambition as Neil Hunter, General Manager of Glasgow Addiction Services, explained: “We have joined forces with Glasgow City Council and Strathclyde Police to tackle alcohol misuse and excessive consumption. Our ambitious plan has put the fight against alcohol-related harm at the very top of the agendas for all three organisations.

“Our health services are particularly focussed on prevention and early intervention for those at risk of misusing alcohol and treatment and support for people who already have significant alcohol-related health problems.”

One of NHSGGC’s key objectives is to introduce an early detection programme to identify and support people who may be unaware that they are at risk of developing serious alcohol-related problems.

The screening programme involves the delivery of brief interventions...
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which are given opportunistically during a GP visit or whilst in contact with other health services. The session is used to discuss a person’s alcohol use and provide advice and support for those who misuse alcohol.

Evidence from elsewhere has shown that these interventions have a significant success rate. Neil said: “People at the cusp of regularly exceeding national recommended levels have been found to reduce their alcohol consumption by up to 40% as a result of brief interventions from a suitably trained health professional. It’s been shown to work equally well for deprived and marginalised groups as for others.”

173 GP surgeries have already signed up to deliver the programme and it’s also being rolled out in other priority areas such as A&E, maternity and other community health services with the aim that, by 2010, brief interventions will be delivered to 35,000 people a year.

To further help identify people at risk of developing problematic alcohol use, Glasgow Addictions Service is carrying out a major training initiative to raise alcohol awareness amongst frontline health staff.

“Traditionally Glasgow has been very good at developing highly specialist drug and alcohol services but there have been gaps in our ability to support and treat patients with developing problems in other health settings. We’re therefore training key staff, including health visitors and practice nurses, to help them spot the signs and tackle alcohol misuse. We believe this is essential because it’s only when we all work together that we stop people slipping through the net.” said Neil.

Significant investment is also being made to further enhance and strengthen the specialist teams that provide treatment, support and care to those with alcohol problems.

An extra £3.5million is being invested in Community Addictions Teams (CATS) over the next three years to create extra medical, nursing, and social care posts. CATS are joint integrated teams with the City Council and were set up in 2003 to provide fast access, a single point of contact for addiction services and reduce the need for clients to deal with multiple assessments. They currently offer a comprehensive range of services to 12,000 users. They also work to link individuals recovering from an addiction to education, training or employment.

A further £1.2 million has been invested jointly with the Homeless Partnership to create a comprehensive network of Community Alcohol Support Services. These teams have been set up to support homeless people with alcohol problems maintain independence and remain out of homeless services. In its first year alone, 445 people were referred to these services and 359 entered treatment – an average uptake rate of 81% across the city. A new 10-bedded residential rehabilitation service is also due to open this spring and will improve bed availability and recovery.

There’s also a plan to expand the highly specialised inpatient services for patients with drug and alcohol problems. A new purpose built 23-bedded addictions unit is planned for 2011, as a sister unit for Eriskay House, a further £1.2 million is being invested jointly with the Homeless Partnership to create a comprehensive network of Community Alcohol Support Services. These teams have been set up to support homeless people with alcohol problems maintain independence and remain out of homeless services. In its first year alone, 445 people were referred to these services and 359 entered treatment – an average uptake rate of 81% across the city. A new 10-bedded residential rehabilitation service is also due to open this spring and will improve bed availability and recovery.

Neil Hunter - Glasgow Addiction Services

Neil does not under-estimate the challenge that his team and others face in tackling Glasgow’s significant alcohol problem.

“We are all aware of the sheer scale of problems related to alcohol misuse and its devastating impact on our health and communities. Concerted action is required to tackle this and we will continue to work with the Government, partner agencies and users themselves to reduce excessive alcohol consumption.”
Doctors on campaign to reduce violence

MORE than 60 doctors have joined a new initiative to reduce violence on Scotland’s streets. Medics Against Violence (MAV) aims to raise awareness of the short and long term impact of violence-related injuries and prevent young people from becoming victims.

The initiative is being backed by the national Violence Reduction Unit and the World Health Organisation as part of their Violence Prevention Alliance.

Dr Christine Goodall, Senior Lecturer, Honorary Consultant Oral Surgeon at Glasgow University Dental School, said: “Scotland’s health service bears a significant burden from violence.

“As healthcare workers, we see the outcomes of these attacks every day. We see how they can ruin lives, not only of the victims, but of their families and friends. Scars caused by knives and other weapons run much deeper than what we see on the surface – they imprint on every part of a victim’s life, from personal relationships to getting a job, an imprint that will impact on them every single day.”

MAV’s first venture is an educational programme aimed at 14-year-olds. The sessions given by the docs will include a short hard-hitting film focusing on the choices young people have to make in risky situations. The film also features real life testimonies, including one from Scott Breslin, who is now quadriplegic as a result of a knife attack.

Dr Goodall said: “We have already had some very positive feedback about our programme.

“We want to reduce the number of young people we see attending hospitals with serious injuries caused by violence. If they come, then of course we treat them, but we would rather they didn’t get into situations where they need our help in the first place.”
HOW does alcohol affect communities in the city of Glasgow? That’s the question Glasgow Community and Safety Services put recently to people in the largest ever community survey of its kind.

The Ripple Effect Survey was carried out to explore and understand the extent to which the effects of alcohol go beyond the individual. The questions were put to almost 5000 people throughout the city and the responses paint a grim picture.

A staggering 99% of respondents believe that alcohol is having an effect on their community. For many, this has created fear in the community, with parks, recreational areas and areas surrounding shopping centres particularly affected. Older people feel particularly restricted because of concerns over safety however young children are also thought to suffer because of vandalism and litter in play parks.

Not only is there a belief that Glasgow’s deep rooted drinking culture can be changed, but that it has to be changed in order to improve the quality of life of Glasgow residents.

The findings from the poll are now being used to help identify priorities for action to reduce alcohol-related harm within our communities.

For more information on the survey, contact Lee Craig, Glasgow Community and Safety Services at lee.craig@glasgow.gov.uk
Healthier and valued

UNEMPLOYMENT and poverty can have huge influences on health.
Most commonly mental health can be affected, often creating a ripple effect of unhappiness and extra unwelcome pressures on the wider family.
But it is now more widely accepted that being out of work, undervalued, and trapped in a spiral of growing despair and poverty directly impacts on physical health.
Heart disease becomes much more likely, even cancers become more likely.
In some households this spiral becomes a generational lifestyle that visits ill-health and despondency on whole families …
It’s little wonder that initiatives such as promoting a healthier diet, helping people to stop smoking, exercise more and cut down on alcohol intake appear to have higher impact on improving the health of those with more advantages.
Every indicator is telling health professionals that being valued, employed and rewarded brings with it a huge boost to self esteem and well-being … and directly impacts on physical and mental good health.
One of the greatest opportunities to redress the health inequalities that exist in the West of Scotland today is to do something to help people (particularly the long-term unemployed) into worthwhile and rewarding work – to boost self-worth and remove the debilitating effects of poverty.

A job’s the best medicine

WORK and self esteem are key to tackling health inequality

PICTURE THE SCENE:
THE patient walks into her GP’s surgery and pulls up a chair.
When asked how he can help she replies that she doesn’t know where to start.
She’s not sleeping well, she’s run down and not eating properly … she is stressed and always confronted with bills that can’t be paid.
Her health files show a pattern of declining health.
The GP knows that medication alone is not the answer to the combined issues his patient is facing... yes he can prescribe something for the sleepless nights that are dragging her down and making her exhausted. A bit of advice about healthier lifestyle could be offered – but he knows just how low she’s feeling and doubts whether any advice about exercise and better balanced diet will really make the seismic change that his patient needs in life to give her better health, wellbeing, confidence and self-esteem.
If he could prescribe his patient a job perhaps her life would change so much for the better.

How the Evening Times reported on our initiative.
GPs in the South East of Glasgow have been empowered to prescribe a job for unemployed patients.
The groundbreaking move empowers doctors to identify patients whom they believe would see significant health and wellbeing benefits from
A job’s the best medicine

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worthwhile and valued work.

The scheme was created by the South East Community Health and Care Partnership.

The prescriptions are an effective passport for a patient to access a special one-stop shop to explore training and employment or volunteering opportunities.

Experts from the special employability advisory service help the patient to link with some of the city’s 130 groups designed to help people back into work.

Hamish Battye, head of health improvement for the Partnership which covers Govanhill, Gorbals and Castlemilk explained that the idea of the prescription pad came from talks with GPs about the easiest way to make a referral. The voluntary scheme gains extra clout because it has a GP’s signature on it.

The “prescribe a job scheme” has now been extended into the west of Glasgow where GPs from Maryhill to Drumchapel have taken up the initiative.

More than 140 of the unique prescription pads have been distributed to GPs and also to other NHS health professionals such as district nurses, practice nurses and health visitors.

GP Linda Wright from Toryglen Health Centre has written around a dozen of the prescriptions in recent months.

When the Evening Times newspaper interviewed Dr Wright about the scheme, she told them: “Sometimes when people have been unemployed for a while they need to get back to work for their self-esteem. I can think of one patient with mental health issues and getting back to work made her happier, she attended the practice less and it made a difference in her level of medication. It’s a great service”.

SINGLE mum Catherine Caldwell felt isolated in her Govanhill home. The 35-year-old wasn’t sleeping properly and was staying in the house feeling “pretty terrible for much of the time”.

She wanted a job but had very little confidence and felt she was going “stir crazy” in her flat.

Catherine used to work for an electronics company but had to give up her work through chronic back-pain – and it was when she visited her GP about her back that she was offered that all important boost … a line from her doctor for the Prescription For Work Scheme.

“It put me back on the right track,” says Catherine, “the doctor said it was a new service that might help me. I made plans to go and see them and they helped straight away. They looked into college courses in childcare and I started a First Aid course. I also started free reflexology classes that got me out of the house.

“I have some of the get-up-and-go back in my life and being busy has taken the focus off my back pain. I’m using my brain again and I feel a whole lot better”.

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Catherine’s Story
Working for Health scheme points way to a career for 300

NHS Greater Glasgow and Clyde was named “Employer of the Year” following the innovative scheme that has helped more than 300 long-term unemployed people join our workforce.

We didn’t go into this to win awards – but the profile of the award has helped other large organisations and businesses see what can be done to train and recruit staff – and help change peoples lives.

Working for Health (WfH) is a six-week training programme targeting people who are out of work and interested in working for the NHS.

The training can take recruits onto the first rung of a career in a wide range of jobs including nursing assistants, domestic and catering staff, porters, admin and clerical assistants and assistant technical officers.

The venture has been a huge success bringing people into the NHS and giving them the training and self-confidence to progress from the training and into quality employment.

Everyone who completes the training programme qualifies to be interviewed for a vacant post and so far more than 300 have been recruited.

Annette Monaghan, our NHS Care Careers Programme Manager, is hugely enthusiastic about the project. She hails it for increasing the diversity in Greater Glasgow and Clyde’s workforce and for helping so many people out of unemployment and into NHS jobs.

Our managers say they have found recruits from this scheme as first class employees with excellent attendance records and commitment to the jobs they secure.

A few months after successfully gaining a job as a domestic assistant in the Beatson (West of Scotland Cancer Centre), one new start from the south-side of Glasgow commented: “Getting this job has helped my confidence and I am generally feeling a lot better because I’m getting out of the house and meeting people and feel valued. I am proud to be working in one of the most modern hospitals in Britain and part of the team that makes everything in the hospital work.”

Before joining our workforce he had worked as a storeman but had to give up the job because of depression.

Manuel Bernardo was helped into the NHS workplace back in 2006 through the Working for Health scheme – he remains a valued member of our workforce today.

There is clear evidence that work is good for your health and that long-term unemployment is associated with higher mortality and poorer physical and mental health. Apart from the Working for Health Scheme detailed above the NHS in Greater Glasgow and Clyde has been involved in a number of local employability partnerships through local community planning activities and national initiatives including Workforce Plus.

One is the Department of Work and Pensions City Pathfinder Initiative, Glasgow Works, which aims to help those on disability benefits, Job Seekers Allowance, lone parents and Black and Minority Ethnic people.

NHSGGC is committed to joining up the health and social care pathway with employability activity and has helped – since May 2006 – to get thousands into good quality employment. We recognise the role of the NHS in improving health can be so much more than delivering direct healthcare. For more information on Glasgow Works, go to www.glasgowworks.eu
A MONEY advice pilot has been launched for people affected by stroke.

If a stroke sufferer is also the main breadwinner for a family, this can lead to financial hardship and anxiety during what can be a lengthy period of rehabilitation and recuperation, and a negative impact on the patient’s recovery.

The new service points patients and families in the direction of specialist community-based financial help, and offers general advice by telephone, as well as hospital and home visits.

One stroke patient said: “Having money advice would be very helpful. The stress of how you are going to pay your bills can affect your recovery.

“It’s very important in the early rehabilitation stages to focus on getting better. Having a positive attitude to your recovery is very important and expending energy being anxious about money does not help!”

Similar schemes to help cancer patients and other conditions are being driven forward to help the most vulnerable in our society cope in times of ill-health and personal, domestic and social challenge.

Short-term support can prevent any catastrophic events from taking place, such as being taken to court, accounts being suspended, or someone losing their home.

Long-term needs can include maximising income, benefit claims, re-organising finances and general financial capability support.
It’s good to get up, get out and get fit

ACCESS to outdoor life and a good living environment are key factors to good health and well-being—both mentally and physically.

Research further shows that in this area there are distinct and significant issues that widen the health inequality gap between some communities.

Just as employment, decent housing, a good diet and lifestyle impact on overall health, so does access to the open air.

Creating environments where people can enjoy walking, get access to leisure pursuits such as market gardening, transport to walk in the woods, cycle clubs and schools’ outward bound trips are high on urban planning agendas. The NHS is fully supportive and working closely with community planning initiatives to hammer home the health improvement benefits of such environmental activity.

So-called “Green Transport” plans come under this umbrella of activity—one statistic that makes it plainly clear that we can do much better in this area is the following: If Glasgow had just 100 people in it only one would cycle to work and 39 would travel by car. The rest would use public transport or walk.

There’s a huge opportunity when the Commonwealth Games comes to the city for massively improved public transport networks, walkways and green-spaces within urban environments. This activity should not be underestimated in its value to the multi-faceted approach to drive down health inequalities and the overall quality of life of the whole population.

Council planners are already looking into integrating health into core current and future city planning.
Equal access

Breaking down the barriers

Doing more for patients with communication difficulties

Imagine the scenario. Your child has suddenly taken very ill. You rush your child to hospital but can’t explain the symptoms – there’s no way you can find to express yourself and let the staff know what’s wrong.

They ask questions, but you don’t understand what they are saying – the words they are saying mean nothing to you. Bewildered and confused you watch as they run tests on your child - you don’t know what these tests are for.

Then they begin emergency treatment but don’t involve you as they can’t explain what’s going on to you.

This is just one of the frightening scenarios which people can find themselves in if they have difficulties with the types of communication many of us take for granted.

Studies show that the average reading age in Scotland is 11 years. In other words, written information unsuitable for children older than primary school age would also be unsuitable for a significant proportion of adults. Around 10% of the Scottish population are thought to have difficulty with reading, writing or using languages.

People with disabilities are one group at greater risk through impaired communication.
Doing more for patients with communication difficulties

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numbers.

This is backed by the findings of Dr Rajan Madhok, Consultant Rheumatologist at Glasgow Royal Infirmary, who studied those patients admitted for more than 24 hours to his department in 2005 and 2006. He found that 50% of patients could be considered unable to read, far higher than the population average, and most likely as a result of lifetime deprivation.

For many of his patients, written instructions accompanying prescriptions and self-management regimes were effectively useless. In some cases they were potentially harmful with patients, unable to read written instructions with their medicines, taking a week’s supply in one day, thereby putting themselves at risk of renal damage and worse.

These findings suggest that information provided in written formats effectively disenfranchise sections of the population and give disproportionate advantage to those with higher educational attainment and wealthier backgrounds – effectively widening the health gap between advantaged and disadvantaged.

And as Jac Ross of the Corporate Inequalities Team explains, an inability to read is not the only language barrier to accessing effective healthcare: “There are many reasons why our patients have difficulty in communicating with staff. They might be in this situation because English is not their first language, they have a visual impairment, are Deaf or hard of hearing, or have a condition such as a stroke or having learning difficulties which makes communication hard.

“Developmental disabilities such as Down syndrome, autism, and Edwards Syndrome – and acquired disabilities such as traumatic brain
Doing more for patients with communication difficulties

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injury and Parkinson disease – are also associated with communication impairments.

“Health staff not being able to communicate effectively with patients can have real consequences for their health and the services they receive,” she continued.

“Many patients miss appointments or are unable to access services because of the language barrier. It is also frustrating for staff who find themselves unable to communicate with their patients.”

This is a significant issue for NHSGGC. 42% of the total Scottish Black and Minority Ethnic (BME) population live in the Greater Glasgow and Clyde area. The 2001 Census figures for the NHSGGC area shows that 3.6% of its population or 42,765 people were from BME populations.

There are approximately 5,340 asylum seekers who are in receipt of support from the National Asylum Support Service residing in Glasgow City. It is estimated that a further 6,500 asylum seekers have been dispersed since 2000.

Almost 700,000 people in Scotland have some form of hearing loss, deafness or may be a Deaf person - that is approximately 163,100 in our area.

To help overcome these barriers, NHSGGC has now developed a Communication Support and Language Plan to ensure our staff provide communication support for those who need it. The plan has been put together by a range of health professionals and experts from various organisations, with widespread consultation with service users.

The plan aims to:

- Ensure that individual patients are assessed for their communication support needs and that this is used throughout the patient's time with our health services.
- Ensure we provide communication support to those from the BME communities whose preferred first language is not English.
- Ensure we meet the needs of those with complex communication needs in our services, e.g. someone with learning difficulties who is also deaf.
- Increase the availability and range of interpreting, translation, and communication support services where there are existing gaps.
- Increase and improve the availability and range of patient and public information in accessible formats.

Of course, language is not the only barrier to effective healthcare.

“Culture, race and religion can also have important implications for how we plan and deliver healthcare,” explained Jac.

“For instance, ethnicity and racism can affect health through people's susceptibility to diseases and conditions, the discrimination they may experience, and the way in which health services should be provided.

“Female service users from several minority ethnic groups have strong preferences for dealing with only female health care staff. Gender issues can play an important factor in the uptake of services.

“Sometimes the language and jargon used by staff can leave patients feeling not only that they do not know what is wrong with them but also that they leave feeling disempowered and unable to challenge a health service that does not necessarily reflect their social background.

“Appropriate recognition of religious practices and preferences, and consideration of the patient's spiritual needs, are particularly important in the care of the dying and in dealing with the deceased and their family after death. This also has a relevance to the care offered in our Maternity Units if a baby is still-born or dies shortly after birth.”

The Corporate Inequalities Team has been conducting a major review of key services to see how sensitive they are to the multiple and complex needs of patients from different backgrounds.
Doing more for patients with communication difficulties

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Whilst many examples of good practice are evident, the experiences of some of our patients that show that more needs to be done to help vulnerable people access health services.

In one striking example, a BME woman who reported experience of domestic abuse, described relying on her husband to act as an interpreter for her. At times when he did not attend appointments, she found it difficult to communicate with staff and understand what was being said. Another patient recounted that she did not have time to cover her face when a male doctor entered the room. The “doctor talked to his papers and told me what I already knew… he confirmed I might not get a female doctor.”

Jac said: “If we are going to achieve equalities in health, one thing we have to do better is to make sure that our vulnerable groups get access to the right healthcare. We need to recognise that if patients are not accessing services, then the problem does not lie with them but with the service. The work that has been underway will help to ensure that our services are more sensitive to the wider issues that affect person’s health and can respond to them.”

IT’S not only poverty that impacts on health. Health outcomes and health risks can vary according to people’s age, disability, gender, race, religion or belief, sexual orientation and other individual factors.

- 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.
- Lesbian/gay/bisexual and transgender people experience lower self-esteem and higher rates of mental health problems and these have an impact on health behaviours, including higher reported rates of smoking, alcohol and drug use.
- Lesbians have specific health issues relating to fertility, pregnancy, sexual health and mental health. However, there is evidence that lesbians are afraid to tell their GP of their sexual orientation in case they experience discrimination.
- Just under a quarter (24%) of all individuals in households with at least one disabled adult or disabled child are living in relative low income, compared to 16% of those in households with no disabled adults or disabled children.
- The employment rate among all ethnic minorities in Glasgow is 10% lower than for white Glaswegians.
- 68% of disabled people have an income of less than £10,000.
- Women more likely to be poor than men due lower paid jobs, part-time jobs, gendered pay gap and 90% of lone parents are women.
- People of African origin formed just over 5% of the minority ethnic population in Scotland in 2001, but represented 33% of the psychiatric patients in hospitals who were from ethnic minorities.
- People with long term disabilities are particularly likely to live in poverty.

Race and gender are just two factors that can impact on health.

Putting new initiatives to the test
Putting new initiatives to the test

GOVANHILL is one of the west of Scotland’s most challenging neighbourhoods, with a significant level of health and social inequalities. It has a comparatively large black and minority ethnic population.

The area has now been selected as one of eight communities across Scotland to test innovative approaches to tackling health inequalities. Working with the local Govanhill community and voluntary sector, NHSGGC and other planning partners will develop a programme of social, economic and physical regeneration, in order to address the many problems of the neighbourhood, including known priorities such as alcohol, drugs and community safety.

The site is one of three in Greater Glasgow and Clyde which will transform and redesign public services that have a major impact on their health and wellbeing.

Whitecrook in West Dunbartonshire is targeting the high prevalence of smoking in the area. An area of considerable socio-economic deprivation, smoking prevalence in Whitecrook is 40.2% compared to a national average of 24.7%.

The area has high rates of coronary heart disease, cancer and cardiovascular disease. The test site will focus on several themes: prevention and education (including work in schools and nurseries with parents and children); enhanced smoking cessation services (including evidence-based group work and piloting more intensive individualised support whilst linking quitters into a wide range of local services); and targeting tobacco sales (including test sales and awareness work with retailers).

Building on previous experience, Glasgow’s east end will aim to develop good practice in incorporating health within the planning process. The test site will incorporate lessons learned from existing experience; provide new and innovative means for partners to engage with each other; offer new ways of shaping the health impact of private sector investment in buildings and land; and assess the impacts on inequalities in health and wellbeing.

Each test site is a collaboration between local services and has high-level buy-in from those with the authority to manage permanent, positive change.

What else is being tested?

- East Lothian is looking at health inequalities in the early years.
- Blairgowrie is looking at delivering health inequality sensitive services for people with multiple and complex needs in a rural setting.
- In Lanarkshire the focus is on sustained employment and supporting people to find decent work.
- Fife is looking at anti-social behaviour in relation to alcohol and underage drinking.
- Dundee is focusing on methods of improving wellbeing.
Why we must rise to the equality challenge

IF the newly elected President Obama were to visit Glasgow and, as part of his speech, issue the challenge: “Are you able to reverse the inequalities in health that so disfigure your city?”

Would we chorus back: “Yes we can” - as crowds did during his election campaign?

My experience is that even among those who are concerned about inequalities in health, two different answers are more typical.

The first is “yes we should”, which is advocacy for social justice and speaks of a desire to see a change. The second is quite simply “no we can’t – we have tried and failed and the prospects for success do not look good”.

Let’s examine this second reaction. Is it true that we have tried to counter inequalities and failed? Well, yes and no. We have, in fact, reversed a number of important inequalities. For example, when I first came into public health, there were profound social gradients in childhood vaccination rates. We have now all but eliminated those inequalities. Why do we succeed in these areas but not others? The reason is that we have a technology that we can apply almost universally. However, where the determinants of inequality are social, economic and behavioural and we have no technology to apply universally, inequalities persist or even increase.

Consider the health of infants and children. Infant mortality has been brought down to such an extent that the large social gradient that existed historically has been markedly diminished. Why? Once again it is because we have a universal system (antenatal care) and a number of technologies that successfully keeps babies alive – rich and poor. But, the health of poor infants and children are, nonetheless, subject to inequalities: there are marked gradients in birth weight, infant feeding, childhood dental health, educational success and much else.

The key insight when it comes to understanding these profound and enduring inequalities is that ‘it all matters’ – physical environment, social environment, income, education, health care and behaviour all interact over the life course to create inequalities. Also, our consumerist and individualistic society is making inequalities worse.

This might sound like a depressing conclusion. If inequalities are an emergent quality of our current culture, how can we bring about meaningful change? The good news is that our culture and societal structures are already beginning a profound process of change. Climate change and a phenomenon called peak oil (Google it, if this is a new term for you – it is a profound issue) will force us all to change.

The bad news is that change can be painful, there are winners and losers, and many will resist even if they recognise that change is inevitable. So, what should we do? My suggestion is that we move quickly to gain a health and social dividend from the inevitable need for transition. As we adapt to climate change and peak oil, we will need new energy systems, transport options, jobs, food sources, patterns of recreation and much else. We could ensure that these changes reduce inequalities - for example, if everyone had the same carbon ration, such a policy would massively reduce inequalities in consumption. A low carbon world could also have less obesity, greater wellbeing and stronger communities.

So, here is a really practical suggestion. Let’s start implementing changes now that will rapidly move Scotland to a position where we use a fifth of our current level of carbon and, while doing so, recreate our cities and our communities as places that are more connected, healthier and more equal.

By Professor Phil Hanlon, University of Glasgow
How ten goals will help us rise to the challenge

THE NHS is determined to tackle inequalities and close the gaps that exist in health and wellbeing.

And within NHSGGC, we have set 10 goals to help achieve equality, split into three areas of activity...

Engaging with populations and patients
1) To know and understand the inequalities and discrimination faced by our patients and population
2) To engage with those experiencing inequality and discrimination
3) To be aware that people’s experience of inequality affects the health choices they make
4) To remove obstacles to services and health information caused by inequality
5) To use an understanding of inequality and discrimination when devising treatment and care
6) To use the Board’s core budget and staff resources differently to tackle inequality

Developing our workforce
7) To have a workforce which represents our diverse population
8) To create a non-discriminatory working environment and a workforce that has the skills to tackle inequality

NHS role in society
9) To spend money invested in buildings, goods and services in a way that tackles poverty
10) To work with partners to reduce health inequality by addressing issues such as income inequality, social class inequality, gender inequality, racism, disability discrimination and homophobia.

Some of the practical actions NHS Greater Glasgow and Clyde are driving forward to achieve the goals set out here have been highlighted in this edition of Health News.

Other examples of how we are engaging with people, developing our workforce and developing our role in society can be viewed on www.nhsggc.org.uk and click on “Equal Access to Health”.

Reducing the health gap... recommended reading

IF you're interested in the issues we've covered in this edition of Health News, and would like to read more, we suggest you visit the following websites. Simply click on the website name.

NHSGGC Equalities Website
- www.equality.scot.nhs.uk

Glasgow Centre for Population Health
- www.gcph.co.uk

GoWell
- www.gowellonline.com

Equally Well Task Force Report
- www.scotland.gov.uk/Publications/2008/06/25104032/0

Equally Well Implementation Plan
- www.scotland.gov.uk/Publications/2008/12/10094101/0

‘Let Glasgow Flourish’, available to download from
- www.gcp.co.uk/content/view/17/34/

Report of the WHO Commission on the social determinants of health
- www.who.int/social_determinants/en/

‘Concepts and principles for tackling social inequities in health’, Whitehead and Dahlgren
- www.euro.who.int/document/e89383.pdf

Women's Support Project
- www.womenssupportproject.co.uk/

Child & Women Abuse Studies Unit, London Metropolitan University
- www.cwasu.org

Scottish Government – Violence Against Women
- www.scotland.gov.uk/Topics/People/Equality/violence-women

Scottish Government - Gender
- www.scotland.gov.uk/Topics/People/Equality/18500/13402

Scottish Women's Aid Resource for young people
- www.scottishwomensaid.org.uk/help-and-info-for-young-people