

# Children, Inequalities and Information in East Glasgow CHCP:

An exploration of the use of routine, survey and local information to describe the impact of social inequalities on children's health

Final Report

January 2007

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**Acknowledgements:**

Thanks to participating project leaders and information specialists and to Sue Laughlin, Catriona Macdonald, David Walsh, Carol Tannahill, Ali Macdonald, Laura Kemp and Christine Duncan for comments on earlier drafts of the report.

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## Summary

The project described in this paper was carried out within East Glasgow CHCP between December 2005 and July 2006, developed by Glasgow Centre for Population Health (GCPH) and Greater Glasgow and Clyde NHS Corporate Inequalities Team, and managed by GCPH. Data was collected and analysed by secondees from ISD and East Glasgow CHCP.

The purpose of the project was to identify and demonstrate the use of data sources that would inform the development of inequalities-sensitive children's services planning processes. We explored the routine data, survey and local sources of information available to a CHCP that could help define the impact that social inequalities might have on children's health, and the ways in which services address these inequalities issues. In addition, we reviewed literature sources to provide a broader context of the likely impact of social inequalities on children's health.

A broad range of routine databases from health, social work and education were examined. Databases from different agencies, or even different departments within agencies are not necessarily compatible and therefore could not provide a comprehensive picture through data alone. Outcomes from service use are generally not captured, even in narrative forms, but this information, particularly for different population groups, would be important to have access to, if services are working towards a more equitable distribution of good health across a population.

Reports written by local initiatives and projects can sometimes provide information on needs assessments carried out, plans for developing projects, narrative final reports, or satisfaction of service users, but not all projects and services produce such reports. Services responding to the complexity of health inequalities are likely to find that they have to simplify reporting in order to fit their activities into existing databases. However, even single inequality issues are not generally dealt with well by routine datasets as data on gender roles, ethnicity or disability are not usually collected.

We concluded from this project that CH/CPs do not currently have the tools to fully describe or analyse the impact of social inequalities on the health and well-being of children, through using either routine, survey or qualitative data. While there is a wealth of general and specific information collected, CH/CPs need to use available data creatively, and fill gaps with a judicious use of information from wider sources, such as locally-based and other research studies. We argue that health and social services need a greater understanding of the gaps in the existing data so that CH/CPs avoid oversimplifying the complexity of health and social inequalities and drawing the wrong conclusions from an incomplete pool of data.

## 1 Background

The project described in this paper was carried out within East Glasgow CHCP between December 2005 and July 2006, developed by Glasgow Centre for Population Health (GCPH) and Greater Glasgow and Clyde NHS Corporate Inequalities Team, and managed by GCPH. Data was collected and analysed by secondees from ISD and East Glasgow CHCP.

Community Health and Care Partnerships (CHCPs) are expected to have a focus on improvements in the health of their local population and in addressing health inequalities. East Glasgow CHCP includes some of the most deprived communities in Glasgow and Scotland, and has a lead role for Children's Services across Greater Glasgow and Clyde NHS, including NHS children's services planning, managing local community child health services through the child development centre, and all of the area-wide child and adolescent mental health services. It is this emphasis on the health of children and young people that has provided a focus for the East Glasgow CHCP project.

The purpose of the project was to identify and demonstrate the use of data sources that would inform the development of inequalities-sensitive children's services planning processes. Our starting points were to explore the sources of information available to a CHCP that could help define the impact that social inequalities might have on children's health, and the ways in which services might address these inequalities issues.

The child population is a complex one, as different groups of children are affected by separate, and combinations of, different forms of inequality, depending on for example, the socio-economic status of their family, their sex and gender, their ethnic group and whether they are disabled or not. Planning for improvements in health for the child population needs to take into account the extent and implications of these different forms of inequality as well as measure the effects of interventions designed to address their consequences. Alongside this, information systems need to be effective in providing the appropriate data for such measurements to take place.

The Aim of the project and objectives were as follows:

### ***Aim:***

To demonstrate in East Glasgow CHCP, information, processes and resources available to support an inequalities-sensitive children's planning process across Glasgow.

### ***Objectives:***

1. To describe the key inequality risks to children associated with socio-economic status, gender, race and disability and their links to poor health outcomes
2. To consider the strengths and weaknesses of current data that can illustrate the extent of these risks in the East Glasgow CHCP catchment area
3. To use existing data to identify key priorities for addressing the effects of different forms of inequality on the health of children within the East Glasgow CHCP area
4. To establish a framework of intermediate indicators and outcome measures based on existing information to monitor progress in relation to these priorities

5. To propose how weaknesses in current data provision might be met in relation to inequality risks and their impact on the health of children
6. To make recommendations to both East Glasgow CHCP and Glasgow wide children's services planning process on the basis of the findings

Objectives 3 and 4 were not met by the current project but will be taken forward by further work, described in the final section of the report.

### ***Format of the report***

The report begins by describing the main inequalities issues likely to affect children in the East Glasgow CHCP area, exploring where routine data might be found to illuminate or describe these, and what the data might say about children in East Glasgow CHCP. We then examine the potential of local services and projects in the CHCP area as providers of data sources through their routine records or descriptive or reflective reports. To offer a practical example of accessing data and local information from a CHCP perspective, we go on to describe an exercise where we identified mental health as a topic to help focus our exploration of routine and informal data sources. Finally, we describe the issues that the project raised for us and suggest ways in which GCPH will take forward further work based on our findings.

## 2 Children and Inequalities in East Glasgow CHCP

The United Nations Convention on the Rights of the Child (Article 24) <sup>1</sup> requires countries to: *“recognize the right of the child to the enjoyment of the highest attainable standards of health...”*

Scottish Executive Policy is firmly rooted in making children and young people a priority and current policy aims to ensure that, *“every child, whatever his or her social or economic background, has the best possible start in life.”*<sup>2</sup>

Extensive research tells us that health inequalities in the adult population are the product of a complex set of social, economic and structural factors which are usually set in childhood. For example, influential documents such as the Acheson Report <sup>3</sup> recommended that giving priority to parents and children was the best way of reducing future inequalities in physical and mental health, and that a concerted effort by a range of agencies is required to reduce health and social inequalities. For example, Curtis and Roberts (2003) argued that:

*“The Health Service on its own cannot tackle inequalities in child health. Adequate income, affordable child care, parental employment, an inclusive education system and accessible health, leisure and transport facilities are all essential for the prevention and eradication of inequalities”.*<sup>4</sup>

Children at risk of poor health or of being affected by difficult circumstances are often described as “vulnerable”. However the definition of vulnerability is often not clear cut and different service providers may use different descriptions/assessments of vulnerability as criteria for accepting children into their services. Appleton, 1994<sup>5</sup> suggests that the concept of vulnerability is a nebulous, transient and complex concept which is influenced by multiple interacting factors. She also argues that families exist on a continuum of vulnerability and that families can move in and out of vulnerable states at various stages in the life cycle, largely dependant on stress factors and coping ability.

Children as a group are at particular risk of a detrimental impact on their health from societal inequality, for a number of factors<sup>6</sup> as they:

- are unable to provide self advocacy;
- are dependant on adults for care, with some children being at risk of poor care, neglect or abuse;
- are dependant on adult focused systems and services;
- services traditionally have failed to consult and engage with children in seeking out their views
- measures and indicators are often based on population profiles from an adult viewpoint, data on individual health and social service use are held by a variety of agencies and departments, few of them are linked, and less are set up to measure children’s issues.

East Glasgow CHCP has a population of 169,530 residents. The proportion of children (aged 0-15) is 1% higher than Glasgow and Scotland as a whole (Source: The General Register Office<sup>7</sup>), contributing to the CHCP's focus on children. For this project, we have examined some of the societal factors that are likely to have a major impact on the health of children, and used a range of local and national routine and survey data sources to help describe this impact on children in East Glasgow. We then describe examples of statutory and voluntary services in the area, which aim to address the impact of these inequalities but also collect additional, "non routine" information. The factors examined here are; poverty, gender, ethnicity, and disability.

## **2.1 Poverty**

Child Poverty is high within the UK compared to other EU countries.<sup>8</sup> This is likely to be due to a combination of factors including a high number of children living with lone parents, the relatively low percentage of lone parents who work, low relative pay and the limited extent of redistribution through the tax and benefit system. Studies have shown that poverty within families strongly affects the present and future welfare of children. For example the New Policy Institute (2005) reports that:<sup>9</sup>

- Almost half of all lone parents in Scotland are living with income poverty, three times the rate for couples with children.
- Although work strongly reduces the risk of being in poverty, it does not eliminate it: a third of all employees in Scotland earn less than £6.50 per hour. Half of all part-time workers earn less than £6.50 per hour, most of them women.

A study by Gregg et al (1999)<sup>10</sup> found that young adults who as children suffered financial hardship, were in trouble with the law or played truant, as adults had significantly greater than average chances of earning lower wages, being unemployed, spending time in prison (men) or becoming a lone parent (women). Furthermore these associations existed independently of socio-economic background or experiences in early childhood, and were only partly accounted for by lower educational attainment. When looking at family-based measures of childhood disadvantage, the study found poverty to be the most important force linking childhood development with subsequent social and economic outcomes. Being brought up in a lone-parent family, for example, did not appear to matter in the absence of family poverty. The study also demonstrated an intergenerational link in the cycle of family disadvantage which suggests there may be effects on the economic fortunes of the children of disadvantaged families.



A local example highlighting intergenerational effects of poverty is described by East Glasgow CHCP Local Grandparents Support Group. These grandparents who are often elderly and in poor health themselves are caring for their grandchildren as their children are unable to do so often due to substance misuse. The grandparents describe financial problems such as being unable to allow their grandchildren to accept invitations to birthday parties as they cannot afford the cost of presents. These types of problems for families are backed up in a study on poverty and social exclusion which discussed conditions and dilemmas facing people living in poverty<sup>11</sup>. In the study almost 14% of people were, like the East Glasgow grandparents, too poor to be able to engage in two or more social activities considered necessary (by over 50% of the population) such as visiting friends, attending weddings or having celebrations on special occasions. The psychosocial effects of being unable to engage in society in this way, which can result in feelings of hopelessness, lack of trust, hostility and depression, are well documented by Wilkinson (1996)<sup>12</sup>, and Marmot and Wilkinson (2001)<sup>13</sup>.

There are a number of data sources that can be used to identify poverty indicators. Currently the most commonly used in health services is the **Scottish Index of Multiple Deprivation (SIMD)**. This classification is based on a range of variables measuring deprivation across six domains: income, employment, housing, health, education and access to services. The SIMD can be mapped to any database that contains postcodes or datazone information. We used SIMD 2004 for our calculations in the mental health exercise described in Section 5, page 19, but the index has since been updated to SIMD 2006. For further details on the SIMD see:

<http://www.scotland.gov.uk/Topics/Statistics/SIMD/Overview>

The main limitations when using the deprivation classification is that information is available at area rather than at individual level. In the UK, those living in the areas of highest mortality are also living in those areas where indicators of poverty are greatest. However, poverty is experienced at an individual level and area-based approaches are insensitive to the wide distribution of people living in poverty. For example, the SIMD shows that East Glasgow CHCP is very deprived with 50% of its datazones located in the most deprived SIMD deciles. However, previous research carried out by McLoone in 2001<sup>14</sup> identified that if 20% of the most deprived postcode sector areas (using Carstairs indicators) in Scotland are targeted for increased resources, only 34% of low income households would be captured, and even if 60% of the most deprived areas were targeted, 26% of low income households would be excluded. While this research was carried out using postcode sectors as the geographical measure, McLoone carried out the same analysis using enumeration districts (which are smaller even than datazones) and found that there was only a small increase in the inclusion of low income households. Therefore, area-based measures used alone have limitations in effectively targeting resources for mitigating effects of poverty in children.

**Census 2001**<sup>15</sup> and **Scottish Neighbourhood Statistics** also contain poverty indicators that impact particularly on children such as:

- Children living in lone parent households
- Children in workless households
- Children living in large family households (4+ children)
- Children living in large lone parent households
- Children living in overcrowded households

- Unemployment
- Social Class
- Ethnicity

Information from the Census 2001 can be used as an indication of how families living in the East Glasgow CHCP are affected by poverty, including that:

- 39% of children are living in workless households and
- 45% of children are in lone parent households

The **Scottish Neighbourhood Statistics** database<sup>16</sup> contains economic activity, benefits and tax credits information. Also collected are information on education, skills and training including, early child development, pre-school provision, absenteeism, school exclusions, special needs in schools, progress through education and staying on in education. This information can help to identify areas in which large proportions of school pupils need additional support. The web site is updated quarterly in January, April, July and October.

The **Social Work Clients and the Local Context Report**<sup>17</sup> contains a summary of the location and concentration of child (0-17 years) social work clients (20% of the social work client base) in Glasgow City. It provides data on the volume, characteristics, location and concentration of social work clients. In the information held the most common group classifications for children are listed below, although they only report on the total number by CHCPs.

- Children- support to families
- Children- looked after
- Children in need
- Children affected by disabilities
- Vulnerable children
- Children- affected by care drug/alcohol misuse
- Children- behaviour difficulties
- Physical Disabilities

Information on school clothing grants uptake is also available from **Glasgow City Council**. There may also be situations where individual families are receiving support from the Social Work Department to provide clothes for their children as well as from the Education Department.

The **Let Glasgow Flourish Report** (Hanlon et al, 2006) contains a very comprehensive description of health and its determinants in Glasgow and the West of Scotland. Chapter 9 considers a number of indicators relevant to the health of children and adolescents. Information is presented on both social environment (children of substance misusers, children looked after by a local authority, child protection register data and children in workless households) and behaviour (obesity, alcohol, smoking and drug-taking, and dental health). The report is available from the Glasgow Centre for Population Health (GCPH) and is also published on the GCPH web site<sup>18</sup>.

Focusing on children living in the East Glasgow CHCP area, data from the Census and from health and social services can provide an indication of the proportion of children living in poor households, the numbers of children who are likely to be vulnerable and those children who are using or are known to mainstream services. Area profiling data can also provide a picture of their environmental and social circumstances.

## **2.2 Gender**

There are marked differences in female and male patterns of illness and death. The reasons around this are complex and result from both biological and social factors. Clearly health is shaped by biological sex but gendered roles which are constructed within society have a major impact on wellbeing.

Wizemann and Pardue<sup>19</sup> in their research list several biological differences in men's and women's experience of illness, including:

- men typically develop heart disease ten years earlier than women,
- women's immune systems make them more resistant than men to some kinds of infection including tuberculosis,
- women are around 2.7 times more likely than men to develop an auto-immune disease such as diabetes, and
- male to female infection with HIV is more than twice as efficient as female to male infection.

Differences due to socially constructed gender roles are more difficult to list as people's experience of gender roles vary between individuals and cultures. Every society around the world assigns gender roles which influence behaviour for men, women, girls and boys. Different gender roles are mediated by social class, income, age and ethnicity, and they lead to different priorities in everyday life, which can be a source of conflict within the home. For example, in many societies the cultural norm is that males in the household have the largest share of income and wealth and greater decision-making power. Impact on health of gender roles includes mental health problems, for example, women who stay at home with young children have a higher rate of depression than other women, or men having to take on life threatening jobs in much greater numbers than women. A WHO website provides a range of accessible reports and discussion papers about the impact of gender roles on health: [www.who.int/gender/genderandhealth/en](http://www.who.int/gender/genderandhealth/en).

Locally and nationally available data on service delivery indicate differences between men and women in uptake and use of services. For example, research has shown differences in referral patterns for men and women for certain health service procedures and men are believed to present to health services at later stages in illness<sup>20</sup>. Within Glasgow Social Work services males dominate the child and adult social work client base, where they form the majority in every age band between 0-4 years and 55-59years.<sup>17</sup> In Glasgow's Addiction services, males also make more use of the service but locally services have been unable to identify the reasons for these differences. Studies<sup>20</sup> suggest that women may be more reluctant to access addiction services as they might be more likely to feel stigmatized as a result of using the service.

Within mental health there are also marked differences between males and females<sup>21</sup>. Scottish suicide rates are over three times higher in young men than in young women, but of the approximately 10,000 yearly hospital admissions for people who deliberately self harm, women are by far in the majority. Children's health also demonstrates differences between boys and girls, such as in autism and some genetic conditions<sup>22</sup>.

In education, Powney's review in 1995<sup>23</sup> concluded that gender differences in attainment persisted at all levels of education although the differences were not always consistent with employment patterns and outcomes of higher education. Although girls in the UK stay on longer at school than boys and leave school with better qualifications, there are fewer girls taking up apprenticeships or obtaining first class degrees.

Most routine data sources record gender by noting whether the subject is male or female, although gender breakdown is not always routinely carried out and presented. Survey data reports more often include a gender breakdown, but information on the impact of socially constructed gender roles on health is only available through specific research. One example of a survey providing Scotland-wide and Glasgow information with gender analyses (including children from 1998) is **The Scottish Health Survey**. This is a national survey undertaken in 1995, 1998 and 2003 on a representative sample of the Scottish population living in private households. It focuses on health status, health care use and health behaviour and also collects a range of demographic and socioeconomic measures. It contains information such as: general health, physical activity, eating habits, drinking, smoking, parental history, psychosocial measures, accidents, dental health, obesity, etc. The 1998 SHS included respondents from 2-74 years old for the first time. The survey is representative only at Health Board level although in 1998 there were some problems with non-response by region, particularly in Greater Glasgow. Results for the 2003 survey have just become available<sup>24</sup>.

**The Growing Up in Scotland Survey<sup>25</sup>** (GUS) will follow the lives of groups of Scotland's children from babies through to their teens, and will provide important new information that will help develop policies affecting young children and their families in Scotland. Gender information is collected in this survey. The survey design consists of initially recruiting a total of 8,000 parents in 2005 in two cohorts of children (5000 from birth, 3000 from age two) and interviewing parents annually, until the child reaches five years of age.

The Child Health Information Team at **ISD Scotland** also collect national information on various indicators of women's and children's health, including breastfeeding report rates at 6-8 weeks<sup>26</sup>, maternal smoking<sup>27</sup> at booking and first visit, immunisation, teenage pregnancies, teenage abortions, age of mothers and low birthweight.

Information relating to gender for children in East Glasgow CHCP is complex. Information from mother's service use can describe the impact of some issues relating to childbirth but there is little that describes gender issues affecting either of their parents and therefore the children by association. In addition, information directly relating to children is sparse, often not reported separately for boys and girls, and is unlikely to be available at CHCP level. However, new data collection activity might provide more gender-related information for children in the future.

### **2.3 Ethnicity**

Ethnicity, race and culture are important determinants of health. Those with minority ethnic backgrounds are likely to experience disadvantage and discrimination which will contribute to inequalities in health. Certain diseases or conditions are more common in some ethnic groups compared to others. For example, studies<sup>28</sup> show that those from minority ethnic groups are more likely to experience diabetes and its complications especially in relation to renal and ophthalmic problems.

Differences in treatment outcomes and health service use also vary between different ethnic groups, and research from the Sainsburys Centre<sup>29</sup> published in 2002 shows that people with mental health problems who come from a black or minority ethnic background may be at particular risk: they may not have adequate access to services, and when they do, the services may not be culturally sensitive and responsive.

In a 2004 report, the Scottish Development Centre for Mental Health<sup>30</sup> suggested that patients from black and minority ethnic communities may be reluctant to access services due to a lack of confidence or trust. They reported that barriers to accessing services for mental health problems have been identified in relation to language, stereotyping, lack of awareness of different understandings of mental illness, cultural insensitivity, “colour blind” approaches, and direct or indirect racism at individual or institutional level.

Reports<sup>31</sup> on the South Asian (mostly Punjabi) population aged 30-40 years compared with the general population in Glasgow in 1991 identified that:

- South Asian men had higher numbers of health advantages, including less long-standing diseases than the general population
- South Asian women were disadvantaged in a number of respects, reporting more chronic conditions than Glaswegian women in general
- The gender difference in the South Asian population is greater than the majority population, particularly in regard to symptoms and chronic conditions
- Socio-economic circumstances of South Asians were worse than the general population.

At national level the only ethnicity information available is collected by the Census every ten years. The main primary and secondary care datasets maintained by ISD Scotland do not contain ethnicity data due to the fact that the ethnicity field is not mandatory for practitioners to complete. As a good area based approximation, areas with high proportion of ethnic minority households can be identified using the Census information and link to other databases by postcode or datazone.

There is a complexity in the relationship between ethnicity and health in that belonging to a minority population group is often linked to poor health, but it can also sometimes act as a protective factor. For example, lifestyle factors such as diet, smoking and alcohol consumption patterns tend generally to be better in the black and minority ethnic (BME) communities as a whole than in the general Glasgow population<sup>32</sup>, although smoking amongst Pakistani men has been found to be higher.

At Health Board level the **Starting Well Health Demonstration Project**<sup>33</sup> in Glasgow collected ethnicity data. The ethnic minority families within the Starting Well project had much higher rates of breast feeding than the remaining population and had a higher rate than the national average. These families were also likely to introduce solids later than the other families.

Findings also suggested that mothers with ethnic minority backgrounds were less likely to be scored using the Edinburgh Post Natal Score. This is possibly due to cultural and language issues, as 70% of the mothers had English as a second language and 27% required an interpreter for all contacts. In addition preliminary analysis suggest they presented with fewer markers of vulnerability such as single parent, worklessness within the household, less breast feeding, and mothers who were smokers.

Using the health visitor Assessment of Family Health Needs, 90% of all families were scored as being of “average” need. However families from BME communities had more contacts than the remaining “average” need families and were more likely to fall into the high visiting group. It would appear health visitor initial assessments within Starting Well did not initially pick up on the needs and vulnerabilities of BME families and this only occurred over time.

Some conclusions might be drawn for East Glasgow CHCP from local or national research about children and ethnicity, but there was no data specifically available for ethnicity in East Glasgow CHCP.

## ***2.4 Disability***

The Disability Discrimination Act (1995)<sup>34</sup> (DDA) defines a disabled person as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities.

Not everyone with experience of impairment or long term health conditions will experience serious disadvantage during their lives. However, large numbers do experience social and economic exclusion which can be increased by other factors such as age, ethnic origin or gender. Both women and some ethnic minority communities have a greater likelihood of having a disability.

In the DDA definition, 'physical impairment' includes sensory impairment. 'Mental impairment' includes learning difficulties and an impairment resulting from or consisting of a mental illness. The definition can include a wide range of impairments, such as dyslexia, autism, speech and language impairments, and Attention Deficit Hyperactivity Disorder (ADHD). An impairment does not of itself mean that a child or young person is disabled. It is the effect on the ability to carry out normal day-to-day activities that has to be considered.

A child's ability to memorise, concentrate, learn, speak and move is central to their education. An impairment that has a long-term and substantial effect on a child's ability to do these things may therefore amount to a disability.

The Disability Rights Commission (DRC) interim report into health inequalities<sup>35</sup> found that people with mental health problems or learning disabilities were significantly more likely than other people to experience some serious physical illnesses. They reported that people with a diagnosis of schizophrenia or bi-polar disorder are more than twice as likely to have diabetes than other people and also more likely to experience ischaemic heart disease, stroke, hypertension and epilepsy. These health problems can both shorten life and reduce life chances. Inequalities cannot be explained by the learning disability or mental health problem alone. Previous research suggests the reasons for the health inequalities are complex and likely to include poverty, lifestyle, access to health assessments and treatments, and side-effects of psychiatric medication. The DRC further described inequalities in health services where those with learning disabilities had lower levels of cervical cytology, mammography and other routine tests than the general population.

Findings from the New Policy Institute report in 2004 included the following in relation to those with disabilities<sup>36</sup>:

- A third of all working-age disabled adults in Scotland are in income poverty , double the rate for their non-disabled counterparts.
- There are 200,000 people of working age who want to work but who are officially unemployed: many are disabled people or lone parents.
- At any given level of qualification a disabled person is more likely than a non-disabled person to be low paid. The disability pay gap is ten per cent.

In relation to children and young people:

- Just under 15 per cent of all 'looked after' children in Scotland have a disability.<sup>37</sup>
- 68 per cent of households with children, where both parents are out of work, include at least one disabled parent; and 32 per cent of lone parents out of work are disabled, meaning disabled people's unemployment plays a major part in relation to child poverty.<sup>38</sup>
- In Scotland disabled young people (aged between 16–24) are 15 per cent less likely to be economically active than their non-disabled peers. Over three quarters of economically inactive disabled people cite their disability as being the primary reason for not being available to start work.<sup>39</sup>
- 12 per cent of Scottish disabled young people need, but do not have, special equipment or adaptations to their homes.<sup>40</sup>

Due to the broad definition of disability it can be difficult to obtain accurate local information and there is currently no national information available on children's disabilities. Local services collect information on service use such as the Social Work Department at Glasgow City Council, and the Child Development Centres. Children affected by disability and physical disability are amongst the common client classifications for children for social work services. However, as the social work department work with only a small proportion of the total child population, use of these data may be problematic due to the small numbers potentially compromising confidentiality. In addition, the Child Development Centres collect information in different ways and again small numbers in each area for some conditions raises confidentiality issues.

For children living in the East Glasgow CHCP area, an attempt to look at the numbers of children and young people suffering from a specific condition or accessing a specific service would present problems, as there seems to be little information available which could be used at CHCP level. Some information may be available via the Child Development Centres but depending on the conditions, children with disabilities can be managed by the primary care team or within specialist services. Some information may also be available from Glasgow City Council's Education database but it was not accessible for us for this report.

### ***2.5 Summary of routine data available for East Glasgow CHCP***

Poverty was the only inequality dimension for which there was data relating to children. Information on gender, ethnicity and disability relating to children could be extrapolated from local and national research studies and surveys, but there were no sources of data available specific to East Glasgow CHCP for these inequalities dimensions.



### **3 Statutory health and social care services for children in East Glasgow**

Concurrently with our examination of routine data sources we explored local services and projects as potential additional data sources. We gathered information about children's service use and outcomes through a process of interviewing key contacts and collecting existing written reports from services that were likely to have some focus on inequality-related issues for children. There are over 300 statutory, voluntary and community organisations in the East Glasgow CHCP area a number of which provide services to children and we could not expect to make contact with all of them. However, we focused on a selection identified through the CHCP and through a process of purposeful sampling.

#### ***3.1 Children and Families Health Visiting/Public Health Nursing***

In relation to health, universal child surveillance services are currently implementing the guidance from Hall 4 <sup>41</sup>(Health for all Children). Hall 4 recommended moving away from universal screening for health and development problems and moving towards a service targeted at children most in need. All children will receive a core service with health promotion information at appropriate times.

Children and families will be assessed within the first six to eight weeks of life according to need and will receive a core, additional or intensive service depending on that assessment. In recognition that circumstances change, families may move between the core, additional and intensive components. Assessment should involve partnership with the parents to include their concerns using a Family Health Assessment which was used successfully by Starting Well. This has been developed from work by Kate Sanders <sup>42</sup> which looked at the methods health visitors used to assess children's needs. This assessment allows parents, in partnership with health staff, to identify a range of areas in everyday life which may cause them concern and subsequently agree a plan to address them.

Findings from the Starting Well Project<sup>33</sup> indicated that those families identified as having additional needs were families for whom a range of vulnerability and risk factors were present, including involvement with Social Work/Criminal Justice, low income, ethnicity, Edinburgh Post Natal Depression Score (EPNDS), and the employment status of both the geographical area and the mothers themselves.

If additional input was offered on the basis of these factors the great majority of families subsequently referred to social work services would be identified. This would mean that in deprived areas such as East Glasgow CHCP a majority of families would be offered additional support. Findings also indicated that more intensive service provision followed identification of need and "referral on" to other agencies/support mechanisms was greater for those families identified with greater need.

Individual case load work continues to be the main focus within core health visiting/public health nursing work. Wider work on improving health such as parenting support, nutrition, oral health, supporting activities to increase breast feeding, Weaning Fayres and reducing exposure to second hand smoke is developing, although often in conjunction with other members of the wider health improvement workforce.

### **3.2 School Nursing**

The school population in East Glasgow CHCP area (which at the time of writing, in addition to Glasgow City Council, includes some schools within North Lanarkshire Council area) is approximately 20,000. The ratio of school nurse to pupil is currently 1:4595 within East Glasgow. The Scottish Executive Framework for Nursing in Schools<sup>43</sup> produced in 2003 proposes a ratio of school nurse to pupil of 1:1700. There is currently no comprehensive school health based computer system resulting in gaps in data and information for planning services and identifying needs. More information may be available in the future as a result of local initiatives, such as the introduction of a monthly team reporting system by the Public Health Team Leader for school nurses, which will provide an audit of the school nurses workload. In addition an audit of information available for the health visitor-school nurse handover has recently been compiled for Glasgow City, and a pupil survey is expected to be delivered this year which will allow a baseline measure for schools against which the Health Promoting Schools model can be measured.

The School Nurse Team is involved in a diverse variety of work from surveillance and immunisation to groupwork, health education, home visits, transition support, and 1:1 pupil “drop ins” within schools. There are indications that child protection work is increasing the school nurse workload, which requires re-prioritisation of daily work, and this might have a future impact on the variety of duties they currently undertake. This will be highlighted through the current team monthly report system in East Glasgow CHCP.

The Education database, SEEMIS, contains Glasgow wide information on areas such as free school meals uptake, clothing grants and Educational Maintenance Allowance (EMA). All of this data can be localized to individual schools and learning community clusters. The information could also potentially be localised to CHCP areas by post code.

### **3.3 Social Work**

The Children (Scotland) Act 1995 lays out the statutory framework for much of social work intervention. By the very nature of their jobs, social workers work with the most vulnerable families and their carers. They are not a universal service and they work with only the “tip of the iceberg” in regards to vulnerable children. Social work criteria for prioritisation of work in regards to children are:

- Immediate danger
- High risk
- Potential risk
- Possible benefit

A social work assessment would link with other colleagues such as health visitors, nursery staff and carers organisations. Often assessments are the starting point for intervention. Social work responds to referrals mostly from health and education and occasionally receive self-referrals. They receive on average over 70 per week within the East Glasgow area office.

Information from social work is collected via the Care First system (introduced in 96/97) which records data on clients, including child clients age 0-17 years with an open case and known main address. This information can be related to CHCP area by postcode although certain information can be difficult to extract. An example of this would be in relation to domestic violence. All cases where the police have been called to a situation where there has been domestic violence and children are involved are at present reported to the local social work department. However, this information cannot be easily extracted from the database for a number of reasons, but efforts are being made to make this type of information more readily available.

Although health and education would argue that they also complete a holistic assessment, generally the information shared with social work tends to be in relation to health matters or education matters only and wider information is often not shared. "Integrated Assessment" which is expected to be rolled out across Glasgow in 2006/2007 should address this.

The Scottish Executive policy "Getting it Right for Every Child" (Scottish Executive, 2005) recommends the introduction of a common assessment of children with all agencies using the same assessment framework which keeps the child at the centre. It involves a physical, social, educational, emotional, spiritual and psychological assessment of their development.

Three domains are considered and the assessment can be described as a triangle as shown below:

## The Assessment Triangle

The Whole Child: Physical, social, educational, emotional, spiritual and psychological development



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Source: *Getting it Right for Every Child, Scottish Executive, 2005, Section 3*

Assessment involves identifying whether needs are being met and consideration is also given to strengths, weaknesses and protective factors in the child's circumstances. Currently this assessment is carried out by a single agency. Integrated Assessment is expected to identify the most vulnerable children and provide a clear action plan to support intervention with all professionals involved working to the same frame of reference, and taking into account the family and community context of the child.

### ***3.4 Integrated Team - Parents and Children Together (PACT)***

These new integrated health, social work and voluntary sector teams have been developed across CHCPs. The staff involved includes health visitors, community nursery nurses, social workers, social care assistants and health support workers. They aim to improve the health and well-being of the most vulnerable children and families via integrated multi agency working by providing intensive, time limited, planned interventions and support to children and families. The information will be recorded and held via the Care First system.

There are current discussions around the PACT taking on the assessments received from Police where there has been an incident of domestic abuse and children are present. This would appear to be a positive move towards supporting vulnerable children in a more multi agency/disciplinary way.

## **4 Voluntary and community services for children in East Glasgow**

Across the East Glasgow CHCP area there are over 300 voluntary and community groups providing a wide range of services. A number of these are in relation to children and young people. There tends to be an accumulation of projects in both parts of the area previously covered by the Social Inclusion Partnership (SIPs) in reflection of the deprivation factors and funding opportunities and consequently these projects often have a geographical constraint to them. There are few services that focus on specific issues and are mostly linked to deprivation generally and not directed to other aspects of inequality. It is not possible to detail all the projects within the East Glasgow CHCP area in this paper; however a description will be given of some projects which are attempting to address needs of most vulnerable children and families.

### **4.1 Geeza Break**

This organization has now been running within the East Glasgow area for thirteen years. It aims to provide a range of services all targeted at enabling children (0-18 years) and their families to enjoy a good quality of life. Families are generally experiencing stress, crises or isolation, usually as a result of multiple factors within their lives. Families may be affected by health issues, addiction problems, parenting issues, behaviour problems or disability. Families can be offered a package of care dependant on needs and includes a variety of services from centre based activities to overnight respite.

### **4.2 Greater Easterhouse Money Advice Project (GEMAP)**

GEMAP initially provided traditional money advice, information and support but has more recently also developed Financial Inclusion modules for young people attending Enhanced Vocational Inclusion Project courses. This is provided in local colleges and aims to give young people (15-16years) who have been excluded from mainstream education, vocational skills which will enhance their employability prospects. The financial inclusion work involves a 20 hour programme looking at all aspects of money from budgeting to credit services. A variety of outcome measures are used including the project facilitating young people in opening bank accounts to receive their Educational Maintenance Allowance. To date, 41 out of 58 young people attending to date have opened bank accounts.

### **4.3 East End Child Safety Project**

This community initiative was established in 1996 in response to the higher rate of accidents occurring in children living in the most disadvantaged circumstances. Its aims are as follows:

- To provide home safety information and equipment to families of newborns within East Glasgow who meet qualifying criteria.
- Capacity Building

The project starts with newborns and provides equipment, information and follow-up support until the child is approximately two years old.

## **5 A Practical Example of Combining Data: Mental Health Information**

While we have presented some examples above of our findings about information and services, our initial exploration of data and local information about children in East Glasgow CHCP revealed a bewildering volume of databases, surveys, research studies and grey literature with few links being made between information, inequalities, and local service developments, either in needs assessments (where they existed) or in project reports. In order to attempt to build a more comprehensive picture of children and inequalities in the East Glasgow CHCP from the available data, the project team chose a topic to provide a focus for our exploration. We chose to focus on mental health, as mental health problems in children appeared to be an issue of increasing concern in Scotland, and we used a broad definition to take in known risk factors such as long-term limiting illness and poverty as measured through lone parent households.

### ***5.1 National and local routinely collected data***

Table 1 contains a sample of eleven indicators that could potentially be used to monitor inequalities related to mental health in East Glasgow CHCP. All indicators have some limitations due to the fact that CHCP-level information was not yet available during the period of study. Nevertheless we think they are a good approximation of the reality of the areas shown and are very useful for local and national comparison.

The figures are mostly presented for Eastern Glasgow and Bridgeton & Denniston communities, which have been merged together to form most of East Glasgow CHCP (with some additional boundary differences). We used population figures from GRO, deprivation indicator from the Scottish Index of Multiple Deprivation, suicide and self-harm hospital admissions from Information Services Division (ISD), antidepressant prescribing information held by ISD's Prescribing Team and Census 2001 information (some of these indicators are also available in the Community Profiles created by Health Scotland<sup>44</sup>). Some notable issues include that:

- East Glasgow CHCP has a population of 169,530 residents. The proportion of children aged 0-15 is 1% higher than Glasgow and Scotland as a whole.
- East Glasgow CHCP is very deprived with 50% of its datazones located in the most deprived SIMD decile.
- Both Eastern Glasgow and Bridgeton & Denniston present a high average rate of suicide and self-harm related hospital admission between the period 2000-2002 comparing with the national rate.
- The number of Antidepressant Defined Daily Doses prescribed in both communities is higher than the Scottish average.
- According to the 2001 Census, the two communities that currently comprise the majority of East Glasgow CHCP present a high proportion of lone parents households with dependent children.

Table 1 Sample of indicators to monitor inequalities on children in East Glasgow CHCP

Indicator	Year	East Glasgow CHCP		Glasgow	Scotland
		Eastern Glasgow	Bridgeton & Dennistoun		
Population All ages	GRO 2004	169,530		867,083	5,078,400
Population 0-15	GRO 2004	32,527		156,133	935,456
Deprivation Median SIMD decile??	GRO 2004	10		8	6
Number of deaths suicide/Intentional self-harm	GRO 2004	NP	NP	106	606
Hospital Admissions-suicide/delib self-harm <sub>1</sub>	ISD/SMR 01 Centred average 00/02	348.2	421.6	NP	312.7
First Psychiatric hospital admission <sub>2</sub>	Let Glasgow Flourish 1999-2001	230	322	NP	192
Long term limiting illness Age 0-16 <i>Census 2001</i>	Census 2001	NP	NP	5.4%	4.6%
Self-assessed health (classified as "not good") Age 0-16	Census 2001	NP	NP	1.71%	1.26%
AD Prescribing <sub>3</sub> <i>Year 2002</i>	Prescribing 2002	2201.6	1769.0	NP	1790.5
QoF Mental Health at Prevalance <sub>4</sub>	Feb 2005	NP	NP	0.6	0.6
Lone parents households with dependent children <sub>5</sub>	Let Glasgow Flourish Census 2001	45%		33%	25%

"NP" Not published

1. Age-standardised rate per 100,000 population.
2. Average annual age-standardised rates
3. Defined daily doses per 100 Pop
4. Prevalence = number of patients on the disease register for this condition, divided by list size, multiplied by 100. The Qof disease registers, on which the



- prevalence rates are based, are intended to cover "people with severe long term mental health problems who require and have agreed to regular follow-up".
5. The denominator relates to the number of households with dependent children

## ***5.2 Data from local services***

In relation to children and young people's mental health, there is an extensive range of services available. While work is currently being developed around children with parents who have substance abuse problems, there appears to be limited information related to parents with mental health problems. The Perinatal Mental Health Pathway is, however, being introduced and this should address some of this issue.

Mental Health Services for children and young people are provided by a range of agencies including health, social work, education, and criminal justice, as well as the voluntary sector. Services are tiered in levels of support and professionals who are able to help, as follows:

- Tier 1 is the universal support from primary care, GP's, school nurses and teachers who are also able to access other local services such as East End Mentoring Project and Listening Ear, and transition work between primary and secondary schools.
- Tier 2 is provided by specialists often working individually and includes psychology both via educational and community child health. Some services facilitate access to Tier 3
- Tier 3 is multidisciplinary mental health services which are designed to deal with more complex problems of a moderate to severe nature. These services are provided for example by community psychiatric teams, residential schools and clinical psychology.
- Tier 4 includes much more specialist services for the management of complex problems that require considerable resources and include specialist out-patient teams, in-patient and day units for children and adolescents who present with severe and complex mental health disorders.

Interventions involve children and young people being referred through tiers as necessary.

Data collection for health services is in the CORC (CAMHS Outcomes Research Consortium) database however not all services are currently using this method.

Other services and projects which have aims that include improving the mental health and well-being of children are provided by a wide range of statutory and voluntary community based agencies in the CHCP area which are too numerous to be included in this short exploration. However, it is likely that we can extrapolate from our initial enquires that there are few data sources that can link with each other to provide a comprehensive picture.

### ***1.3 Conclusion from the exploration of mental health data***

We found a range of useful indicators which could be used to monitor progress on some of the determinants and outcomes for children's mental health, and signs that initiatives are in place that might contribute further in the future. However, there were many gaps in routine, survey and local data: a comprehensive picture of prevalence of mental health problems, determinants, service need and service use would, therefore, require additional data collection and research.

## 6 Discussion

In the light of current policy drivers to reduce health inequalities, this project aimed to examine the ways in which data from routine databases, surveys and project reports could be brought together to understand and describe health inequalities issues as they affected children at a local level.

We were probably not the first team to find that this is a complex arena with many gaps and dilemmas. One of the main problems encountered when looking at databases of routinely collected data is that they were not set up with an inequalities perspective. For example, poverty is presented in geographical terms, but experienced at an individual level. That is, not all people who live in deprived areas are living in poverty, just as not all people living in affluent areas are well-off. Knowing the geographical distribution of deprivation therefore only provides one dimension of understanding the link between poverty and poor health. Similarly, the gender of the patient/client is usually recorded in routine and survey data collection, but provides only information about the biological outcome of the impact of gender on health and offers no comment on the effect of gender roles on health. In addition, other societal factors linked strongly to health inequalities are not routinely collected such as ethnicity and disability.

Survey data can help to bring a deeper understanding of patterns of behaviour and outcomes relating to health and social inequalities, but they rarely capture children's perspectives, and usually do not include sufficient numbers to be able to draw conclusions about small areas.

Information from community based services and projects come in a range of formats, are of variable quality, and are often incompatible with other local data, which presents difficulties in building a comprehensive understanding of local health issues and community and service responses to them. Local information ranges from formal data collected on service use, which may be collected at different levels, such as for Glasgow City, Greater Glasgow and Clyde NHS Board area or Scotland-wide, to reports on individual project developments. For example, we found some surveys and projects around young people's and parents' confidence and well-being, and data on service satisfaction. However, this type of information is usually collected in order to review the worth of specific projects within a given timescale. The information is rarely recorded and displayed in formats that are useful beyond the specific project it is gathered for, and is rarely followed up due to the short term nature of the initiatives or funding opportunities.

In trying to build a picture of the services available to children in East Glasgow from an information perspective, we looked at a broad range of databases from health, social work and education. There are some initiatives ongoing at the time of writing to bring together different databases - for example, to support the implementation of single, shared assessments, or to integrate services such as care pathways between statutory and voluntary agencies for specific conditions. However, databases from different agencies, or even different departments within agencies are not necessarily compatible, and trying to match information can highlight a number of problems with both the matching process and with the individual databases. In addition, most of this type of data describes access to and use of services, but does not often shed light on service outcomes. The latter are important to know for different population groups so as to ascertain whether services are working towards a more equitable distribution of good health across a population. For example, prescribing data can only tell us what prescriptions are written but not whether patients take the medicines.

Project reports can sometimes provide information on needs assessments carried out, plans for developing projects, narrative final reports, or satisfaction of service users. However, reports tend to be of varying quality and are unlikely to have generalisability, as there appears to be a lack of staff capacity and IT resources within projects and services for collecting, analysing, using and reporting data. Statutory services at a local level, as well as local projects, generally provide holistic services that deal with a range of issues relating to health and well-being of children. They are likely to have different starting points, objectives and lines of accountability, and therefore their services fall into different data collection categories even if they are responding to the same issues. In addition, services responding to the complexity of health inequalities are likely to find that they have to simplify reporting in order to fit their activities into existing information sources.

In order to demonstrate ways in which routine, survey and local data might be collated for a CHP on an inequalities issue impacting on children, we focused on mental health as it affected children in East Glasgow. We found a range of indicators that could be used to identify an expected level of serious mental health problems affecting children and their carers in East Glasgow and a small number of indicators that might help to predict potential prevalence. Indicators were drawn from a number of sources, some of which are accessible to anyone who requires them while others would have to be calculated from raw data by a specialist (indicated as “not published” in the table). There were no gender analyses available and no data on ethnicity. There were a large number of projects and agencies providing services to support children and families, but no narrative or project reports that we could find providing information specifically about the delivery of mental health services to children.

The exercise also highlighted the need for expertise in accessing and analysing data if CH/CPs are to make best use of available data and narrative reports. Our team member responsible for the database exploration was seconded from ISD, with contacts and expertise in database use, which would not usually be easily accessible to East Glasgow CHCP. Similarly, local projects were explored by an experienced, senior CHCP professional, who had worked in East Glasgow communities for over fifteen years, and had a comprehensive knowledge of children’s services and community provision that cannot be guaranteed across all CH/CPs. The information was collated and interpreted by a small team including the secondees and additional public health expertise, which again is not routinely available to CH/CPs.

In summary, despite the expertise available to the project, and the vast amount of information produced, we found that the process of identifying indicators for risk factors and health impact of social inequalities on children, was limited by three main factors as follows:

- availability of information relevant to health inequalities collected nationally and locally
- accessibility of databases, and
- capacity for analysis and interpretation within CH/CPs.

## **7 Conclusions and next steps**

In this project we attempted to use routine, survey and local information sources to build a picture of how social inequalities might impact on the health and well-being of children in East Glasgow CHCP, and to identify from this priorities relating to inequalities and children. The project was time-limited and the complexity and extent of national and local data sources that could potentially be explored meant that we spent a great deal more time exploring the availability of data than expected and consequently were unable to produce conclusions about priorities and indicators meaningful to service activity for children and inequalities within the project timescale. We will carry these objectives forward to be explored further by a longer-term initiative, “Developing a CHP Monitoring Framework for Health and Social Inequalities” by Glasgow Centre for Population Health in conjunction with Greater Glasgow and Clyde NHS, Greater Glasgow and Clyde CH/CPs and Glasgow City Council.

We conclude from this project that CH/CPs do not currently have the tools to fully describe or analyse the impact of social inequalities on the health and well-being of children, through using routine, survey or qualitative data. While there is a wealth of general and specific information collected, CH/CPs need to be able to use available data creatively and fill gaps with a judicious use of information from wider sources, such as locally-based and other research studies if data is to be used to inform planning processes. We argue that health and social services need a greater understanding of the gaps in the existing data so that we do not over-simplify the complexity of health and social inequalities and consequently draw the wrong conclusions from data that is incomplete.

The project highlighted issues that we believe must be taken into consideration when using available data for exploring health inequalities issues at CH/CP level, and that further work needs carried out in order to strengthen CH/CPs use of data for understanding of and monitoring activity on health and social inequalities. GCPH will take forward these issues by working with partners and others, including ISD, GG&C NHS, Council departments and CH/CPs to address the main issues highlighted as follows:

- 1. Expertise is available to CH/CPs for analysing and interpreting data, but it is spread thinly on the ground. We will explore how capacity within CH/CPs can be improved for quantitative and qualitative data analysis and interpretation.**
- 2. Issues relating to health and social inequalities do not always fit with current information structures and should not be assumed to do so. Support is required for CH/CPs to identify and explore alternative sources of information relating to health and social inequalities, and the GCPH project mentioned above will identify relevant means of support for the CH/CPs.**
- 3. An additional area identified by the project which might warrant further exploration was whether development of the role of voluntary sector organisations in providing information for population research can be balanced against their roles in service provision in a climate of financial restriction.**

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