



TAYSIDE HEALTH INEQUALITIES STRATEGY

BEST PRACTICE AND EVIDENCED INTERVENTION IN INEQUALITIES

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1 INTRODUCTION

This paper is intended to provide information, based on current research, on the main contributors to poor health in the community, in particular their association with inequalities in health and assess the evidence for the various interventions to tackle these behaviours.

It focuses on the six health behaviours that will have the greatest impact on reducing inequalities in health:

- smoking;
- diet and nutrition;
- exercise;
- substance misuse;
- sexual health; and
- mental wellbeing

and assesses the relative effectiveness of the different interventions and makes recommendations for best practice.

Appendix 1 shows how each of these themes impacts on the areas identified in the Population Profile as significant inequalities in Tayside.

Whilst evidenced practice should underpin the actions we take, it is important to acknowledge that conclusive evidence is not always available. For instance the lack of research aimed at assessing the effectiveness of interventions that tackle the broader determinants of health should not be seen as evidence that these policies are not effective. It may simply reflect that there is insufficient research in this area or they are less amenable to research aimed at assessing effectiveness. In these circumstances we may have to rely on an intuitive response to guide our action.

There are a number of common features for effective health improvement: partnership working, involving local communities and health needs assessment that underpin the actions recommended in the paper.

The recommendations need to be interpreted in the context of local needs and circumstances. It will also be important to link up, integrate and build on local programmes that are already being developed.

2 SMOKING

2.1 Links to ill health

Smoking is a major contributor to illness and death. It causes 1 in 3 cancer deaths in the UK and accounts for 84% of all lung cancers deaths. It is also a cause in many other serious conditions such as heart disease, stroke, diabetes, chronic obstructive lung disease (COPD), asthma and other respiratory diseases, peripheral vascular disease, osteoporosis and complications in pregnancy. Smokers are also at an increased risk of type-2 diabetes. A 35 year old male smoker who continues to smoke can expect to live seven years less than a non-smoker. In addition many smokers will also face years of discomfort and disability from tobacco related disorders.

Around a third of Scottish women smoke in early pregnancy. Women who smoke during pregnancy are at greater risk of giving birth to preterm and/or low birth weight babies. Smoking during pregnancy can also increase risk of disease such as diabetes in later life. Smoking during pregnancy is the single largest preventable cause of disease and death in the foetus and infants and accounts for a third of all perinatal deaths.

Smoking rates in deprived communities are considerably higher than other communities. Smoking rates are five times higher among women and three times higher among men in the most disadvantaged groups. In men smoking accounts for 50% of the difference in risk of premature death between social classes. Premature deaths from lung cancer are five times higher in men in unskilled manual work than among the professional classes. Pregnant teenagers are most likely to smoke. This is because of the link with deprivation and is also associated with early school leaving, unemployment and living with other smokers. Regular young smokers are more likely to use illegal drugs. Young smokers are more likely to demonstrate poor academic performance and have an unhealthy diet and drink more heavily.

Recent studies have shown that smoking levels have remained virtually unchanged among the poorest groups in society.

2.2 Evidence for interventions

A comprehensive, community wide approach has been identified as the strategy most likely to have the greatest long-term population impact on smoking. The World Health Organisation stated in 1998 that *“As well as approaches aimed at the individual, there has been a recognition of the need for policy and legislative measures and social and environmental as essential components of any strategy to reduce tobacco use”*. The key elements of a comprehensive policy are set out in the Tobacco White Paper and include:

- strong mass media led information campaigns
- smoke-free public places, especially workplaces
- NHS smoking cessation programmes
- Community based initiatives
- Harm reduction strategies

Mass Media Campaigns

These can raise level of awareness. However they only have a very limited impact in terms of attitude and behaviour change. However the use of media to support local cessation services can be effective.

Smoking in Public Places

There are strong public health grounds to restricting smoking in public places. The creation of a non-smoking environment to create a climate of non-smoking as the norm is a crucial element in the smoking prevention/cessation agenda. Shops and licensed premises are key target areas. Strict no-smoking policies within the Public Services sector are also important. Workplace bans can reduce smoking and consumption rates.

Smoking Cessation

Smoking Cessation Services (SCS) have been established as a cost effective means to reduce smoking. Repeated brief advice from any health professional can result in an increase of 2% to 3% in number of smokers not smoking for 6 months or longer compared to no advice. And intensive advice – one-to-one or smoking cessation clinics - can result in an increase of 8%. The use of Nicotine Replacement Therapy (NRT) and Bupropion (Zyban), in conjunction with advice and support of health care workers, can double the chance of success of smokers wishing to stop. Cessation advice and support for hospital patients can result in a 5% increase in the number of smokers giving up for six months or longer.

Smoking cessation programmes for young mothers and their partners during the early part of pregnancy are critically important. Advice and support for pregnant women can result in a 7% increase in number of women still not smoking at 6 months or longer. The development of pre-natal education programmes, including smoking, could contribute to reducing smoking in pregnancy.

There is little evidence that cutting down shows any health benefit, and although it lead to positive behavioural patterns, quitting should be emphasised in cessation programmes.

Recent evidence from work in Tayside has indicated that a large proportion of those seeking support to give up smoking are from lower socio-economic groups.

Who to target: young people or adults?

Many people feel instinctively that since smoking is so difficult to give up, it would make more sense to concentrate efforts on preventing its uptake by young people. Young people are already aware of the health risks associated with smoking. They do not think about the long-term risks and this is particularly marked in young people from deprived communities. However, there is little evidence that teenage interventions, especially in absence of adult strategies have any impact on the uptake of smoking among children. There is a view that it is more effective to target young adults.

Currently there is a lack of evidence regarding the effectiveness of smoking education in schools. However the holistic **health promoting schools** approach, which includes smoking prevention and cessation, is considered as a model of best practice. This approach should include the development of total no-smoking policies for teachers and pupils.

Under-age Purchase of Cigarettes

Access to cigarettes is a crucial factor in young people starting and continuing to smoke. The drive towards stopping this illegal practice needs to continue.

Community based initiatives

These kinds of projects are usually local and community driven and involve many agencies. Initial activities are not necessarily targeted directly at smoking behaviour but may address other issues that contribute to the incidence of smoking behaviour and create barriers to cessation.

Attempts to set up community-based project to promote smoking cessation have been mixed. One problem encountered with community projects is the difficulty of sustainability – often linked to funding. It is important to recognise that these initiatives will only produce measurable outcomes after a lengthy period of time.

2.3 What action we have already taken in Tayside

In addition to mainstream health services, NHS Tayside and the Community Planning Partnerships have already begun to take action that addresses the level of smoking within our communities. Some of the key elements in this work include:

- smoking cessation services
- providing training courses for staff
- a smoking helpline
- initiatives through the Health Promoting Schools and New Community Schools
- No-smoking at work policies, including support for staff to give up
- Support for National No-Smoking Day as part of our programme to raise awareness
- Supporting the Healthy Living Initiative in Dundee

We have been successful in obtaining funding in 2003 through ASH to further develop services to tackle smoking among pregnant women in Dundee. We have also applied for funding from the New Opportunities Fund that will allow us to address smoking prevention in young people.

2.4 Recommendations

- NHS Tayside should provide a specialist smoking cessation service for pregnancy women their partners and families who do not currently access mainstream services (about 1000 women per year) by December 2003.
- NHS Tayside should provide recurrent funding for population-wide smoking cessation services as well as additional resources that will target communities where there is a high level of smoking by March 2004.
- NHS Tayside should support initiatives that address smoking amongst young people, including the recent NOF bid and explore with the Community Planning Partners how we can begin to address under-age purchasing of tobacco.
- NHS Tayside should sponsor an award scheme, which will reward schools that show progress towards locally agreed targets and/or support activities designed

to reduce smoking in young people. This scheme, which will reward schools that make greatest progress in reducing smoking, will be in place by March 2004.

3 DIET AND NUTRITION

3.1 Links to ill health

The Scottish diet is high in fat, salt and sugar and low in fruit and vegetables. Next to smoking our diet is the single most significant cause of Scotland's poor health. Diet plays a fundamental role in the development of Coronary Heart Disease (CHD) and a number of other important chronic conditions such as stroke, type-2 diabetes and obesity.

Death in middle age in Scotland is twice as likely as in many western European countries. Our poor eating habits are a significant factor in many of these premature deaths. The probability of dying under the age of 65 is currently 34% greater than in England. Diet-related disease among the population contributes substantially to healthcare costs in Scotland and to a much reduced quality of life for sufferers.

The type and amount of fat and its relationship to blood cholesterol levels have been recognised for some time as being particularly influential. High levels of salt in the diet may contribute to high blood pressure. There is an association between the intake of fruit and vegetables and a reduced rate of CHD and certain cancers, for example colorectal, stomach, oesophagus and mouth cancers.

Obesity is a major and growing cause for concern. This is a condition in which body fat stores are enlarged to an extent that it impairs health and is a contributing factor to heart disease, several cancers, stroke, and type-2 diabetes.

Diet in early years is a very important influence on health in later life. Early childhood experiences strongly influence dietary preference and good eating habits. Breastfeeding can reduce risk of sudden infant death, a wide range of infections, such as asthma and eczema, reduce risk of diabetes, and enhance immunity as well as reduce the risks of breast cancer and ovarian cancer in women who breastfeed.

There are inequalities in diet between those on higher and lower incomes. The most striking difference is that people living in the poorest communities tend to eat 50% less fruit and vegetables than professional groups. The numbers of overweight and obese people increase with social deprivation. Breastfeeding rates are also linked with deprivation. In Tayside 70% of mothers in the least deprived areas breastfeed compared with only 30% in the most deprived areas.

High consumption of sugary foods and carbonated drinks are linked to high levels of dental caries, especially in small children. One of the main contributors to severe tooth decay in young children is the inappropriate use of baby feeding bottles, especially where bottles are used for squash or fruit juice and are left in the child's mouth as a pacifier. Studies have shown that level of tooth decay in childhood is a good predictor of oral health in later life. Children from more deprived communities and ethnic minority populations are more likely to have higher incidence of dental caries.

Studies have shown that people on a low income can describe a healthy diet as well as those on higher incomes. Affordability, knowledge and access to healthy foods and a healthy and varied diet have been identified as possible barriers. In some areas it is difficult to access affordable quality fruit and vegetables. Understanding of healthy eating messages varies widely among ethnic minority groups and certain ethnic groups use a lot of fat in their cooking. Older people, especially the frail elderly, have difficulties in accessing food both in terms of transport and income. In general people still do not understand the nutritional messages.

3.2 Evidence for interventions

Dietary interventions can be effective in reducing risk factors for CHD and some cancers. The type and amount of fat in a person's diet and the relationship to blood cholesterol and risk factors for CHD are well recognised. A reduction of 10% in the consumption of saturated fats in the UK population would be associated with a reduction of 20% to 30% of deaths from CHD. Increasing the population's average intake of fruit and vegetables to at least 5 portions each day is the second most important strategy in reducing cancers after reducing the rate of smoking.

Providing information is not enough to change behaviours – information needs to be linked to action to improve peoples' access to the right foods and cookery skills. The most effective interventions to promote a healthy diet are characterised by:

- A focus on diet alone or on diet and exercise
- Personal contact was maintained with individuals/small groups over time and individuals were given feedback on any changes in behaviour and risk factors
- Local shops and catering outlets were involved to help people make healthy food choices

Strategies to promote healthy eating among children will benefit in the longer term.

A Whole School Approach to Promoting Healthy Eating

This approach, which ideally should be part of the wider Health Promoting Schools initiative, includes developing healthy menus, tasting opportunities, developed curriculum, cooking skills, parental involvement and provision of free fruit (to primary schools and pre-schools), healthy tuckshops and breakfast clubs.

This whole school approach is more effective than individual activities in isolation. It develops knowledge and positive attitudes towards healthy eating and has shown changes in the intake of foods such as fruit and vegetables.

Healthy School Menus

Good nutritional standards in school meals are an important contributor to a healthy diet and encourage young people to eat more healthily. In primary schools it can help to establish a behaviour pattern, while in secondary schools it can help to keep youngsters away from the chip vans and shops.

Breakfast Clubs

The creation of breakfast clubs has led to improvements in behaviour and attainment in school as well as increased consumption of cereal and juice, intake of iron and micro

nutrients. However, to be successful breakfast clubs must have parental support, effective management, foster a “club” atmosphere as well as school ownership.

Healthy Tuck Shops

These can offer alternatives to high fat and high salt snacks and provide opportunities of increasing consumption of fruit and vegetables. Pupil-led initiatives also foster good self-esteem and ownership.

Free Fruit in Primary Schools and Pre-schools

The provision of one piece of fruit to each pupil every day will contribute to a healthy diet.

Cooking Skills Clubs

This can stimulate interest and confidence to develop cooking skills especially with healthy foods. If focused on young people, it can help reinforce what is being taught in class. These clubs are usually in out of school hours or in holidays.

Promoting healthy eating in pre-school

Educational programmes to increase children and their parents' nutritional knowledge and can improve main meal provision and also provision of free fruit and main meals.

Oral health

The only interventions that have reliably demonstrated a reduction in caries were those involving the use of some form of fluoride. Meta-analysis of studies that looked at the effect of enhanced tooth brushing has shown a 30% reduction in plaque levels. Simple advice appears to be as effective as more time-consuming oral health promoting activities. There is increasing evidence that community nurses are effective in providing oral health education and advice; this may be of particular importance in deprived areas where these staff may already have a rapport with families.

Community projects

Food projects are not the only answer to improving health inequalities, but they can be part of a wider strategy to improve health. They can give people greater confidence in buying cooking and eating a wider variety of foods. Effective community interventions appear to focus on diet or diet plus physical activity; use a theoretical model; use different multiple interventions at individual group, community and environmental level. Successful projects are also characterised by their adaptability to local needs and circumstances; access to secure, ongoing resources, effective partnership with the local community and involvement of local people as active and equal partners as well as having time to develop.

Community Cafés can offer healthy affordable meals in an informal setting. Evidence to show that young people find this kind of outlet attractive and will eat healthy foods if presented in interesting and innovative ways, for example ‘juice bars’. **Food co-ops** can offer increased availability and affordability of fresh fruit and vegetables as well as contributing to self-esteem and confidence of those members of the community who run them. **Cookery classes** can be run in conjunction with local groups and local food retailers and help provide people with the knowledge and skills to improve their diet. Evaluations also report wider health benefits such as reducing social isolation and building self-confidence. **Transport to shops schemes** can improve peoples’ access to affordable health foods. Supermarkets can also provide delivery services to deprived

communities – this avoids the discomfort felt by people in poorer communities when shopping in a spend-focused retail environment.

The elderly

Evidence points to the importance of initiatives, which tackle under-nutrition for homebound and institution-bound elderly people. More research is needed on nutritional content of meals that elderly people prepare in their own homes.

Obesity

Specialist obesity services can contribute significantly to the reduction of this problem. However, integrated health promotion initiatives are also crucial. Intervention focusing on increased exercise and regulation of diet can help to reduce this problem, but earlier prevention approaches focusing on self-esteem are also important.

Primary Care

There is evidence that supports continued strengthening of primary care services in providing primary and secondary prevention including one to one advice and support.

Breastfeeding

Normalising breastfeeding in society would help resolve the social and cultural attitudes and barriers. 90% of women who stop breastfeeding cite embarrassment as the reason (Hamlyn et al 2002). Recommendations on best practice focus on the development of peer support groups, roll-out of baby-friendly GP pilots in LHCCs, further development of initiatives in Child and Family Centres, incentives for young mothers (under 20) to breastfeed.

3.3 What action we have already taken in Tayside

In addition to mainstream health services, NHS Tayside and the Community Planning Partnerships have already begun to take action that will improve diet, access and consumption of healthy foods within our communities. Some of the key elements in this work include:

- supporting food co-ops
- supporting the Healthy Living Initiative in Dundee
- nutrition guidelines introduced for older people
- schools across Tayside have set up healthy tuckshops, breakfast clubs and introduced healthy options for school meals
- a Breastfeeding Co-ordinator
- Health Visitors provide free toothpaste and toothbrushes for all 8-month to one year old children and to children aged two to three in areas of deprivation
- encouraging healthy food choices in the workplace (SHAW)
- NHS Tayside runs a healthy choice award scheme for catering outlets

3.4 Recommendations

- NHS Tayside should support the development of food co-operatives allied to cookery skills programmes in order to improve access to healthy foods and support people living in areas of greatest deprivation to make healthier choices.

There should be a least one new or expanded food co-operative set up in each Perth and Kinross and Angus and two in Dundee City by March 2004.

- NHS Tayside should explore opportunities to work with partners to support community cafes
- NHS Tayside should develop an action plan designed to meet national standards for nutrition in the elderly who are cared for in hospitals and care homes by March 2004
- NHS Tayside should work with local communities to set up peer support groups to encourage and support breastfeeding amongst women living in the most deprived communities
- NHS Tayside should sponsor an award scheme, which will reward schools that show progress towards locally agreed targets and/or support activities designed to improve diet. This scheme, which will reward schools that make greatest progress in improving access and take up of a healthier diet, will be in place by March 2004.

4 PHYSICAL EXERCISE

4.1 Links to ill health

A physically active lifestyle is important for health. Currently 27% of boys and 40% of girls are not meeting the requirements of one hour of moderate activity on most days each week. 72% of women and 59% of men are also not meeting the requirement to accumulate 30 minutes of moderate activity on most days each week. The trend starts before young people have left school.

Lack of exercise is linked to a number of serious illnesses. People who do not take the recommended level of exercise are:

- at twice the risk of heart disease,
- almost four times more likely to get cancer of the colon,
- more likely to suffer from higher blood pressure, and
- be overweight.

In addition statistics predict that each week 42 people in Scotland will die of heart disease because they are inactive.

Physical exercise is also important in controlling diabetes (can reduce the risk of type 2 diabetes by 50%), regulating weight and reducing the risks of osteoporosis, and colon cancer. Exercise can improve self-esteem, reduce anxiety, contribute to a longer life, reduce disease and contribute to overall well being.

Evidence shows that the proportion of sedentary adults in the lowest socio-economic groups is double that of those from highest socio-economic groups.

The reason target groups do not take exercise include:

- prefer to do other things
- feeling fat
- do not enjoy exercise
- too old
- lack of time
- lack of facilities/or expense
- lack of transport
- skills/confidence

Minority ethnic groups may also experience additional barriers of racism and concerns about body shape.

4.2 Evidence for interventions

A review of randomised controlled trial of physical activity promotion found some evidence that exercise can be increased and maintained for up to two years. Interventions that encourage walking and do not require attendance at a facility appear most likely to lead to sustainable increases in physical activity. Brisk walking can lead to the majority of health benefits associated with physical activity.

Children and Young People

Physical activity programmes in schools have been associated with a number of positive changes. Interventions are more likely to be successful when young people are involved in planning programmes, the programmes are designed according to young peoples' needs and are part of a whole school approach to the promotion of physical activity, including the curriculum and safe transport routes to school.

Adults of Working Age

There are mixed results on the effectiveness of primary care interventions, but these have been shown to be moderately effective. Frequent professional contact is associated with adherence. Long-term effects are more likely with continuing interventions and behavioural approaches. A benefit of primary care intervention is that it can reach large numbers of the population. There is some short-term evidence that **exercise referral schemes** increases the level activity. However, there is no evidence for sustainable behaviour change.

Research shows that co-ordinated health programmes in the workplace can lead to increases in physical activity.

Reducing inequity

Good practice in work on physical activity and inequalities include proactive outreach work; a multidisciplinary approach, involving the targeted communities and developing partnerships with professionals who have good access to 'hard to reach' groups.

4.3 What action we have already taken in Tayside

In addition to mainstream health services, NHS Tayside and the Community Planning Partnerships have already begun to take action that will encourage and enable people to take regular exercise. Some of the key elements in this work include:

- Exercise referral schemes are operating in Dundee and Perth and Kinross and will soon be implemented in Angus
- Initiatives through the Health Promoting Schools and New Community Schools
- In Angus schools there is daily 20 minutes exercise classes for children in primary classes 4 to 7
- Supporting the Healthy Living Initiative in Dundee
- Supporting Scotland's Health at Work Schemes

4.4 Recommendations

It is crucially important to increase the range and quality of physical activity in schools. Children should take part in at least two hours of physical activity classes per week. All children including those with disabilities should gain the movement and behavioural skills necessary for an active life (sports & dance programmes). These programmes should also apply to Further Education.

- NHS Tayside should work with community planning partnerships to support initiatives designed to increase the number of adults who take 30 minutes of moderate exercise and children who take one hour of moderate activity on most days. This will focus on increasing the level of brisk walking and will include community based fitness initiatives.
- NHS Tayside should sponsor an award scheme which will reward schools that show progress towards locally agreed targets and/or support activities designed to improve levels of physical exercise. This scheme, which will reward schools that make greatest progress in improving levels of physical activity, will be in place by March 2004.

5 DRUGS AND ALCOHOL

5.1 Links to ill health

Drugs and alcohol misuse has a wide ranging and highly damaging effect on the quality of life for individuals, families and communities. One in four adults in the UK are drinking hazardously. Alcohol misuse is a causative factor in a number of cancers and other disorders. The misuse of alcohol can also lead to violence – the Scottish Crime Survey reported that alcohol was involved in 62% of cases of domestic violence.

Patients with alcohol problems consult their GPs about twice as frequently as other patients in the practice and incur significant prescribing costs.

There is also a strong link to deprivation, which in turn ties into other behaviours such as smoking, poor diet and criminal activity. Men living in the most deprived areas (Deprivation Category 7) are seven times more likely to die an alcohol-related death than those in least deprived areas. People living in the most deprived areas are seven times more likely to be admitted to an acute hospital with an alcoholic related diagnosis. Alcohol problems often underlie or exacerbate homelessness.

Children living with alcohol problems within the family are more likely than others to experience physical and sexual abuse, family relationship problems, truancy and other school problems such as under-achieving and bullying. Children who drink frequently themselves are more likely to report drug use.

5.2 Evidence for interventions

It can be difficult to establish the effectiveness of prevention and communications activity on alcohol problems because of the long timescales involved. No one type of action is likely to reduce alcohol problems on its own. A range of action is needed to influence culture, individual attitudes and behaviour.

Campaigns

The evidence to support the effectiveness of campaigns in changing attitudes or behaviour poor is poor. Campaigns may do little more than reinforce the motivation to act by higher socio-economic groups or raise the fear levels of those who already know very little, for example parents about recreational drugs.

School Education

Integrated programmes with more holistic agendas (**Health Promoting Schools**) can be effective. However schools education in isolation will always have a limited benefit and needs to be part of a wider integrated community approach. Best practice for schools will include peer education, use of facilitation models, needs assessment, skills, training, involvement of parents and media training of teachers.

Primary care

The quality of both the effectiveness reviews and the underlying primary studies is variable. However, there is evidence that brief interventions by GPs, nurses, health

visitors and other health professionals are effective in changing drinking behaviour and reducing alcohol consumption of certain groups. Brief interventions to reduce the number of problem drinkers. There is also evidence to support the cost-effectiveness of home and outpatient detoxification for relapse prevention and the use of acamprosate as an adjunct treatment in relapse prevention.

Community

Initiatives should focus on life circumstances. The misuse of alcohol and/or drugs is linked to individuals' lack of hope, feelings of helplessness, poverty of opportunity and environment. Alcohol and drugs issues are priorities for current community development initiatives and New Community Schools.

Initiatives must be undertaken in conjunction with local Drug and Alcohol Action Teams and support the development of integrated multi-agency initiatives, which target at-risk groups.

5.3 What action we have already taken in Tayside

In addition to mainstream health services, NHS Tayside and the Community Planning Partnerships have already begun to take action that will reduce drugs and alcohol misuse in our communities. Some of the key elements in this work include:

- Setting up the DAATs in each local authority area to develop strategies for prevention, as well as treatment and care for people with drugs and alcohol problems
- Health education programmes in schools
- Drop-in facilities for young people
- Supporting the Healthy Living Initiative in Dundee
- Supporting SHAW

5.4 Recommendations

- NHS Tayside should work through the three Drug and Alcohol Action Teams (DAATs) to develop action plans by March 2004 that tackle inequalities relating to the use of drugs and alcohol. This should focus on education and prevention, as well as care and treatment and look to link this work through health promoting schools and community resource centres.
- NHS Tayside should work with community planning partnerships to reduce the availability to alcohol to underage young people and access to drugs as well as working with identified vulnerable groups.

6 SEXUAL HEALTH

6.1 Links to ill health

Unintended pregnancies, especially pregnancy in young teenage girls and sexual infection can have a long-term effect on people's lives.

Sexually active individuals are at risk of a range of sexually transmitted infections (STI), of which *Chlamydia trachomatis* is the most prevalent bacterial infection. Genital chlamydial infection and untreated gonorrhoea can cause considerable short and long-term ill health, which can result in pelvic inflammatory disease (PID), ectopic pregnancy and infertility in women and men.

Poor sexual health is commonly associated with poverty and social exclusion. In Tayside, of prime concern is the pregnancy rate among 13-15 year olds, particularly in areas of deprivation where rates are the highest in Europe. Teenage mothers are more likely to have low birth weight babies, be dependent on state benefits, have a poor knowledge of child development.

6.2 Evidence for interventions

Information and Health Promotion

There is a lack of evidence about educational interventions that will alter sexual behaviour. However, some general points can be established from the social science literature. There are three distinct groups that education should be targeted towards: patients, the general public, and health professionals.

Studies have been undertaken to evaluate the effectiveness of a range of intervention programmes, for example to promote condom use. Community interventions to increase awareness of STIs, promote prompt treatment seeking, and reduce high-risk sexual behaviours have also been reported. However, the effects of the interventions on subsequent behaviour are inconclusive.

Education campaigns that have used multimedia advertising to increase awareness about other sensitive issues, for example HIV/AIDS, have proved successful. However, translating increased awareness into behaviour change is problematic.

There are relatively few studies available on the effectiveness of sexual health promotion in the context of STIs other than for HIV/AIDS. However, countries such as the Netherlands where positive sexual health is addressed from a very early age and which fosters an open culture, has significantly lower rates of STIs.

Successful treatment and control of STIs involves a complex set of behaviours: prompt seeking of health care, compliance with therapy, referral of sexual partners, return for follow up and prevention of re-exposure. The educational needs of patients are likely to vary according to age, gender, social class, social vulnerability, sexual orientation and ethnicity.

The involvement of target groups in the design and distribution of information on sexual health and sexual health services for professionals, the public and especially young people has been shown to be beneficial.

One of the most important components of any educational effort will be the reduction of stigma associated with STIs in general and GUM services.

Sexual Health Programmes in Schools

Integrated sexual health programmes in schools can be successful in raising awareness and developing skills in young people. The involvement of health service staff within an integrated school health plan is crucial. These programmes should also include parents and training of teachers and health staff. School nurse drop-ins should also be provided. The frameworks of the Health Promoting Schools and New Community Schools are useful models.

Contraception

Use of contraception by young people is linked to sex and relationships education, better understanding of services which meet young people's needs, communication with partners and family prior to sex, and access to emergency contraception.

Screening

Appropriate testing for chlamydial infection in defined clinical settings should lead to lower complication rates for individuals and, coupled with wider access to contact tracing, should lead to significant falls in re-infection rates and a reduced pool of infection within the community.

Accessibility of local services

It is important that trained health service staff are able to provide broad-based support and advice to young people in local, young-people friendly venues. This would include nurse-led clinics and school nurse drop-ins and would be focused where need was greatest, usually communities with the highest level of deprivation. These services would also provide sexual health advice and treatment for Sexually Transmitted Infections (STIs). To make sure that these services are successful there should be consultation with young people about the range and type of services offered.

6.3 What action we have already taken in Tayside

In addition to mainstream health services, NHS Tayside and the Community Planning Partnerships have already begun to take action that will improve sexual health. Some of the key elements in this work include:

- Supporting the Corner in Dundee to provide drop-in facilities and information on sexual wellbeing for young people
- Developing young-people friendly services in Angus and Perth and Kinross
- Angus LHCC have created a Youth Worker to work with young people on sexual health issues
- Sexual health programmes in schools
- Set up, CHANT a website aimed at providing accessible information for children and young people

- The Condom Initiative to provide free and easily accessible condoms
- Needle Exchange Services
- Education and outreach services for gay men

6.4 Recommendations

- NHS Tayside should produce a Sexual Health Strategy by December 2004. The strategy should include proposals to:
 - address high levels of teenage pregnancy;
 - reduce transmission rates of STIs;
 - improve access to services , especially for disenfranchised groups;
 - improve service integration and;
 - promote general sexual well-being
- NHS Tayside should continue to work with partners to increase young people friendly services and facilities that will provide sexual health advice and extend the range of direct access services.
- Sexual health promotion should be an integral part of contraception provision wherever this is offered.
- NHS Tayside should explore, with partners, how we effectively promote messages for target groups about prevention and treatment of STIs, especially chlamydial infection.
- Opportunities should be taken to deliver education in a wide variety of non-health care settings e.g. youth clubs, community centres, schools. Education about STIs should be integrated with other sexual health education and condom promotion initiatives.

7 PROMOTING MENTAL WELLBEING

7.1 Links to ill health

In Scotland depression is the most common reason for women aged 25 to 44 to consult their GP, followed by anxiety. Depression ranks in the top five reasons for women of all ages to consult their GP. Mental wellbeing is also linked to other health behaviours such as smoking, substance misuse and poor sexual health.

Life circumstances and lifestyle have a profound influence on mental health and wellbeing. Social disadvantage, emotional strain and family disruption can lead to mental health problems in childhood, adolescence and early adulthood. Children living in poverty are at particular risk, as are looked after children. The recent Child and Adolescent Mental Health Needs Assessment (2002) found the highest proportion of children with any mental disorder (13%) was found amongst families living in areas classified as *striving*. This was about two and a half times the proportion found in more affluent areas.

Suicide rates are also linked to deprivation.

7.2 Evidence for interventions

Promoting mental welling should be focussed around societal change to reduce poverty and social exclusion. Mental wellbeing should be an integral part of other health improvement initiatives/programmes rather than being singled out as an isolated component.

Good practice in service provision should include promotion of mental health, prevention of problems and disorders, identification and assessment of problems and disorders, intervention and management approaches and interagency and liaison and consultation work.

7.3 What action we have already taken in Tayside

In addition to mainstream health services, NHS Tayside and the Community Planning Partnerships have already begun to take action that will improve mental wellbeing. Some of the key elements in this work include:

- Supporting the Corner in Dundee
- Supporting the 'Explore' project in Dundee
- Initiatives through the Health Promoting Schools and New Community Schools
- In Angus we have appointed a Mental Health Promotion Worker through *Sure Start*
- Set up, CHANT a website aimed at providing accessible information for children and young people
- Supporting the Healthy Living Initiative in Dundee
- NHS Tayside held a seminar in 2002 on Prevention of suicide and Self-Harm and produced an Action Plan
- Implementing the Mental Health promotion Framework

7.4 Recommendations

- NHS Tayside should host a conference to explore the broad issues affecting mental well-being and encourage local debate about the contribution that communities can make to a socially inclusive society, which supports people with mental health problems. The conference should develop a working definition of mental wellbeing and provide a forum to draw up realistic action plans designed to promote the wellbeing of disenfranchised groups.
- Training of staff to raise awareness and understanding of mental health promotion should be given priority.
- Mental health promotion in schools should be integrated with social and pastoral care and the wider health promotion agenda, for example sexual health, diet, drugs/alcohol, smoking and exercise.

8 ACCESS AND HEALTH INTELLIGENCE

8.1 Links to ill health

Health is determined by a complex interplay of factors. The way people access and make use of health services has potential implications for their health status and outcomes.

Studies that have looked at the availability of services in different geographical areas show clear differences in provision. A review of the location and accessibility of GP surgeries in Aberdeen found that the location of surgeries clearly favoured the longer established middle class districts of the city and that the deprived areas were poorly served. Transport difficulties to GP surgeries also appear to have a deterrent effect on use of primary care services.

There is evidence that people in lower occupational classes make less use of preventive services for themselves and their children. Lower service use has also been shown for screening and health promotion services, attendance at assessment clinics for pre-school children, frequency of attendance for dental services, attendance a well-women, well-man and cervical cytology clinics. There is an association between deprivation and late presentation with illness.

There is also evidence that classes I and II are more likely to be referred to specialist services by their GP than people in IV and V. There have also been studies that show that clinical investigations for heart disease are performed more frequently on patients from more affluent neighbourhoods. This coupled with the delays in seeking treatment may be an additional contributor to poor health outcomes for social classes IV and V.

There are undoubtedly inequalities that are related to rurality and in particular to isolation to services. These include:

- lack of and difficulty in accessing service and healthy lifestyle choices in the more remote parts of Tayside, especially for the elderly;
- the fear of stigmatization and concerns over anonymity and confidentiality; and
- lack of access to both private and public transport, exacerbated by higher fuel costs.

Members of the ethnic minorities often face additional barriers in accessing and making use of health services.

At present there is limited information about differences in access and uptake of services by different communities in Tayside. This hampers our ability to identify and address the wide range of factors that contribute to health inequalities.

8.2 Evidence for Interventions

It is important that sound methods are developed for evaluating the impact of policies, programme and initiatives on the health of the population and different communities, since activities might have different effects on different groups. Impact on health is not the same as impact on health inequalities – some interventions might generate overall health benefits, but may increase social inequalities in health.

8.3 What action we have already taken in Tayside

Work on taking forwards the **Hierarchy of Care** model will bring more services into local communities. This should help begin to address some of the access issues highlighted above.

NHS Tayside has invested in new, purpose-built primary care facilities to support and extend the range of services available to people living in the more deprived communities of Tayside. We are also piloting **Advanced Access in Primary Care** in 18 practices across Tayside. The scheme aims to provide 90% of patients with a 'same-day' appointment and so far it has resulted in more than a 30% reduction in the time to see a GP and/or practice nurse.

The **Fair for All Action Plan** completed in March 2003 identifies a number of actions that will begin to address issues of race equality in relation to service access and use.

The recommendations of the Tayside Child Health Strategy were based on a self-assessment of local services and Phase 1 of the Child Health Population Profile. The second phase of this work reported in February 2003 and includes not only a Tayside analysis but postcode data in each of the local authority areas.

Phase 1 of the Inequalities Population Profile has drawn on currently available reliable information and has informed this strategy.

8.4 Recommendations

Phase 1 of the Inequalities Strategy has provided limited information on access and uptake of services and their implications on health. Phase 2 will examine in this influence on health inequalities in more detail and include progress on the following SMART objectives:

- NHS Tayside should ensure that guidelines are in place for prescribing statins to make sure that prescribing standards are equally applied across all communities in Tayside. As part of this NHS Tayside should work with the Tayside Centre for General Practice (TCGP) to monitor areas where the prescribing of statins has been shown to be consistently lower.
- NHS Tayside should work with the TCGP and the Community Planning Partners in Angus and Dundee to explore the significance of the data on the admissions to hospital with asthma related symptoms in 0-19 year olds in Angus and Dundee. This will include looking at prevalence and day to day management of asthma.

- NHS Tayside should explore with clinicians working in secondary care the implications of the inequalities strategy on the pattern of provision within Tayside and consider how the particular needs of people living in more deprived communities can be more appropriately met.
- Through the implementation of the Oral Health Strategy NHS Tayside should put in place initiatives that reduce the levels of tooth decay in 0-5 year olds and address the inequalities in dental health within Tayside.
- NHS Tayside should put in place appropriate education and training for staff which will improve our ability to provide culturally competent services.
- In the workplace the **Scotland's Health at Work (SHAW) Initiative** should continue to be rolled out with an emphasis on venues, which have workforces from lower socio-economic groups.
- NHS Tayside should review its provision of information and produce action plans to make sure that there is equal access to information for citizens in all social, educational, cultural and ethnic backgrounds.
- NHS Tayside should work with the Community Planning Partnerships to improve the data on health status of people living in remote and rural areas and issues around their access and uptake of services.
- NHS Tayside should seek to improve the data on older people's health with particular reference to relative health inequalities.
- NHS Tayside should put in place a system to routinely collect ethnic minority monitoring information, including postcodes in the SMR datasets by
- NHS Tayside should undertake jointly with Angus Community Planning Partnership, a project to explore the emerging evidence about the increasing problems related to drugs and alcohol in Angus.

ANN J PEARSON
Assistant Director of Strategy & Development
NHS Tayside

PAUL BALLARD
Consultant in Health Promotion
NHS Tayside
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