the impact of austerity

Also inside this issue of Health Equalities:

Sex and relationships
Reducing teenage pregnancy and sexually transmitted infection rates

Vitamin D
Rickets was thought to be a condition of the past but has lack of sunlight put us at risk?

Faith and HIV
Is the Christian faith a barrier or opportunity for HIV prevention?

GPs at the deep end

the Armed Forces – a health minority?

health inequalities at a local level

Image by Mark Gamsu
Welcome to our second edition of Health Equalities, produced by BHA, the North West based health equality charity. We got really good feedback from our first issue in April: “I think the new magazine looks really good, with lots of interesting material”; “Very useful to have a publication with such a direct focus on health inequalities”; “Really great idea”.

More importantly we got a steer from our readers: “Poverty itself is a major cause of inequality and perhaps a focus on the wider determinants of health needs to be developed more and not just on the disease aspects”, “Inequality in take up of Personal Budgets - older people and BME are not taking up PBs but instead remaining on managed budgets - needs investigation!”.

In this issue we focus on how the economic crisis and the programme of austerity are affecting the lives of individuals and communities, hitting hardest those who already face marginalisation and social exclusion.

• Dr David Blane and Professor Graham Watt summarise the hard-hitting “GPs at the Deep End” report that looks at the impact of austerity on patients and general practices in 100 of Scotland’s most deprived areas. The case-studies give a clear, but shocking, account of the multiple impacts of ill-health, poverty and benefit cuts.

• Simon Blake, Chief Executive of Brook, investigates the impact of austerity on progress made in the last decade on reducing teenage pregnancy rates and the spread of STIs

• Valeska Matziol, from Manchester Local Involvement Network, links a study on the impact of social care funding cuts on people with dementia to the introduction of the ban on age discrimination on 1st October 2012 – arguing that the one undercuts the other.

This edition also covers areas around health inequalities and how we can tackle inequalities faced by different communities.

• Professor Mark Gamsu gives a personal take on how to use the recent King’s Fund report on “Clustering of Unhealthy Behaviours over time” to develop approaches that tackle social and economic determinants of health at a local level.

• Andy Bacon, Director of the Armed Forces Network for NHS Northwest, highlights the issues which mean that service personnel and families face health inequalities – but busts some myths along the way.

• Reverend Ijeoma Ajibade reflects on the fact that for many HIV positive people, religion plays a vital role in their lives, providing a source of well being and explores whether faith is a barrier to or opportunity for HIV prevention.

We’d like to thank these and other contributors to this issue and welcome comments and suggestions for contributions to issue 3 in April 2013.

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BHA would like to thank all contributors and stakeholders who have donated/provided their expertise and time to enable the production of this issue of Health Equalities. To submit an article to the editors: info@theBHA.org.uk

The opinions contained in health equalities are not necessarily those of BHA
Contents

GPs at the Deep End
Scottish GPs give graphic accounts of the health impacts from the Government’s welfare reforms and other austerity measures. Page 4

Tackling Health Inequalities at a local level
Professor Mark Gamsu comments Page 8

A Wider Perspective
Is the social care economy in tatters? and European Public Health Association snapshot 2012 Page 11

Are the Armed Forces a health minority?
The British Armed Forces have been involved in a level of operations not seen for a generation but their dedicated health services have decreased. Page 12

Delivering fairness in revalidation
Niall Dickson, Chief Executive of the GMC, outlines how the new way of regulating licensed doctors, will work when it is introduced in December 2012. Page 16

Age Equality in the Age of Austerity
A closer look at the impact on austerity measures on older people’s equality Page 18

Sex and relationships education - under pressure in an age of austerity
Sustaining the recent progress on reducing teenage pregnancy & sexually transmitted infection rates Page 22

Faith and HIV
Reverend Ijeoma Ajibade reflects on the issue and explores whether faith is a barrier to or opportunity for HIV prevention. Page 24

It takes a whole village to raise a child
The important role of specialist foster carers Page 28

Time to see the light
Rickets was thought to be a condition of the past but is our lack of sunlight putting us at risk? Page 30

Research reviews
by the Health Equality Library Portal Page 34

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Focus on austerity

GPs at the deep end

There are growing concerns about adverse health impacts of the Government’s welfare reforms and other austerity measures. Dr David Blane and Professor Graham Watt present findings from the Deep End Austerity report, which highlights some of these concerns.

Austerity measures were introduced following the UK Government’s spending review announced by the Chancellor in October 2010. This included £81bn of cuts in public spending over four years.

In April 2011, claims for benefits on the basis of incapacity for work were transferred to claims for Employment and Support Allowance (ESA). Entitlement was re-assessed using the new stricter criteria of the Work Capability Assessment (WCA).

The Welfare Reform Act – representing the biggest change to the welfare system for over 60 years – received Royal Assent on 8th March 2012. The Act introduces a new Universal Credit which will replace most existing benefits and limits the total amount of benefit a person can claim.

In February 2012, in response to concerns about the impact of austerity measures, the “GPs at the Deep End” group asked general practitioners working in the 100 most deprived general practices in Scotland the question: “How have the current austerity measures affected your patients and your practice in the last week (beginning 20 February 2012)’?”

Responses to this question, in the form of general comments and individual case studies, were collated and edited to produce the Deep End Austerity Report. The report was sent to all Scottish MPs and MSPs, widely disseminated in the third sector, and reported in the media.

The report gave expression to frontline healthcare providers with an immediacy and relevance that more formal research often lacks. It also raises important questions about the role of GPs and other healthcare workers as advocates, as well as witnesses to society. What follows is an edited version of the report.

Dr. David Blane is Academic Fellow in General Practice at Glasgow University

Professor Graham Watt is Professor of General Practice at Glasgow University
The Deep End Austerity Report’s main findings

Most of the issues raised relate to the direct and indirect outcomes of austerity policies: benefit cuts, service cutbacks, and an increasing number of patients being taken off Employment Support Allowance (ESA) or Disability Living Allowance (DLA). These can be divided into issues affecting patients; practices; secondary care/support services; and social work/housing:

Patient health
A central concern of Deep End practices is the number of patients with deteriorating mental health.

At one end of the spectrum, there are those who are in work, and previously well:
- under increasing stress at own jobs due to cutbacks
- taking on extra work/jobs, with resultant impact on family and relationships
- experiencing stress of job insecurity

At the other end of the spectrum, there are those with chronic mental health issues and established physical problems who are “deemed fit for work” and have their benefits cut:
- struggling to make ends meet
- increasing contact with GPs and psychiatry
- increasing antidepressant/antipsychotic use
- self-medicating with drugs and alcohol

Aside from the direct detrimental effects of drugs, alcohol, and worsening mental health on physical health, it can also be affected indirectly as many patients are reluctant to take time off work due to job insecurity. Additionally, GPs report less time to deal with physical problems, as these many patients are reluctant to take time off work due to job insecurity.

Changes to the benefit system were cited by most respondents as impacting on patients’ health and practice workload. Practices described an “endless cycle” of appeals, during which time the patients’ benefits are reduced. One GP calls this “completely unnecessary [and] completely avoidable”; another felt that the WCA (Work Capability Assessments) were ill-matched to the clinical reality.

Practice impacts
- Changing workload. Most patients appeal the WCA decisions and ask for letters in support of appeals. This is encouraged by benefit support workers and solicitors. As noted, however, it impacts on practice time that would otherwise have been spent on health concerns.
- Access affected. Pressure on appointments and appointment length as a result of the above, including increasing volume of unscheduled appointments in some cases.
- Staff morale. Several practices report sadness and frustration among staff members at their inability to alleviate the suffering they see, and increased stress due to extra workload. Again, this has potentially significant detrimental impacts on patient care.

Secondary care and support services
- Patient transport for outpatient appointments has been affected by cutbacks, such that there have been reports of many patients complaining about long waits, with some elderly, frail patients arriving home after midnight. It is possible that such transport problems will result in higher DNA rates.
- Delay of discharge letters from secondary care, which can result in potentially serious prescription errors, is often due to typists being off or posts being unfilled.
- Addiction workers struggling to do any structured addiction work because they are too busy trying to help patients in crisis.

Social work and housing
- Several descriptions of a service that is overworked and understaffed and that is, ultimately, failing some of the most vulnerable members of society.
- Reports of vulnerable adults and children being unallocated despite serious concerns for their safety and/or wellbeing.
- Difficulty getting social work colleagues to attend practice meetings.
- Increased difficulty getting patients into respite care.
- Increasing reliance on voluntary sector.

Other examples that Deep End practices gave included rehabilitation services, occupational therapy, and heart failure nurses being harder to access.

One respondent felt like GP practices were a “dumping ground”, as other services are affected by cutbacks.
Focus on austerity

The impact of austerity on patients’ lives

Case studies

Please note that patient details such as age, nationality and location have been changed in order to ensure anonymity.

Patient refugee, fleeing violence from another city, staying in a temporary voluntary sector night shelter (winter initiative) every night last week, presented looking for mental health support and medication. Previously on antidepressants, no money, all worldly goods with him in a small bag, winter initiative closing at end of week and no idea where to go now. Signposted to State homeless centre but as no local connection unlikely to be housed for more than 28 days, given basic food and toiletries from health centre stock, very distressed/sobbing.

Woman, mid 40s, with chronic depression and multiple previous suicide attempts. She also suffers from angina and has had a previous MI. She has recently been deemed fit for work, but is appealing this decision. Money is extremely tight, and she and her boyfriend are currently surviving on his benefits alone. She has suffered from physical, sexual and emotional abuse all her life and her current relationship is no exception. She wants to visit her daughter (whose young child has recently been removed from her care), but can’t afford the coach fare – she is waiting for her daughter to pay it as her partner refuses to. The daughter in turn is waiting for her own benefits to come through. Another daughter is homeless.

Mother, early 40s, who was sexually abused in her childhood. She has been seen regularly since mid-2010 when she presented with alcohol dependency, talking for the first time in her life about her abuse, contemplating change. She received a detox in late 2010. She is currently trying to consolidate her life and I am working slowly towards confidence issues and possibly return to work. She was found to be capable of work, a judgement I disagree with at present, and I worry that her mental health will deteriorate. Her benefits got stopped. She was diagnosed with diabetes in November and instead of working with her setting goals for her diabetes I wrote a letter for an appeal and referred her to the benefits worker as these were her priorities.

Single woman in her 30s asked to do work of several staff at self scanning in supermarket where she works due to cutbacks. Can’t cope, stressed, makes looking after three teenage school kids with behavioural problems harder. Attends emergency surgery crying uncontrollably. Feels unable to address own problems, doesn’t know who to turn to so comes to GP. Long, unscheduled consultation.

Male Eastern European patient with insulin dependent diabetes and likely retinopathy and degree of renal impairment. No access to public funds and getting food from shelters and other charitable donations. Sleeping rough but recent access to bed in a flat though he has to find another £100 in next week to pay rent or will have to sleep rough again. Requesting letter to support him attending locations distributing food, explaining his medical problems. In theory not entitled to secondary care services but requires secondary diabetic services. The Tuesday started with half an hour on the phone to give the police the relevant medical information for two of our patients who had been found dead in their homes the previous day. Separate incidents – both in their thirties and both with drug paraphernalia around – one with a tourniquet still on his arm the other recently self-discharged from hospital with cirrhosis. I think we get inured at times to these deaths of young people, but two on the same day... This week I have felt particularly hard hit and sad. For them, for their families and friends, and for all our young folk. Where are our priorities?

Single parent, late 30s, developed acute onset sciatica having been fit and well and working previously. She was walking with a stick and required a variety of analgesic agents to control unpleasant sensory symptoms. MRI showed clear nerve root impingement, but due to a high BMI she required to lose weight before she could be considered for general anaesthetic. She was referred to the local weight management service but has not yet managed her weight goal because of extremely stressful social circumstances. Early on in her sickness, she was assessed and found fit for work, and had her money stopped. In my opinion this was a medically inappropriate decision.

Female, mid 50s, with lifelong mental health problems and a history of self-harming and has never worked. She has mild learning difficulties and limited literacy skills. She has been presenting more frequently in the surgery with increased anxiety and episodes of self-harm. She lives on £168 per fortnight because her benefits have been cut. She relies on handouts from her family (who are all local residents and also struggling financially) but goes without heating over 3 days a week until her money is sent through. She is already linked into the community health team but this will not address the underlying trigger to her increasing mental health problems – poverty.

Male, early 50s, out of work because of osteoarthritis and depression. Until a few years ago he was working in the labouring trade and was rarely out of work. Since the economic downturn he has essentially become long term unemployed. He was receiving DLA but this was then cut and he has now entered the appeal process. His family are helping him with his mortgage because he is unable to make his payments. Like many patients who have little savings (because they have worked in low paid jobs) and find themselves unemployed later in life there is a great deal of anxiety and uncertainty about the future. His mental health problems have escalated and he is being seen by mental health services. At this juncture he could not psychologically cope with re-training.

Divorced man, late 40s, recently unemployed, struggling with depression – deemed fit for work. If his story had been listened to it would be clear that he is currently unfit for work. His response? “Really low”. His family are very worried; his daughter has moved to live with him as she does not want to leave him on his own. This is a concerning situation exacerbated by the attitude of the local Benefits Agency. His own safety is borderline – he is clearly unfit to hold down a job.
**Focus on health inequality**

Tackling Health Inequalities at a local level - lessons from the King’s Fund

The recent Kings Fund Publication, *Clustering of unhealthy behaviours over time* - Implications for policy and practice, this document is neither an academic treatise nor a justification of interventions to improve health primarily through behaviour change.

The report is a helpful document which builds on evidence from the Health Survey of England to present some useful ideas and actions on tackling health inequalities at a local and national level. It is essential reading for all local health leads because of its critique of government policy and the actions that it proposes.

It provides some useful levers that local champions (both statutory and voluntary) can use to influence the priorities of the Health and Wellbeing Board and Joint Health and Wellbeing strategies.

In summary it says that:

- The overall proportion of the population that engages in 3 or 4 unhealthy behaviours has declined significantly from 33% of the population in 2003 to 25% by 2008.
- However, these reductions have been seen mainly among those in higher socio-economic and educational groups.
- People with no qualifications were more than 5 times as likely as those with higher education to engage in all 4 poor behaviours in 2008 compared with only 3 times as likely in 2003.

One of the dangers of a focus on healthy behaviours is that the focus shifts to blaming the most disadvantaged and focussing on changing their behaviours rather than creating the conditions, that lead to better social and economic conditions with citizens and communities having more control over their own health and wellbeing.

The report is pragmatic: using data that measures lifestyle behaviours, it is careful to highlight that our behaviour is significantly affected by our social and economic context and that the relationship between these factors is complex and not always well understood. For example, on page 17 the authors state:

- “Our choice of lifestyles - and the cut-off points for what is termed ‘unhealthy’ behaviour are obviously subjective”
- “We do not know whether the effectiveness of strategies to change behaviour differs according to the comparative ease of change”
- “How do large changes in income or wealth, moving in or out of employment ... impact on taking up multiple behaviours or reducing them?”

**Behaviours as a way in to socio-economic issues.**

Starting with the way in which people behave always makes me feel uncomfortable - because I am clear that it is people’s socio-economic circumstances which are the biggest determinant of wellbeing. Past and present governments have always placed a great deal of emphasis on encouraging, motivating and sometimes forcing people to change their behaviours for healthier ones. This approach can work - seat belt legislation, smoking in public places and even to some degree campaigns like ‘5 a day’. However, it is also the case that behaviour change interventions work better with people who experience less socio-economic inequality.

I believe that the apparent rationality and simplicity of behaviourist approaches make them more attractive to governments than more complex and potentially more controversial programmes to create a more
equal society. This is recognised to some degree by Duncan Selbie, the Chief Executive designate of Public Health England, who recently published a note on the Department of Health Website, where he used information from the University of Wisconsin that gives a ranking to factors that affect health and wellbeing:

- social and economic – education, employment, and violent crime, 40%
- health behaviours – alcohol, tobacco and sexual behaviour, 30%
- clinical – quality and access to health care, 20%
- environmental – air and water quality and building design, 10%

So, the authors use data that measure behaviour to remind us that health inequalities continue to persist and to make the argument for a more coherent system-level approach to addressing health inequalities. They do this through building on two useful reports.

The first is Health Foundations - A Segmentation Model which provides a helpful framework to make the case to commissioners for a model that is built around active citizens (see the box at the top of the page)

The second report the authors refer to is the excellent briefing From illness to wellness: achieving efficiencies and improving outcomes produced by the NHS Confederation in association with the Faculty of Public Health. This report is a localist counterpoint to the failure of government to offer joined up policies. It draws attention to the integrated wellness service model, which has much to offer Health and Wellbeing Boards and Joint Health and Wellbeing Strategies.

Every Relationship Counts

Finally, while the authors provide conditional support (p19) for Every Contact Counts, the government’s soundbite behaviour change programme calling for investment in training and support for staff - they also present a more thoughtful and nuanced view than that promoted by the Department and its Strategic Health Authorities. The report notes that “successful intervention is likely to require coaching and structured decision making support to help people with multiple risk factors to focus on areas that motivate them and give them the confidence to change”. This does not sound like “every contact counts” at all. They go on to say that “people are likely to require a more long term relationship rather than a series of one off interventions” suggesting that the policy would be better titled ‘every relationship counts’. This feels better particularly when combined with its next recommendation “Exploiting the potential of lay and peer support” (p20): “lay and peer support offers considerable potential for tackling multiple lifestyle risks... which offer tailored advice, motivation and practical support to people wanting to adopt healthier lifestyles delivered by staff who are representative of their communities”.

The report notes that “appropriately skilled health trainers and lay ‘health champions’ represent an under-used and ready made workforce to help drive the reduction of multiple lifestyle risks in the context of local Joint Health and Wellbeing Strategies. This role has a good fit with the ‘Fighter’ group described in the Healthy Foundations document mentioned earlier.

A model of an integrated wellness service

INTEGRATED WELLNESS SERVICE

Healthy lifestyle
Stopping smoking
Healthy eating
Healthy mind
Physical activity
Sensible drinking
Healthy literacy and skills

Families and early years
Healthy pregnancy
Breastfeeding
Parenting support

Health protection and personal safety
Dental health promotion
Substance misuse
Violence prevention
Sexual health

Welfare
Housing advice and homelessness
Debt advice
Welfare rights

Self-care and Independent living
Self-care/condition management
Affordable warmth
Care and repair
Equipment, aids and adaptations
Advocacy

Work, learning and skills
Occupational health
Employment support
Volunteering
Education and learning
Healthy literacy

Community development and leisure
Arts and cultural
Leisure services
Community events/training
Health walks
Cook and eat

Figure 2, taken from NHS Confederation Briefing Issue 224
Focus on health inequality

Recommendations for Actions

For local commissioners

- The lifestyles data from the Health Survey of England is useful information for Health and Wellbeing Board members - reminding them of the need for action to address health inequalities
- It is not appropriate to focus primarily on behaviour change and ignore people’s socio-economic circumstances
- It is important to have an explicit coherent local whole-systems model in order to mobilise all sectors and stakeholders to achieve positive change.
- There needs to be a much more nuanced approach to ‘every contact counts’ with a greater focus on the quality of relationships than on the quantity of the contacts.
- Systems need to be designed to support co-produced relationships with active citizens building on health champion and health trainer models

For local community and voluntary sector champions

- The data presented in the King’s Fund report provides evidence of the need for continued action to tackle health inequalities
- Models such as ‘Healthy Foundations’ provide a useful way in to communicate with NHS commissioners in particular and can be used to promote greater citizen voice and co-production.
- Behavioural models to address health inequalities are not sufficient and need to be challenged and tested by Health and Wellbeing boards, Scrutiny Committees and Healthwatch.

References

1. Buck D, Frosini F: Clustering of unhealthy behaviours over time (2012) The King’s Fund

Mark Gamsu is a visiting professor at Leeds Metropolitan University. He has a strong interest in the relationship between Citizenship, Inequality and Wellbeing. As well as freelance work in public health, he works part time for Health Action Partnership International coordinating a European Programme promoting Health in All Policies across 16 Member States. He is also a Director of Citizens Advice and is on the board of a number of voluntary organisations in Sheffield.

When working for the Department of Health, he led on the national work on Joint Strategic Needs Assessments and before that was responsible for the Department’s regional work in Yorkshire and Humber on Health Inequalities, mainly with local authorities. He also established the nationally recognised Altogether Better Health Champion Programme and continues to be an advisor to it.

Mark has worked in a range of local government departments including Housing and Social Services and was the healthy city co-ordinator for Sheffield.

Prior to moving to Sheffield he worked with neighbourhood based voluntary and community organisations in Lambeth and Lewisham.

You can follow Mark on twitter @markgamsu. He also runs a regular blog on citizenship and health - www.localdemocracyandhealth.com
Is the social care economy in tatters?

The impact of austerity policies on services for people who need care services is widely acknowledged. In England, the number of people receiving funded social care has dropped by 40% since 2009. With a move to personalize services and provide Individual Budgets many basic services such as meals on wheels and day centres have closed. Despite recognising the need for preventative services and early intervention 85% of councils in England now only provide care when need is ‘substantial’.

The ‘other side of the coin’ is the impact of these changes on the people who provide social care, how their health and wellbeing is affected and the wider economic impact. In 2011 a report by King’s College London suggested that between 150,000 and 200,000 care workers may be earning less than the minimum wage – a figure at least five times higher than the government’s own estimate.

Recent evidence from UNISON’s ‘Time to Care’ survey paints “a shocking picture of an exploited, underpaid and unrewarded workforce and a service creaking at the seams”. The survey showed that 60% of respondents had had their hours cut and 52% had been given additional duties within the same working hours in the last year. 56% of members surveyed were not paid for travel time, 56% of those working for private or voluntary sector employers are on zero-hours contracts, as are 22% of local authority employees. 61% of all respondents had varying amounts of monthly pay, making it difficult to budget or make expenditure plans. ‘Time to Care’ is available from UNISON. Contact M.Egan2@unison.co.uk for details.

Unsurprisingly staff turnover in such precarious and poorly paid work is high with an annual ‘churn’ in April 2010 of 21.4%. The impact of staff changes affects services, limiting the ability to train and develop staff, particularly to cope with more complex needs. For service users the result is frequent changes in carers, a deeply unpopular aspect of services.

The health and wellbeing of low-paid, mainly female, care workers is a problem in itself. That services for which there are growing needs are being starved of resources and reducing in scope has even wider implications – potentially destroying the ‘social care economy’ as an engine for growth.

We will look at the issues in more detail in future issues of Health Equalities.

European Public Health Association snapshot 2012

A scenario of global crisis

In 2008 the world was plunged into a major economic crisis. There is widespread concern that the current economic crisis will impact population health. Unemployment, cutting back on health care and increased taxes are major factors affecting public health.

It has been suggested that the financial crisis will lead to further income inequalities, which are linked to differential health outcomes, including differential rates of communicable diseases. It is likely that tuberculosis rates have the potential to increase in several European countries.

The Economic Crisis and its Impact on Public Health

The economic crisis is affecting public health:

- Increase in inequality in access to health care
- Increase in the spread of infectious diseases

A Greek Tragedy

The Greek economic crisis showcased the possible impact on public health (2011):

- There was an increased use of street clinics by Greeks
- There were reports of substantial increase in heroin addicts
- A substantial rise in HIV infections was also reported
- There are unconfirmed reports of 40% rise in suicides in 2011
- Accidents related to drunk driving went down

A wider perspective
Focus on veterans’ health

Are the Armed Forces a health minority?

The last ten years have seen the British Armed Forces involved in a level of operations not seen for a generation. At the same time their dedicated health services have decreased. Are the Armed Forces all “Heroes” and in need of special treatment, or a minority in need of services to remove any disadvantage from service? Andy Bacon offers an overview

Historically, the Armed Forces have often been in the equalities headlines for all the wrong reasons and they have been perceived to be slow in adopting the equalities agenda. This may be in part because of their innate conservatism as institutions, which can protect them against fashionable (and occasionally dangerous and expensive) change but can make them slow to respond to legitimate social change. However this conservatism can also provide some “colour” and eccentricities of behaviour, like the officers (including this author) who wear spurs for supper, in the certain knowledge that they will not see a horse!

Ironically the Armed Forces now find themselves in the circumstances of being a minority. Less than half a century ago, all able bodied men were expected to do National Service; now less than 3.5% of the population are ex-services personnel. After the recent reductions in service personnel are complete, the British Army will struggle to fill Wembley Stadium. As well as the small numbers, the armed services are by their nature less visible than other occupational or minority groups. Despite their distinctive uniforms, they don’t often wear them in civilian environments and they often live in geographically isolated communities and can become socially isolated due to the regular moves that they make (either for operational deployments or as part of the normal rotation of jobs).

Furthermore, the nature of military training, the type of structures needed to wage war and the nature of combat itself can make them still more isolated. The very team development that the training of service personnel provides emphasises the cohesion needed for success, but also creates a feeling of separation and exclusiveness. Decision making on operations seldom allows the “luxury” of democratic and “inclusive” processes and so the armed services can also often appear very unequal and hierarchical. This is in direct contrast to the closer physical and emotional bonds that exist within all fighting units regardless of rank.

Finally, the very (thankfully not widely encountered) nature of warfare is that it is not a set of experiences that are widely shared with others. Each of these three factors tend to make the Armed Forces separate from the mainstream groups in society and this is often a source of pride! Thankfully most, if not all, of the barriers that existed to entry the Armed Forces have now gone and service life creates a strong bond of loyalty and is largely meritocratic. It therefore can frequently transcend traditional barriers of discrimination, once you have earned your place and are accepted as one of the team. In fact the vast majority of ex-service personnel have their health improved by military service.

The Health System and Needs of the Armed Forces Community

Up until relatively recently, the Armed Forces had their own separate health systems for personnel and their families (in the Navy, Army and Air Force). This worked from the GPs, right up to general and specialist hospitals. However these separate services no longer exist and are now restricted to primary and community medical services (which may be staffed by civilians) and 6 wards in NHS hospitals (5 small units and the larger centre at Birmingham).

Apart from the variety within the three services, the Armed Forces community has also to be divided into 4 distinct elements to reflect the different (and changing) responsibilities for commissioning, funding and providing healthcare. These are the serving personnel themselves, “part-time” reservists (like the TA), veterans (all that have served for one day or more) and the families of each of these groups. As well as the differences in the arrangements for their care, they also have very distinct health needs. In general those in the first 3 categories are largely male (84%
of veterans) and in the last group female (reflecting historic recruiting patterns and the nature of the work). The serving personnel and the reservists are also largely young but the veterans relatively old (60% over 65).

Since the Second World War, Armed Forces personnel have died in conflict every year except 1968. However the intensity of operations has increased substantially in the last 20 years. This increase in activity and the decline in dedicated facilities has given rise to the Military (National) and Community (Local) Covenants that seek to mitigate the disadvantages of service and redress the balance.

### Health Needs of the Armed Services

If we were to believe the press ex-service personnel are either heroes or they are suffering from Post Traumatic Stress Disorder, or homeless or in prison! However each of these has been shown to be exaggerated and in some cases a myth. The prevalence of PTSD is very low (3-4%) of those deployed on operations and treatable in most cases. Also more recent studies are suggesting that anxiety and depression are also more prevalent than PTSD.

Studies like those of the Howard League for Penal Reform have found that whilst ex-servicemen represent a significant proportion of the prison population, they are broadly representative of the populations that they are recruited from (with a smaller proportion of the population than would be suspected in most areas except for those in middle age and for sexual and violent crime). A similar pattern is also seen to be true of the homeless. We must therefore look further afield to find the particular needs of this minority.

Despite lower than average use of recreational narcotics (due to cultural attitudes and random testing and enforcement), the Armed Forces are dangerous users of alcohol. This has strong historical precedent dating back well before the “grog” rations of the Royal Navy. Alcohol is widely used and abused for building team cohesion and for recreation, even above those levels widely reported amongst young people generally. This is often done in the form of binge (using the term correctly) drinking by having periods of abstinence (or minimal use) punctuated by period of excess (operational tours in Afghanistan are periods of abstinence).

The level of mental health for service personnel and veterans can be affected by both the nature of operations and the abuse of alcohol. It is also suspected that the transition from military life to civilian life can be very difficult for some. This is possibly caused in part by service personnel moving from work of perceived high value and status, in a controlled and structured environment with a cohesive social environment, to one that has none of these features (and does not seem to share the same value set). I would not wish to overstate the different nature of service personnel for most (perhaps over 85%) people their armed forces time has proved to be a very positive and enriching experience (some psychologists are now speaking of Post Traumatic Growth). Indeed there is a significant community that do feel that the issues associated with service life have been overstated and are in danger of adversely affecting the employment opportunities of the many.

The second area of specialist health (and social) needs of this community is their mobility and they suffer some of the same issues as the traveller/gypsy communities (albeit in different circumstances). These are characterised by the Armed Forces which are national (UK wide) organisations interfacing with local (Local and Devolved Authorities/Governments) ones. So for example there are issues for a family moving in the middle of an in-vitro fertility treatment cycle (from an area that funds this to another that does not), or a child starting education a year “late” moving from Scotland to England (due to different ages of the start of formal schooling).

There is also a category of health needs that relate to the occupations that service personnel carry out. These range from the general, such as acquired hearing loss (from exposure to weapons, explosives, engines etc. and where hearing protection is not practical) to the very specific, such as historic exposure to asbestos in old warships. The physicality of service life can improve general fitness but can cause stress to even the hardiest musculoskeletal systems! (The discharges for MSK are 4 times those for mental health). There are also the specific needs of those who have suffered traumatic limb loss on operations and will now require a range of services such as prosthetic limbs, pain management, mental health support etc. Though the numbers of these are small (around 20 per year) they are severe and complex to deal with.

### Areas of Focus

The current area of focus is to ensure that the Armed Forces community does not suffer any disadvantage and indeed the NHS Constitution (for England) states that it will “pay particular attention to groups or sections of society where improvements in health are not keeping pace with the rest of the population”. It can reasonably be argued that this applies to this community.

This has led the NHS to develop a range of bespoke services for mental health and prosthetics. It has also led to work within the Armed Forces to promote good health and prevent the bad. Most recently the focus has moved to those moving out of the services into civilian life. It is felt that by working together (sometime using the Military or Community Covenant and resources associated with this) the military, the public sector and the voluntary/charity sector can work smarter to mitigate the effects of service departure and get a better success rate than we have to date.
Case Studies

29 year old male, self referred to our service as feels his life is out of control. He joined the Army at 20, to follow in his father and grandfathers’ footsteps, after having been an “angry teenager”. He had a successful career in the Paras, including being a semi-pro boxer. Operationally deployed, including a tour of Afghanistan when he was involved in an incident where a young Afghan girl was killed. In 2011 he left the Army expecting to get a better paid job in marine security to better support his long-term partner and children. The job hasn’t panned out, he’s in debt after taking a large loan to finance his wedding, he’s unemployed, says he has no discipline, his days lack structure, he drinks too much and is frequently in conflict with his partner and irritated by his children – a situation he summarises as “my life has gone to sh*t!”.

After being part of a traumatic incident in Iraq and after 12 months of being symptom free this high performing professional nurse started to experience symptoms:

“...my nights and days is to say it was like watching a film that could not be stopped. Whatever I was doing in my life when the ‘film’ started I was compelled to watch it all and re-live the emotions and energies of war, like a frozen consciousness. I began to bargain with the symptoms, talking to the dead, promising to watch the ‘film’ later if it intruded in my working life. After the film I was always left crying, distressed melancholy and feeling so lonely. I withdrew from family events, deliberately destroyed a long term relationship and pursued lone hobbies like horse riding, swimming, walking etc. Interestingly although I became emotionally numb I did not become depressed. I declined prescribed medication fearing it would numb my senses or dull my ever fragile personality; I felt so ashamed, a failure, embarrassed and worried my clinical colleagues would discover what I perceived to be weakness and failings. Every day became harder and harder work; I suspected I was experiencing Post Traumatic Stress Syndrome but I refused to believe or accept it; how could experienced clinicians suffer like this? “It will go, I know it will pass” became my daily mental chant.”

Four years after the symptoms had started and on her way to deliver a presentation to a large corporate client:

“I suffered something of an emotional collapse outside Stafford Railway Station. My GP referred me urgently to the mental health care team; I was seen very quickly by the Veterans Lead Nurse and diagnosed with severe Post Traumatic Stress Syndrome. I entered into the care of Dr Shirley Timpson and over a period of months slowly recovered helped by Eye Movement Desensitisation Therapy (EMDR). Initially the therapy was very difficult and my flashbacks increased, but over time and with the kindness, support and professional skill, Dr Timpson aided my return to normal mental health. I could speak a thousand words here about my care at St George’s but it’s probably enough to say I am well now and working as a specialist continuing to care for others and stronger than ever.”

This has already started to happen with those who have been very seriously injured and/or are being medically discharged. There are now regional Personnel Recovery Units (PRUs) that have transformed the complex management of patients out of the Defence Medical Services into the NHS. It is hoped that we can now learn from this and improve the transition for those not suffering with health needs. This area of the social needs for those transferring appears to have been poorly studied and would welcome some attention.

A further potential area for research is linked with the higher incidence of ex-service personnel being under-represented in much of the prison population but over-represented in middle age for sexual and extreme violence. There are also anecdotal tales that would seem to suggest that domestic violence may be more prevalent in the Armed Forces community.

The intensity of recent conflict has also given rise to a range of charities to meet perceived unmet needs and in response to generous donors. These charities range from the widely respected and well known to the new, untried and one or two that could be dangerous. Work is now on going to see if a directory with some basic accreditation can be provided.

Conclusion

The increased focus on Armed Forces issues has been helpful, as it has followed a period where the issues were not well looked after. We should also expect that history will repeat itself and today’s “Heroes” will become tomorrow’s “Drains on Society” very shortly after active hostilities are concluded. We should therefore put in place services and systems that will support the special needs of this community, especially as some of them will not emerge for many years.
Delivering fairness in revalidation

Niall Dickson, Chief Executive of the General Medical Council, outlines how the new way of regulating licensed doctors, revalidation, will work when it is introduced in December 2012. Revalidation will mean that doctors undertake regular appraisals based on the GMC’s core guidance for doctors, Good Medical Practice.

The vast majority of doctors are good doctors – they have the skills and experience to deliver first class care and the range of interventions at their disposal is wider than it has ever been.

But just as their capacity to do good has never been greater, the risks associated with medical care are also greater than ever. Revalidation is a response to those risks and opportunities. It is recognition of the critical role doctors play, and recognition too that safety and quality should be the organising principle in healthcare.

For most doctors perhaps the greatest potential benefit of revalidation is the opportunity it will provide for self-reflection - the chance to review their own practice and identify areas for development and improvement. As more comparative data becomes available it will also enable individual practitioners and teams to benchmark the outcomes of their practice against others, something we know is a major driver for improvement. All this must be good for both patients and doctors.

Our ability to deliver revalidation, which will safeguard patients and help doctors improve the care they provide, relies on us being able to maintain the trust and confidence of everyone involved. This includes the patients we are seeking to safeguard, and the doctors we approve for revalidation. This requires us to be, and to be seen to be, fair, open and transparent in everything we do.

We have engaged extensively with those who have an interest in our work across the UK. From this we know there are concerns that revalidation may have an unfair or disproportionate effect on particular groups of doctors, including locums, doctors working overseas, doctors working part-time and doctors who take career breaks.

On this, first it is worth noting that revalidation has the potential to drive more consistency and fairness in evaluating a doctor’s practice. The process should help to ensure that all doctors receive an annual appraisal and the support they need to reflect on their work.

We are working with others to put in place safeguards that will help make sure that the process is fair. We know that some doctors are concerned that some elements of revalidation have the potential to be ‘unfair’. I want to address each of these concerns and set out what we are doing, in partnership with others, to respond.

First, some doctors are concerned that access to appraisals and supporting information may be harder for particular groups of doctors, such as locums (in primary and secondary care). We have seen that by making a doctor’s revalidation dependent on them receiving a regular appraisal, revalidation is helping to drive up rates of appraisal and improve access for all doctors. NHS Employers have also produced supplementary guidance aimed at reminding employers of their responsibilities towards locum doctors and we have said publicly that we will not penalise doctors if their employers or responsible officers fail to prepare for revalidation or put in place ineffective systems of appraisal.

Secondly, we need to ensure flexibility for doctors who find revalidation challenging because they are absent from work due to ill health, periods of time overseas or career breaks to care for family. To ensure flexibility, we will have the power to vary a doctor’s revalidation date in response to individual circumstances. Responsible officers will also have the ability to defer their recommendation if the doctor has not been able to gather all the supporting information by the time a recommendation is due. Deferral does not signal anything negative - it is a neutral act - and in those circumstances the doctor would continue to hold their licence. We have also made it clear that we will not penalise doctors if they have been unable to engage with revalidation because of ill health.

Thirdly, doctors have, perhaps understandably, expressed some concern about bias in feedback that they may receive from patients. GMC patient and colleague questionnaires have been subject to detailed research by the Peninsula Medical School which has enabled us to identify particular limitations. As with any questionnaire of this kind it is important to take into account any bias when interpreting and providing feedback. We have made this clear in the instructions that accompany our questionnaires and in more detailed guidance to help appraisers interpret and handle the results. Remember too that the questionnaires are just one piece of information that feeds into the appraisal process - useful though they will be as a development tool, it would be a mistake to place too much weight on them. In any event, the evidence is that
patient feedback on all types of doctor and from every background is overwhelmingly positive.

And finally, a key fairness challenge will be to make sure the recommendations from responsible officers are consistent. To tackle this we have drawn up clear guidance on how to assess evidence and make recommendations. Responsible officers will themselves be subject to revalidation like all other licensed doctors and will receive regular appraisals to check and review their recommendations. It is also worth noting here that designated bodies (which employ responsible officers) are subject to the 2010 Equality Act.

We believe these safeguards should ensure that revalidation is delivered fairly, openly and transparently. But we will need to evaluate its impact to make sure it is working fairly and to learn how it can be improved. As a result we will be conducting a programme of evaluation, supported by commissioned research, to assess its impact, including the impact on different groups of doctors.

In tandem with this, there will be a separate quality assurance programme. We will collect and analyse data about the recommendations that responsible officers are making, to ensure they are consistent and fair.

Revalidation will not be perfect and there are bound to be glitches in a programme of this size, but with goodwill on all sides, the medical profession and the UK health system will have created an assurance system that can be developed and improved over the years.

Revalidation is about underpinning the trust patients have in their doctor. Once it is fully implemented patients should have confidence that the doctor who treats them will have demonstrated on an ongoing basis that they are competent and fit to practise. This is good for patients and for the profession.

The greatest potential benefit of revalidation is the opportunity it will provide for self-reflection - the chance to review their own practice and identify areas for development and improvement.

Niall Dickson is the Chief Executive and Registrar of the General Medical Council
Age Equality in the Age of Austerity?

With a ban on age discrimination now in force and a drive to personalise services, are things likely to get better for older people using services? Valeska Matziol looks at the evidence from work with people affected by dementia and concludes that austerity measures threaten both aims.

In theory, policy development aimed at greater personalisation has put patients and social care clients firmly in the driving seat in terms of making their own individual choices about the care they receive. In turn this should help minimise discrimination and exclusion, for if we focus on the requirements of individuals rather than those of groups (organised, for instance, around medical conditions), surely structural differences on the basis of age and disability will be less influential.

In reality, however, there is limited evidence for this as the system of personalisation in itself seems to work better for some user groups than others. Following the In Control pilots undertaken in 13 local authorities across England between 2005 and 2007 the Individual Budgets Evaluation Network team found variations in outcomes between different groups of Individual Budget users. According to the final report satisfaction with these budgets was lowest among older people, who also reported feeling happier when receiving conventional services, and highest among physically disabled working age people and mental health service users.

Generally two reasons are given for this. On the one hand the current system based on personalisation came about as a consequence of intense pressure from the Disability Rights Movement. Within the movement physically disabled people have traditionally had a stronger voice and therefore their needs have been better represented and in turn become better catered for. On the other hand older adults have been found to be less willing or able to get involved in care planning and the management of an IB.

If this did not already offer cause for concern it has been suggested...
Focus on age equality

that recent austerity measures introduced by the coalition government are impeding personalisation reaching its full potential and that once again older adults are bearing the brunt. In this context it is useful to consider the current situation of people with dementia since this set of conditions and symptoms is closely linked to age and forecast to present the biggest challenge for the NHS and social care in the coming decades.

The impact on people with dementia

Manchester Local Involvement Network (LINk) has done just that, investigating the impact of reductions in social care funding on this particular client group in Manchester. The resulting report, Dementia: Care in Crisis? describes how the local authority financial settlement of 2010 forced Manchester City Council to reduce its social care budget by £8.8 million in 2011/12. This has led to a greater reliance on short-term ‘reablement’ services, a tightening of eligibility criteria and the associated Resource Allocation System, and increases in the amount service users have to contribute to their care.

The report finds the impact on people with dementia and their families to be varied. For some nothing much seems to have changed although this does not mean that their health and social care support were adequate or appropriate in the first place. For others their lives have been turned upside down. As a consequence of the reorganisation of social care they have seen their entitlements and Individual Budgets reduce, charges for services increase, and voluntary and community sector organisations offering less support that is free at the point of access. For many this effectively means having to pay more for less while struggling to bridge the widening gap in support arrangements.

The heightened financial pressure that some families find themselves facing as a result is compounded by other changes in welfare benefits and co-occurs with long periods of uncertainty and a lack of adequate information, advice and advocacy. The latter, in itself, has a significant effect on the health and wellbeing of service users and carers with participants reporting higher levels of stress, anxiety, hopelessness, isolation and distress, as well as faster physical deterioration. In addition, it often means that older adults are forced to opt out of services they hitherto relied on to meet their needs, especially those that are seen as lower down the hierarchy of needs such as day services or activities aimed at reducing social isolation.

Interestingly, this is happening at a time when existing needs are reframed through changes in the assessment process. An older adult’s ‘social isolation’, for example, has become recast in terms of ‘community involvement’, and this development described as a shift of focus away from statutory service provision towards communities
Focus on age equality

filling in the gaps. Moreover, professionals point to the system as a whole becoming more skewed in favour of physical needs, which puts those with sensory, psychological or social needs at a disadvantage.

In addition, budget reductions are not just affecting individual older adults. They have an effect on the local social care economy as a whole by reducing available business for care providers and employment opportunities for care workers. This triggers a restriction of the sector due to organisations failing or being forced to discontinue services that have become unprofitable to run. As the sector (including statutory service providers and commissioners) relies on a reduced workforce to meet an increased demand for support it is more difficult to maintain high quality services, and there is greater potential for mistakes to be made and for abuse and neglect to go unnoticed. Importantly this leads to the needs of people with dementia and their carers not being met properly and causes serious concerns about their safety.

The findings from the Dementia: Care in Crisis report clearly illustrate how the core principles of personalisation – choice, control and independence – are under attack by the politics of austerity and the resulting pressures on NHS and social care funding. Overall budget reductions as well as reductions in Individual Budgets for service users drastically restrict choice and control both in terms of having different options to choose from and being able to afford to pay for them. In turn this increases service users’ dependence on those few organisations or options still available to them, and on informal care and support provided by relatives and friends to fill in the gaps. In the longer term it also leads to greater dependence on more intense and hence costly care arrangements as service users deteriorate more quickly.

But what does this tell us about age equality?

It is clear that the challenges to personalisation are likely to hit older people particularly hard for a number of reasons. Firstly, older people are more likely to develop age-related conditions such as dementia that may require less physical and more social and psychological support. If the system primarily focuses on physical needs older people are likely to be disadvantaged.

Secondly, the 2005-7 evaluation suggests that older people will find it more difficult to negotiate the personalised social care system and use it to its full potential.

Thirdly, with information, advice and advocacy services being decimated older people are increasingly left to fend for themselves.

Finally, older people form the biggest group of health and social care service users overall. Therefore if the system suffers, for instance in terms of the quality and availability of services, so do older people. It remains to be seen whether the new ban on age discrimination is sufficient to stem that tide. Evidence so far suggests not, unless care commissioners and providers actively work to tackle discrimination against older people.

Case Studies from Dementia: Care in Crisis

Nick has to pay privately for his mum Doris to attend a dementia day centre for an extra day a week to help out his dad who cares for her full-time. He says: “I feel like I’ve lost two parents if I don’t pay for the extra and give my dad a break.”

Oscar has an IB managed by his daughter Carey. In the past they have used this creatively to employ personal assistants (PAS) and allow Oscar to do the things that are important to him. This included taking Oscar for a daily walk around the local area, which he says keeps him stable and involved in his community. Because of the budget cuts Oscar’s IB has been reduced drastically and Carey in turn had to reduce their PAS’ hours. Therefore, Oscar is now stuck at home and becoming increasingly isolated, which makes him angry and frustrated. Carey explains: “He’ll sit there ready with his hat on, stick in hand and can’t understand why they can’t go out. When I tried to explain that we need to spend the money on the most essential things, he said to me ‘I get so very lonely here. I love seeing people.’ The next day he got himself up in the morning and put his clothes over the pull-ups and pyjamas to prove to us that he could do it himself, that he could go out by himself.”

Tina and Tim are frightened about the future as Tina’s mum Emma is running out of money to fund her own care. They are concerned that the local authority will not provide enough funding for Emma to continue receiving the services that allow her to stay safe while living independently. Since they have small children and are both in full-time employment they cannot fill the potential gaps in care and are scared Emma will have to move into a care home.

Max lives with his dad, Dean, who requires round the clock care and supervision. Although they receive some support from outside care services this is not sufficient and the recent cut in day centre entitlement from two and a half days to one day is threatening to push Max over the brink. He told Manchester LINK: “The current situation is impossible and I can’t cope for much longer. When I break down my dad will have to go into a home anyway and my life will be ruined as well. It’s not fair and I am quite angry about it all.”

Philip who has dementia and his wife Charlotte who is his full-time carer have just received a significant bill for Philip’s respite care. Their son Eamon says: “This came as a massive shock to my mother, who also is a very sick lady with severe heart trouble. It’s making her ill. She’s saying ‘just leave it, just leave it.’”

Valeska Matziol is a Community Engagement Officer for Manchester Local Involvement Network.
Focus on sexual health

Sex and relationships education under pressure in an age of austerity

During a time of austerity, high unemployment, cuts to contraceptive services and a lower priority for sex and relationships education, how can we sustain the recent progress on reducing teenage pregnancy and sexually transmitted infection rates. Simon Blake OBE, CEO of Brook, looks at recent best practice and what still needs to be done

Children and young people learn about sex and relationships from a very early age. They learn whether parents, teachers, faith leaders and educators teach them formally or through the internet, from friends and peers, from the media and advertising. It is right and important that we ensure children and young people get good quality sex and relationships education, medically accurate, positive about sex and sexuality and sensitive to the diverse views and experiences in the UK.

In the Sex Education Forum (www.ncb.org.uk/sef), sex and relationships education is life-long learning about sex, emotions, sexuality and relationships.

There has been significant investment in and attention on teenage pregnancy and sexual health over the last decade which has included good quality education as a central driver for achieving the desired outcomes. Through sustained efforts at local and national level over the past decade we have made good progress in reducing teenage pregnancy and improving identification and treatment of sexually transmitted infections, particularly chlamydia.

Last year Brook reached almost 300,000 young people including some of the most disadvantaged and vulnerable. Sex and relationships education is absolutely critical in enabling young people to only have sex when they want to do so, and to make positive active choices about their personal and sexual relationships.

Ensuring entitlement

A good, inclusive education in sex and relationships promotes a positive understanding of diversity and addresses inequality. This should include the following three elements;

• **legal and civil rights in the UK** – our personal beliefs and values as an educator are irrelevant. As educators it is our responsibility to ensure that young people know and understand their legal rights including their right to confidential contraceptive advice and treatment, that abortion and being gay, lesbian or bisexual are legal etc.

• **health perspectives** – young people need to know and understand the health benefits of behaviours – for example the impact on emotional well being of being in violent relationships, or the impact of using a condom if they are going to have sex.

• **religious and secular perspectives** – as well as their legal rights and health perspectives, young people also need to learn that people within and across cultures will have different beliefs and values, and that there are universally shared values.

It will be underpinned by anti-discriminatory practice approaches which value the beliefs and rights of individuals to hold those beliefs as long as their behaviours do not impact on the rights of others.

From needs to practice

The following checklist will help ensure sex and relationships education is inclusive and addresses inequalities:

• **understand the diversity of the local community, use health data and information so you understand local health trends and issues;** participate in multi-disciplinary forums that work with community groups to build your confidence in issues of diversity and difference

• **ask young people what they want, what they think is important and**
Focus on sexual health

Involving them in building the SRE programme
- ensure that SRE is both mainstream and targeted so it meets the needs of everyone. For example, schools can deliver SRE in the classroom, and utilise youth workers to provide SRE for friendship groups during lunch time or after school
- assess learning, evaluate the process and review your practice with young people on a regular basis
- model empathy and awareness of difference, diversity and inclusion through the work that you do; build a group agreement which is clear about prejudice and does not ever permit discrimination
- ensure people understand it is right that people will hold different views and beliefs; however, they do not have the right to stereotype, hurt or discriminate against somebody who does not share those beliefs
- use language that is inclusive of different cultures and social norms – for example, talk about finding an adult you trust and can talk to, rather than a parent
- organise activities within lessons that mean everyone can learn. It is important that the issues are broad enough for people with different abilities and disabilities, sexualities and genders to feel connected and engaged to the issues
- ensure that the resources you use do not make assumptions about people’s sexualities, their beliefs or values and be sure they reflect the communities you are working with – if they don’t, talk about why they don’t and what a better resource might look like.

Given the current social and economic climate we are working in, it remains to be seen whether we can sustain the progress on reducing teenage pregnancy and sexually transmitted infection rates that were made through the first decade of the 21st Century. During a time of austerity, high unemployment, cuts to contraceptive services and a lower priority given to sex and relationships education it will certainly be a challenge and I doubt we can – we know that those young people who already experience inequalities are the ones who will be affected the most.

Research shows that young people who have low expectations about how their futures will develop are more likely to experience negative risk taking, poor sexual health and unplanned pregnancy. The programme has been a great success with 90% of secondary schools and 90% of Foundation Learning Apprenticeship Providers in Wirral taking on the programme.

Young people who complete the programme also have the opportunity to gain a level one Skills Towards Enabling Progression qualification (STEP UP) in Personal Confidence and Self Awareness from the Open College Network. This provides opportunities for young people to gain recognition for cross-curricular dimensions of their learning, can enable the more “hard to reach” 14-19 year olds to achieve success, and can improve retention and progression rates by recognising frequent smaller steps of achievement.

Good practice examples

Set out below are two case studies which show how work both within a mainstream school setting and in the community can meet the needs of a wide range of young people.

**All Different, All Beautiful**, run by Brook in Wirral, is an award-winning five day personal development programme exploring values, relationships, interpersonal skills, confidence and self-esteem within the context of sexual health and relationships.

Staff work with up to 14 young people in schools/colleges and youth settings and the programme incorporates interactive games and activities that encourage young people to learn through participation and group interaction.

The programme is aimed at young people who have been identified as ‘at risk’ or vulnerable. Research shows that young people who have low expectations about how their futures will develop are more likely to experience negative risk taking, poor sexual health and unplanned pregnancy.

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**Diversity Role Models** is an anti-bullying charity that was set up to take lesbian, gay, bisexual and transgender role models into schools to challenge homophobia and prejudice in a positive and creative way as part of a whole school approach to anti-bullying.

The evidence shows that unless young people see, understand and build empathy with people that they perceive to be different then bullying will persist. Homosexuality in schools is often invisible – teachers and pupils alike are often uncomfortable or feel unsafe being open about their sexuality in a school environment – and this incubates homophobia and prejudice.

To address this DRM operates a model where a trained teacher takes a trained role model into school and facilitates a lesson with young people and provides the opportunity for young people to learn about homosexuality, understand the impact of homophobia, see that gay people are ‘simply normal people’ and that they achieve in all sorts of environments. This approach can challenge those who are homophobic, and provide a visible life line for those who are gay or questioning their sexuality, and many young people will talk to the role models afterwards to get further advice and signposting.

Simon Blake OBE is CEO of Brook, the leading young people’s sexual health charity. He was previously a community based sex educator, a director of the Sex Education Forum, and a trustee of Black Health Agency. Simon is co-author of Faith, Values and Sex and Relationships Education.

Follow him on twitter @simonablake @brookcharity
The issue of religious faith and whether its impact on HIV prevention is beneficial or not is a question that is not easily answered. For many HIV positive people, religion plays a vital role in their lives, providing a source of well being and a basis from which supportive relationships are formed. Reverend Ijeoma Ajibade reflects on the issue from the perspective of the Christian faith and explores whether faith is a barrier or opportunity for HIV prevention.
Focus on faith and sexual health

‘Religion is for the hesitant, the guilt-ridden, the excessively timid, and those lacking clear convictions with which to face life,’ so said a standard British textbook of psychiatry until 1969. The implication from this is clear, faith is for the weak and is probably not good for your health, but is that really the case? Over the years this position has changed and in the UK today the issue of faith is taken seriously and we can see this within health care.

Last year the House of Lords Select Committee on HIV and Aids stated that ‘faith and religion play a strong role in the lives of many people. It is essential that faith leaders engage with HIV as an issue and provide effective and truthful support and communication around the subject.’ The Select Committee then went on to recommend that the Department of Health ensures continued funding and support for faith work within HIV prevention.

The Select Committee has recognised that faith has an important role to play within HIV prevention and for many people living with HIV. Faith can succour and encourage people and give them the strength that they need to face life’s challenges, but the Committee also highlighted the important fact that faith leaders need to be adequately equipped and supported in order for them to then support others and this is the case with any issue, but particularly within HIV Prevention. The aim of this article is to provide a broad overview of some of the issues that surround faith and HIV, and is the basis from which relationships are formed. If faith communities can improve their awareness and understanding of HIV they could assist with the implementation of prevention strategies at local levels and provide much needed support within their communities.

The Role of Faith Leaders – an Opportunity for HIV Prevention

In order for positive people to receive appropriate support within their church communities there is a need for faith leaders to understand HIV. Faith leaders are in a key position to:

- Assist in HIV primary prevention by addressing some of the myths that surround HIV.
- Ensure that places of worship are places of welcome and acceptance for people living with or affected by HIV.
- Respond to the spiritual needs of people living with HIV.
- Contribute to decision making on HIV at local levels.

Faith and Living with HIV

Faith plays a key role in everyday life for many people from black and minority ethnic communities (BME). It is a form of identity and for many new migrants one of the ways of integrating into life in the UK. For some people, participation in the life of a faith community is vital for well being and is the basis from which relationships are formed. If faith communities
I have worked with many people to engage church leaders to think about how they might respond. An example of this is a course on HIV for Anglican clergy which I piloted in 2009 in the Diocese of Southwark. I followed this up in 2011 and organised a London-wide conference for clergy. This year I am working with the UK Consortium on International Aid and Development to do something different and we are hoping to engage African Christian faith leaders on the issue of HIV treatment adherence and the question of miracles. This is following on from the media reports at the end of last year about some churches that have been encouraging people to stop taking their HIV treatment.

There are a range of different resources available which can support attempts to engage faith leaders on HIV, but I have found that this kind of work is difficult. The vast majority of the work that I have been involved in is not funded. It has been done by committed volunteers and the lack of funding has limited our ability to reach out and train faith leaders in a sustained way.

I feel that there is a lot more that could be done across the UK to engage both faith leaders and their congregations on the issue of HIV prevention, but it cannot be done without funds and so this lack of funding is a huge barrier.

Is Christian faith a barrier or opportunity for HIV prevention?

I feel the answer is mixed:

• Create a safe space in which the challenges of living with HIV can be discussed. It is therefore crucial for health providers to engage faith leaders in the HIV response because of the authority they hold within their communities and their regular involvement and relationships with people, especially at key life stages.

• Encourage people to share their stories and experiences with others, which can help to reduce stigma and discrimination.

Barriers

Stigma and Discrimination
Although participation in the life of a faith community is key to the well being of some people living with HIV, people still experience discrimination, stigma and marginalisation from within the very communities that should be a source of support for them. This is largely due to a lack of knowledge about HIV, and how it is transmitted and how it affects people. This means that some people are unable to disclose their status within their faith community and are prevented from seeking the support they need. In these circumstances, instead of being a place of safety for the positive person, faith communities may become a place of fear.

Poor Teaching
Last year we had media reports illustrating situations where faith can be a hindrance, with reports of some churches claiming to heal HIV and encouraging people to stop taking their treatment. In some churches the experience of God and the belief is that God is immediate and intervenes in daily life in ways that are concrete, physical and can be evidenced. People may be encouraged to act on their faith and show that they believe that their prayers have been answered. This in itself may not necessarily be a problem, but it becomes a problem if it means that you stop taking treatment or medication, even more so when that treatment is for HIV.

Opportunity

Community and Support
In other faith communities people have found succor and support from their faith, both in terms of what they believe and from the pastoral support given to them. Churches play a vital role in the lives of people and particularly of migrant communities across the UK. They form the backbone of many communities, giving people an opportunity to worship in their own language and within their own culture. Such churches may act as a kind of support network or extended family. For people who have come to work, study or settle here in the UK, these churches provide an important way in which to integrate and to socialise. They ensure that people are not isolated and they provide strong links to families and cultures that have been left behind. To many people they are family away from home.

Opportunity: Positive Voices
Churches can be places where people living with HIV can speak out and find their voices to articulate what they want for their lives, to find support, but also to act as agents of change. In 2009 we had an event in Southwark Cathedral called 'Speak Out and Care'. It was a service of reflection put together by people living with HIV. People used the icons and spaces in the Cathedral as points of public prayer and personal reflection. It was incredibly moving to see how people were able to articulate both what they believed and also what it meant for them as positive people. It also gave them an opportunity to remember people that they have lost to Aids, which is something that we don't always do so well in the UK HIV sector today.

Opportunity: Christian Peer Support
Another area that some people find helpful is faith led peer support. I have come across a number of groups where people do this very informally, but one of the more organised groups is Positive Catholics. For some people they are family away from home.

Christian Faith:
opportunity or HIV prevention?

Rrevd Ijeoma Ajibade is a self-supporting priest and minister in the Diocese of London and at Southwark Cathedral. Ijeoma has worked on the issue of HIV for a number of years, developing a training course for diocesan clergy on theological and ethical perspectives of HIV. She is the Deputy Executive Director of the Kaleidoscope International Diversity Trust, a trustee for the Naz Project London and a trustee for Progressio.
Denise has been a foster carer for Modus for the past 8 years and has looked after a number of children and young people with a variety of needs and vulnerabilities. Denise is a single carer with 2 biological children of her own, a boy aged 16 and a girl aged 14, and her family come from the Caribbean.

Denise was a local authority social worker for ten years and it was during this time she became aware of the number of young people who appeared to be ‘lost’ in residential homes. She would often see vulnerable teenagers going into ‘hardcore’ residential homes and know that they would struggle there, but it was often their only option.

Another member of Denise’s family began to foster around this time. One of her first placements was a white teenage girl who had been brought up in an area associated with racism by a family who also held racist views. Initially, the girl appeared to resent being placed with a black family and frequently absconded. Denise describes the foster carer as simply just sticking with her, giving her space, time and consistency. The young girl ended up living with the family for 7 years. She is now described as “one of the family” and regularly calls round for dinner.

Denise saw how perseverance and consistency worked for this young person and decided she could offer a vulnerable young person a safe and secure place to live. At the time, Denise’s children were still primary school aged and, as a single carer, she knew it was a big commitment. However 8 years later Denise is able to look back and see the difference she has made to the young people living with her.

There are rewards and challenges that come with fostering, as with everything. Denise believes strongly that fostering is very rewarding; however, you “never see it at the time.” She describes one boy who was at his most vulnerable when living with her. She sees him occasionally and he is now a confident young man who is getting on with his own life. Another placement was a young mother and her new born baby. She describes the day they left as very emotional, as the new born baby that had arrived 2 years previously walked out of the door with her mother to continue their life together. Denise reflected that “it is only when young people leave that you can sit back and think, yes, I did well there.”

One of the main challenges of foster care is to help new children to understand you’re on their side. This can take a while and you can often be the one whom they blame for their being in care. As a former social worker who can appreciate both sides, Denise has noticed the level of stress social workers are currently under and how that filters down to the foster carer. This results in some social workers “dashing in and out of the house without enough time to communicate properly.” It can make the foster carer occasionally not feel valued; however, Denise consoles herself with the fact that she’s doing her best for the young person in her care and the consistent support she receives from her supervising social worker.

One of the first things that attracted Denise to Modus initially was the support provided. It was important to Denise to feel like a valued member of a team rather than a small cog in a wheel and she stressed that she does feel a sense of belonging in her role at Modus. Each child that has lived with Denise has had their own support worker, who will see them on average once per week. Denise has developed strong relationships with the support workers, as well as her supervising social worker.
A typical day

Denise is up first and into the shower. The teenage girls are woken up in staggered times to allow them to shower, while Denise gets the breakfast things out. While the girls are getting ready, Denise wakes the 8 year old, helps him to wash his face and sits down for breakfast with him. The girls are teenagers and usually make their own toast or cereal. The 8 year old gets himself ready for school and will normally get ‘fixed’ by Denise – shirt tucked in, tie straightened – before he leaves.

Denise drops the two looked after children at school, as their school is several miles away and her daughter gets herself to school. Denise is normally home for 9.10am and uses this time to open windows, clean up, speak to social workers or other professionals, attend any appointments/meetings and do the food shopping. 2.30pm comes round very quickly and time to pick the children up. When all the children are home Denise will be in the kitchen cooking and chatting. The children tend to sit together to watch some TV, nipping in and out of the kitchen talking and eating. Everyone normally sits down for dinner about 5.30 except Denise’s 16 year old son who has just finished his GCSEs and “eats at midnight!” Denise is very keen on the children eating fresh, healthy home cooked food and they all seem to enjoy the family ritual. The children have a routine of warm milk and a snack to get them ready for bed. They will then read in bed either with Denise or on their own.

Some advice Denise would give to new foster carers is to be realistic with your expectations. You are not going to get lots of praise for doing this job. The children and young people living in your home are usually at a time of stress and trauma in their lives and will be unlikely to show you gratitude. However, the motivation is to know that you are making a positive difference to a young person’s life – even though it may not be clear today or tomorrow.

For more information and to apply, please contact Nicola Daly or the duty social worker on 01204 399514, or through www.moduscom.org.uk

Yoni Ejo is the service manager for Modus

Modus
we care, we challenge, we support

Modus are recruiting families, couples and single people in Manchester who are able to foster teenagers.

We believe that children grow up happier within a family, and many children who want to live in a family don’t get the chance. We want to change that. With the right support, encouragement and care young people can reach beyond their wildest dreams.

We need people with energy, committment, imagination, patience and the space in their home and their heart, for a teenager. In return we offer excellent support including financial, together with outstanding levels of personal support and professional training. 90% of our carers think support from Modus is excellent or good!

For more information, phone Modus on 01204 399 514, or www.moduscom.org.uk
In December 2011 the parents of baby Jayden Wray were acquitted of murder. A post mortem showed he had severe rickets, due to a lack of Vitamin D. Coincidentally, in 2011, we saw two children, in a practice of 4000 patients, diagnosed with rickets.

Why do we have a problem with Vitamin D deficiency in the UK?

Many people assumed that rickets had been eliminated by the fortification of certain foods. However the UK is an increasingly diverse society with more people with darker skin colours. Unfortunately, north of Birmingham, the sunlight isn’t strong enough to manufacture Vitamin D for six months of the year (October to April) especially if your skin is darker. In Liverpool, for example we had an increase in refugees, particularly from Somalia, in the nineties. In addition, many people spend more time indoors with the “sofa culture” and advent of computers. A growing number of older, often housebound, people are at risk of deficiency, and obesity, now known to be associated with Vitamin D deficiency, is also increasing. Finally, the skin cancer health messages have been heard and have resulted in many parents covering their children, including those with darker skin colour, with sun protection creams (Fig 1).

Why is Vitamin D deficiency not a top public health priority?

Although many people may be at risk of deficiency, this issue may not have the attention it deserves as it has been seen to be something affecting a small proportion of the population, mainly from Black

In 2004, GPs noticed that many Somali patients had bone/muscle pain and some had frank osteomalacia with biochemical and X ray changes. A community study of 307 Somalis aged over 2 years old found 82% had severe Vitamin D deficiency (<15nmol/L). Concurrent research indicated the Somali diet was low in Vitamin D and a “food map” using appropriate foods was produced.

A supplementation study found that many Somalis who were deficient did not continue with treatment as they found the tablets unpleasant to take. In 2008, an audit of Liverpool GP practices found very different rates of testing for Vitamin D deficiency in practices with similarly diverse populations.

Testing rates increased following GP education.

One issue locally and nationally has been the unpalatability of Vitamin D products available for prescribing. Until recently these tablets always included Calcium, which people found unpalatable. However the availability of high dose Vitamin D formulations means Calcium is no longer always required. This availability, coupled with the persistence of a dedicated group of health professionals, has enabled development of Mersey Cluster guidelines for prevention and treatment of Vitamin D deficiency this year. These have been launched publically and a community awareness campaign is underway.
Minority Ethnic groups. Our Liverpool research began with our local Somali community and was seen as something affecting a small group of people. However, over the last five years Vitamin D deficiency has been recognised as an increasing problem that affects significant numbers of the UK population.

Issues in prevention of deficiency

Vitamin D supplementation for all pregnant and breastfeeding women has been recommended since 1991 and reiterated by NICE in 2008. Healthy Start vitamins became available for eligible children and pregnant mothers (with low income) in 2009. However, access required a complex application process and uptake is still very low. In 2010, Liverpool PCT considered universal supplementation unaffordable, though some other North West PCTs are providing it. Local research is currently examining the most effective strategy to reach all those at risk. This is likely to be universal supplementation, using a simple message and a simple delivery method, probably via Children’s Centres. Increasing awareness of the importance of Vitamin D is an essential part of this strategy, as prevention of deficiency in children relies on understanding on the part of pregnant women and consistency of message from midwives, health visitors and GPs, which is not always happening.

The recent resurgence of rickets and accompanying publicity prompted the UK Chief Medical Officers to write to all GPs, nurses and pharmacists in February 2012, pointing out the risks of Vitamin D deficiency and strongly recommending Vitamin D supplementation for pregnant and breastfeeding women and all children under five years. Implementing this has been left up to individual PCTs and future CCGs.

Meanwhile questions remain about the role of Vitamin D including: what is the optimal Vitamin D level for health; does deficiency affect pregnancy outcomes; can higher levels reduce risk of cancer and other chronic diseases; how much sun exposure is needed to optimise levels in different skin types and what is the role of diet and supplements in achieving optimum Vitamin D? In Scotland, food fortification is being advocated currently by senior medical specialists.

Case Studies

Karim was born in Liverpool to parents of Moroccan origin. He attended a walk-in centre when he was 14 months with an abnormal gait. Rickets was diagnosed via X-ray and he was treated with intravenous Vitamin D. He was still partially breast-fed at the time. His mother had been identified as Vitamin D deficient in pregnancy and her GP noticed that at three months after birth, she was not collecting Vitamin D prescriptions. The GP reinforced the importance of Vitamin D. However, a review of the mother’s notes showed she was still not picking up prescriptions regularly. She was found to be deficient and treated with high dose Vitamin D.

Patricia, a thirty year old pregnant black British woman, who worked in the health service locally, mentioned that she was feeling tired and achy. Her GP found her to be Vitamin D deficient. She stated in the local press: “I started to take Vitamin D and I still take these now. I noticed a real difference in my energy levels and have no more aches and pains”.

Mary, a white British nurse, was advised to use total sunblock after being treated for a melanoma. A year later she told her GP: “I feel as if I had been buried deep underground, dug up and made to work”. She was found to be severely Vitamin D deficient and treated. After this she was fine.

I started to take Vitamin D and I still take these now. I noticed a real difference in my energy levels and have no more aches and pain

Conclusion

Recognition of the crucial role of Vitamin D in maintaining health is likely to increase over the next few years. Meanwhile, a substantial proportion of the population, including pregnant women and children and a considerable proportion of BME communities, and an increasing number of older people, continue to be at risk of deficiency.

Action is needed at a local and national level to raise the profile of Vitamin D which is likely to contribute substantially to health inequalities in the UK.

Dr Katy Gardner, GP in Liverpool, lead for Vitamin D
Dr Ewan Wilkinson, consultant in public health Liverpool PCT, public health lead for Vitamin D
Vitamin D is used in the body to create a hormone, 1,25 dihydroxyvitamin D3, which is essential for bone health. Rickets and osteomalacia, softening of the bones leading to fractures and deformity in children and adults respectively, are recognised symptoms of Vitamin D deficiency. There is increasing evidence of its role in a variety of disorders for example heart disease, diabetes, cancer and autoimmune disorders including multiple sclerosis, although the strength of the link is not yet fully understood. Vitamin D deficiency is also associated with musculoskeletal pain, a symptom which prompted research in Liverpool with the local Somali community and led to local interest in this issue. Recent population surveys have indicated that 5 to 30% of adults in the UK are vitamin D deficient, depending on the time of year and skin colour.

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Vitamin D deficiency is detected by measuring 25-OH-Vitamin D in the blood. Unfortunately people who have healthy levels at the end of summer may slip into deficiency during the winter months. High dose vitamin D in the form of colecalciferol is now available to prescribe as a short course of treatment.

What does Vitamin D do?

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What are the risk factors for Vitamin D deficiency?

• People with darker skin colour
• Housebound people of all ages
• People aged 65 years and over
• Infants and young children under 5 years
• Intestinal malabsorption conditions e.g. coeliac disease
• Cystic fibrosis
• Routine covering of face or body/habitual sunscreen use
• Vegan/vegetarian diet
• Liver or renal disease
• Medications including certain anticonvulsants
• Obesity (BMI >30)
• Pregnant and breast feeding women, especially teenagers and short interval pregnancies
• Low Vitamin D dietary intake
• NB: If one family member is Vitamin D deficient it is likely other family members may be deficient

Where do we get Vitamin D from?

Approximately 90% of Vitamin D is manufactured in the skin following absorption of ultra violet light from sunlight (UVB light). 5-15 minutes daily sun exposure between 10am and 3pm from April to October (longer for darker skin) is needed to maintain vitamin D status. Dietary sources provide only 10% and include oily fish e.g. sardines, herring, mackerel, with small quantities found also in eggs and mushrooms. Margarine, some breakfast cereals and infant formula milk are fortified with Vitamin D.

How do you detect and treat Vitamin D deficiency?

Our team of experienced and skilled interpreters come from a wide range of diverse backgrounds and communities ensuring a culturally appropriate service. We pride ourselves in offering a service which empowers both local communities and our customers.

We are committed to providing our customers with an accurate, appropriate, confidential and cost efficient service.

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For a quote, call 0161 874 2161 or email interpreting@theBHA.org.uk Alternatively visit our website www.theBHA.org.uk/interpreting

We are interested in all languages.
This briefing summarises the findings and recommendations from a report, commissioned by the Department of Health, into race equality in mental health. The report is based on a series of interviews with NHS and local authority leaders. Ensuring that more people have good mental health, and more people recover, means there must be a focus on tackling inequalities in access and experience. Some Black and Minority Ethnic (BME) groups, particularly people from Black African and Black Caribbean backgrounds, have historically experienced poorer outcomes than the rest of the population. Some groups continue to have higher rates of admission to inpatient units and greater rates of detention than the rest of the population.

Real world examples of using evidence to improve health services for minority ethnic people

Designed for all practitioners in health and social care, this collection of 10 case studies shows how evidence can be used in commissioning for ethnic communities to: 1) Raise the profile of BME issues, 2) Understand particular needs, 3) Design solutions and 4) Monitor and create on-going improvement. The case study book contains short, one page 'teasers', linking to more detailed descriptions of the project and background online.

Why better income equality brings better health for all

Presentation based upon the book 'The Spirit Level- why equality is better for everyone' by Richard Wilkinson. The central thesis is that health in societies is related to income differences; health is poorer in countries with bigger income difference between rich and poor.

Better cervical screening for disabled women in Salford

This case study demonstrates how NHS organisations are improving equality outcomes for their local populations. More women in Salford are now able to use cervical screening services thanks to a number of new services developed by NHS Salford. Ensuring the service is more accessible for disabled women, for example, NHS Salford now provides transport to and from the clinic, hoists and specialist beds and volunteers to meet and support patients upon arrival. Staff are also trained in working with patients with unique physical needs, sensory impairment, learning difficulties and those with mental health difficulties.
**Research reviews by Health Equality Library Portal**

### Part of the Picture: Lesbian, gay and bisexual people's alcohol and drug use in England (2009-2011)

**Publisher:** University of Central Lancashire  
**Author:** Jez Buffin, Dr Alastair Roy, Heather Williams and Adam Winter  
**Published date:** 1st Jul 2012

Part of the Picture (POTP) aims to establish a national database of lesbian, gay and bisexual (LGB) people’s drug and alcohol use; to use the database to inform local and national policy and practice in addressing the drug and alcohol use of LGB people; and to improve knowledge and understanding of the needs of LGB people amongst drug and alcohol agencies through dissemination of the research findings. This report presents findings from the first three years (2009-11) of POTP, from a total sample of 4,206 lesbian, gay and bisexual people.

### One minority at a time - being black and gay

**Publisher:** Stonewall  
**Author:** April Guasp and Hannah Kibirige  
**Published date:** 13th Aug 2012

This report from Stonewall and the Runnymede Trust reveals failings in public services to meet the needs of Britain’s black and minority ethnic lesbian, gay and bisexual people. The report, based on detailed interviews with black and minority ethnic gay people, exposes widespread assumptions that black people are heterosexual. Many participants said this perception often leads to inappropriate and poor-quality responses from public services.

### Making equalities central to the business

**Publisher:** NHS North West  
**Author:** Equality, Inclusion and Human Rights Team, NHS NW  
**Published date:** 24th Jul 2012

This case study is one of a series being published by NHS North West to demonstrate how NHS organisations in the region are improving equality outcomes for their local populations. The Equality and Diversity team at Salford Royal NHS FT ensured that equalities work was seen as ‘core business’ by linking the outcomes from their work to other key quality standards and outcomes in the organisation’s business plan. In this document, Tammy Pike, Salford Royal’s Equality and Diversity Lead, explains their approach.

### Low income groups at highest risk of diabetes

**Publisher:** British Medical Journal  
**Author:** Stringhini, A., et al  
**Published date:** 22nd Aug 2012

Low income groups have higher rates of Type 2 diabetes and obesity is the most important risk factor. Lifestyle-related risk factors such as smoking, diet and exercise are a major reason for the difference. Researchers analysed long-term data on 7,200 British civil servants to assess the link between socioeconomic status and several major risk factors for type 2 diabetes. During an average follow-up period of 14 years, more than 800 people in the study were diagnosed with diabetes. Those in the lowest job category had a 1.86 times greater risk of developing diabetes than those in the highest job category.
Fill in the missing letters

sl_v_ry is when one person belongs to another

fr__d_m is having the right to live your life the way you want

em_nc_pat__n is when you break away from slavery and become free

_wn_r is the person who has bought a slave

p_n_shm_nt is what happened to a slave who tried to escape

m_r_tis where the slaves were sold

ab_lit__n is the ending of slavery

r_m_ni are the people who were enslaved

m_s__cn is one of the professions the slaves used to have

c_cpp_r is something the roma slaves used to make things from for their owners

Long Roads is an educational resource to support educators in teaching young people about the heritage of the romani people

To order a pack, please visit the BHA website - www.theBHA.org.uk or phone 0161 874 2152 or email info@theBHA.org.uk