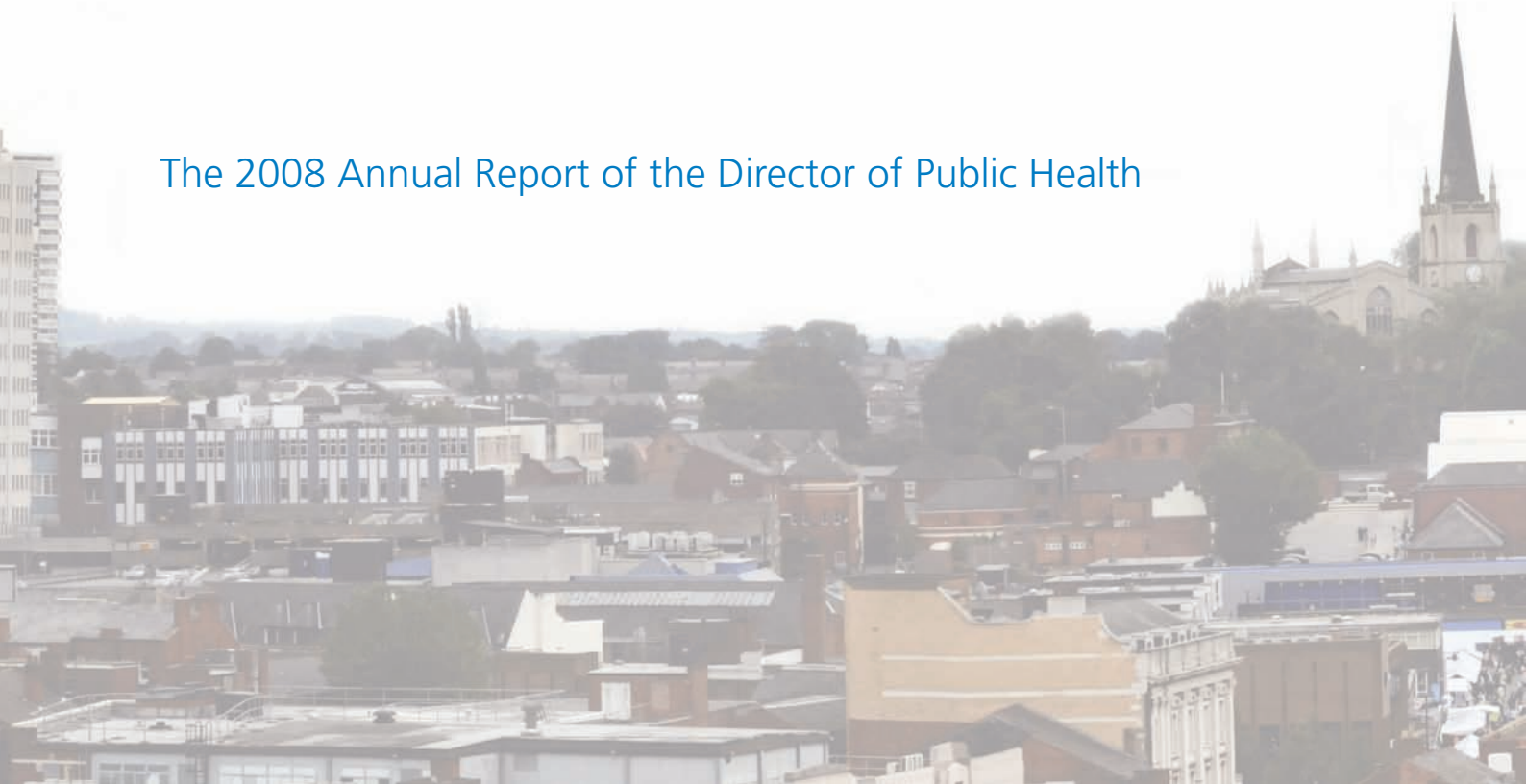
NHS Walsall

Walsall's socially excluded: who are they?

The 2008 Annual Report of the Director of Public Health



Most of the public and concerned professionals have a view on the estimated 10,000 socially excluded people living in Walsall: who they are and where they can be found. However, the reality is that agencies are geared for the majority, and although they do focus on the neediest, they often miss those with complex and multiple needs, but who require less help from any one particular service. The socially excluded may not meet the threshold of any given agency to trigger a fuller intervention, despite the scale of their problems or the harms caused to the communities in which they live. Many socially excluded people are not being picked up.

Using a range of acknowledged markers for social exclusion, and computing them all together, this report has attempted to define and map *Walsall's socially excluded: who are they?* with a fair degree of precision. The Conclusions section of this report (Chapter 9) defines where Walsall's socially excluded population are likely to be found.

Contents

The focus of this report is on socially excluded people who are largely part of the deprived and settled resident population of Walsall, whatever their ethnic affiliations. There is little consideration of people who freely choose a socially excluded lifestyle.

Foreword

Social exclusion is largely the domain of local authorities. So what is its place in a public health annual report? It is much to do with timing, since health inequality is a high Government priority and we are expected to work closely with Council. Many argue that partnership working to tackle health problems among poorer communities is the true public health. In this regard, social exclusion is the toughest challenge. We can examine it from the public health perspective, make recommendations, and pledge to support our local authority team of specialists in this most difficult of areas.

The title of this report - *Walsall's socially excluded: who are they?* - questions our understanding of the term. There is no universal agreement on definition, but there is widespread interpretation of associations and effects, often creating unease among the general population. Socially excluded people may become angry and resentful. Many seek relief in alcohol and drug misuse, and may resort to crime. They may evoke concerns over personal safety. Yet other socially excluded people invite feelings of pity or shame. They may be desperately poor, abandoned or chronically ill.

Some socially excluded groups actually choose their lifestyle, an example being many traveller families. However, social exclusion is mostly associated with poverty. There are dynamics to the socially excluded state. Some escape through work or training, but social drift is mostly in the opposite direction. There are critical periods during life - redundancy being one of many - that can lead to psychological damage, ill health, and risk of social exclusion. Through our social services, we can provide safety nets, but many say that Government should do more by providing springboards. In the meantime, are our safety nets efficient or effective enough? Can we do more?

The Chapter 9 conclusions of this report have come as a surprise. We are accustomed in Walsall to the east-west divide, whereby increasing poverty is encountered as we move westwards through the borough. However, through the work in this report, and through applying our methodology in arriving at a Social Exclusion Index, we find that the socially excluded communities of Walsall, while veering towards the west, are very much centrally aligned - along an axis from Blakenall in the north, southward, through and including the Town Centre areas.

We should prick the conscience of our policy makers. As a Spearhead borough, being among the nation's bottom fifth in health and deprivation, Walsall will come under the spotlight. It is logical that we examine our most disadvantaged people. The aim of this report then is to raise the profile of social exclusion in Walsall by:

- Attempting to determine the size of the socially excluded population.
- Establishing what are their needs for healthy and productive living.
- Asking to what extent we are addressing these needs.
- Recommending what more could be done.

I believe this report is a timely one and sincerely hope it raises more awareness of the plight of socially excluded people living in Walsall, as well as directing attention to those parts of the borough where health and other agencies need to focus in order to address these issues.

Dr Sam Ramaiah
Director of Public Health

November 2008

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Note on Map displays in this report

It should be noted that although the key to maps in this report may appear to display overlapping data ranges, there is no actual data overlap and the ranges are mutually exclusive. For example, Map 3 displays a range 14.1 to 20.7 in the key, followed by 20.7 to 26.9 as the next range. However, the data input is actually 14.1 to 20.6999, which the mapping package rounds up to 20.7 in displaying the key to the Map. Similarly, for the next range the data input is between 20.7 to 26.8999, which is rounded in the display key to 26.9.

Chapter 1: Introduction and overview

There is no agreed definition of social exclusion, but there is agreed understanding of its dimensions, associations, and effects. Socially excluded people:

- Refers not only to people living in conditions of relative deprivation, but also to those who are marginalised from aspects of social and community life.
- Includes those who are marginalised and not always economically deprived, but may be stigmatised and denied access to society's resources such as educational opportunities, social networks, health and support.
- May appear to be accepted members of society, but through life events - such as debts, job loss or housing insecurity - may become depressed, desperate, or vulnerable, and gradually assume a marginalised and/or deprived existence.
- Tend to be associated with a number of factors, including unemployment, low income, poor housing conditions, low educational level, ill health, stigma and discrimination, issues around citizenship, and lack of integration into society.
- Can identify themselves as such because the environment or area where they live, or the group to which they are affiliated, is itself socially excluded.

Tackling social exclusion requires: (1) legislation to protect human rights; (2) social services, housing, and interventions to remove barriers to health; and (3) income support or minimum wages, along with educational and employment policies. In this report, different examples of socially excluded people in Walsall are described against a background of groupings according to the social determinants of health. Extensive reference in this report is drawn from the classic text on social determinants of health by Marmot and Wilkinson (2006).

Social Exclusion and Poor Health

We have always had socially excluded people in society. They are ever present. Indeed, their numbers are increasing, along with the widening gap between the very rich and very poor. Inequalities are made worse very easily. Socially excluded people and those living in deprived communities have poorer health.

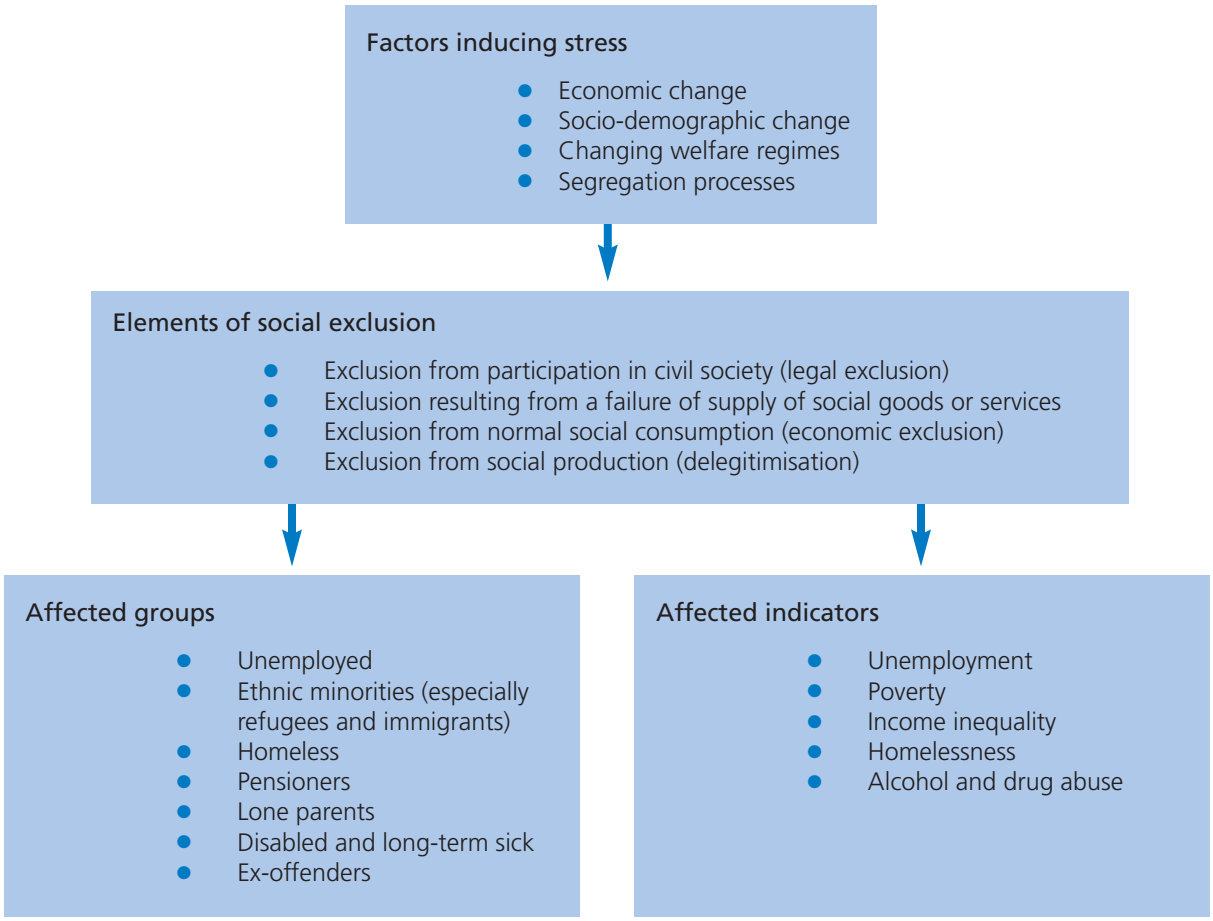
Socially excluded and poorer people have less choice. For example, significantly reduced spending on parks has made choosing exercise more difficult, especially when joining a gym is costly and the streets are deemed unsafe. Again, better diets are more easily available in richer areas. Better off, better educated and socially included people are quicker at taking up health information. They access medical care earlier and are better at complying with treatment. Socially excluded people are less likely to be screened for cancer, are more likely to be admitted to hospital as an emergency, and are more likely to die younger. Highly relevant to life expectancy, and accounting for around 50% of it, is smoking - which is significantly more prevalent in the socially excluded.

The socially excluded contain *hard to reach* groups but they are easily reached by the tobacco industry. Also by the drinks industry, at a time when alcohol is more easily available and cheaper than ever before. They are disproportionately harmed by all substances, notably drugs, tobacco and alcohol.

A useful summary of social exclusion has been provided by Shaw *et al* (2006), describing the condition as affecting individuals or areas that suffer from linked problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdowns. The socially excluded have lesser access to economic resources, educational opportunities, social networks and support. In the UK today, there are increasing problems of access to scarce resources, so that the quality of social relations in our modern society is built on material foundations. For this reason, the problems of social exclusion are for the most part intimately associated with material and relative deprivation, and closely correlated with health inequality (Wilkinson 2006).

White (1998) describes the processes leading to social exclusion, which include economic change (increased unemployment, widespread job insecurity), demographic change (increased proportions of single households, lone parents, elderly), changes to welfare regimes (cuts and withdrawal), and specific spatial processes of segregation and separation (stigmatisation and marginalisation of certain groups, often leading to spatial segregation of minorities).

The process and outcome of social exclusion in Europe (White 1998)



Social exclusion can refer to communities, since they can become victims of deprivation or stigma. All people within a community may become affected, such as when a factory closes down and no other alternative jobs become available. Areas with high unemployment and high levels of deprivation are also likely to have poor schools, and so an individual's circumstances and risk of social exclusion can depend very much on his or her geographical setting. Other findings confirm the fact that social exclusion is not just about individuals. Work in Glasgow has shown not only differences in self-reported health between local areas, with more advantaged areas reporting fewer health problems, but there was also an association between people's perceptions of their local social and physical environment which could not be explained by social class differences (Sooman and Macintyre 1995). Such perceptions were based on important factors such as local amenities, area reputation, fear of crime, neighbourliness, and area satisfaction. Later work reported on the important role of social cohesion (Macintyre and Ellaway 2000). There is a spatial dimension to social exclusion, whereby you can be born into such an existence and remain there.

Chapter 1: Introduction and overview

To feel depressed, cheated, bitter, desperate, vulnerable, frightened, angry, worried about debts or job and housing insecurity; to feel devalued, useless, helpless, uncared for, hopeless, isolated, anxious and a failure: these feelings can dominate people's whole experience of life . . . The material environment is merely the indelible mark and constant reminder of the oppressive fact of one's failure, of the atrophy of any sense of having a place in a community, and of one's social exclusion and devaluation as a human being (Wilkinson 1996).

Social exclusion and health inequalities

Tackling social exclusion is part of addressing health inequalities. We are reminded that the National Health Service (NHS) was set up in 1948 to provide health care for all, based on need rather than ability to pay, recognising that health care is a basic human right. NHS core principles include responding to the needs of different populations and working to keep people healthy, while reducing health inequalities. The Black Report (Department of Health and Social Security, DHSS 1980), and those that followed, managed to keep inequalities at the front of the public health agenda. The Acheson Report (Department of Health, DH 1998), made recommendations around poverty, income, education, mothers and children, and ethnicity, which fed into *Saving lives: Our Healthier Nation* (DH 1999). The *NHS Plan* (DH 2000) put inequalities on the agenda in terms of NHS delivery and in 2001 the Health Secretary announced health inequalities targets relating to life expectancy and infant mortality.

Government has introduced the most comprehensive programme ever seen in the UK to address health inequalities. A national Public Service Agreement (PSA) health inequalities target has been introduced, along with specific targets.

Health Inequalities PSA Target

By 2010 to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.

The PSA target is underpinned by two more detailed objectives:

- Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between routine and manual groups and the population as a whole.
- Starting with local authorities, by 2010 to reduce by at least 10% the gap in life expectancy between the fifth of areas with the worst health and deprivation indicators (the Spearhead Group) and the population as a whole.

Specific health inequalities PSA target elements have been added:

- Reduce the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole by at least 40% for cardiovascular disease and by at least 6% for cancer.
- Reduce adult smoking prevalence in routine and manual groups to 26% or less by 2010.
- Halt the year on year rise in obesity among children under 11 by 2010.
- Reduce the under-18 conception rate by 50% by 2010.

Tackling health inequalities is one of the top 6 priorities for the NHS, as set out in the NHS Operating Framework 2006/07.

Department of Health health inequalities website (www.dh.gov.uk)

Primary Care Trusts (PCTs) have been designated the responsible bodies to take the local lead in achieving the targets, in conjunction with Local Authorities (LAs), NHS Trusts and other partners, through Local Strategic Partnerships (LSPs). The Public Health White Paper *Choosing Health* (DH 2004) ensures that priority is given to health inequalities, so that all groups in society can benefit from improvement in public health. This followed *Tackling health inequalities: a programme for action* (DH 2003), which sets out actions, roles and responsibilities, and ways to monitor progress. More recently, the Government established a Public Service Agreement (PSA) target to address geographical inequalities in life expectancy, cancer, heart disease, stroke and related diseases; the objective being to see faster progress in the fifth of areas (Spearhead Groups) with the worst health and deprivation indicators compared to the average. Government defined Spearhead Groups among the bottom fifth of areas as having at least three of the following five indicators:

- Male life expectancy at birth.
- Female life expectancy at birth.
- Cancer mortality rate in the under 75s.
- Cardiovascular disease mortality rate in the under 75s.
- Index of Multiple Deprivation (IMD) 2004, average score.

Government had already played its initial part in addressing inequalities through a range of national programmes, such as Sure Start (to support the development of pre-school children from poorer families), the National Strategy for Neighbourhood Renewal (to support an integrated approach to regeneration in the most deprived communities), and the UK Fuel Poverty Strategy (to support housing improvements targeted at vulnerable households). Key lessons were learnt from such initiatives, not least that in order to achieve the targets and tackle the underlying determinants of inequalities, action will be required across government. While action will be taken nationally, the main contributions will be made locally, given that local planners and communities know best what their problems are, and how to deal with them.

The Department of Health (health inequalities website on www.dh.gov.uk) (2004) has listed actions likely to have the **greatest impact over the long term:**

- Improvements in early years support for children and families.
- Improved housing and reduced fuel poverty among vulnerable populations.
- Improved education and skills development among disadvantaged populations.
- Improved access to public services in disadvantaged communities.
- Reduced unemployment and improved income among the poorest.

Clearly, this potential impact will kick in beyond 2010, but will benefit the majority of the socially excluded population if successful and sustained by Government policy. Specific interventions among disadvantaged groups most likely to have an impact, for the 2010 target, in **closing the life expectancy gap** are: (1) reducing smoking in manual social groups; (2) preventing and managing other risks for coronary heart disease and cancer, such as poor diet and obesity, physical inactivity and hypertension; and (3) improving housing quality by tackling cold and dampness. To **close the infant mortality gap,** key short term interventions include: (1) improving the quality and accessibility of antenatal care and early years support in disadvantaged areas; (2) reducing smoking and improving nutrition in pregnancy and early years; (3) preventing teenage pregnancy and supporting teenage parents; and (4) improving housing conditions for children in disadvantaged areas.

Local delivery plans (LDPs) are now in place to ensure that the recommended interventions are in place. They are an important requirement that forms the basis of the management relationship between the NHS and the Department of Health (DH). There are planning requirements for the NHS, including specific ones in the LDPs on tackling inequalities. The DH has provided guidance to support NHS planners and commissioners: *Tackling*

health inequalities: what works (2005), and goes on to state that the health inequalities programme is organised around four themes:

1. **Supporting families, mothers, and children** - ensure the best possible start.
2. **Engaging communities and individuals** - ensure relevance and sustainability.
3. **Preventing illness and providing effective treatment** - NHS leadership.
4. **Addressing the underlying determinants of health** - secure the long term.

Implications for Walsall

Walsall is among eight of 17 PCTs across the West Midlands that fall among the Spearhead Groups. Walsall is in the bottom fifth for the following three indicators:

- Male life expectancy at birth.
- Cardiovascular disease mortality rate in the under 75s.
- IMD 2004, average score.

In Walsall, large variations are observed, with increasing infant mortality, and life expectancy ranging from 71 to 81 years in men and 76 to 83 years in women. Smoking in pregnancy and breastfeeding rates are better in the east and south of the borough, compared to the north and west.

The PSA targets of reducing health inequalities by 10%, as measured by infant mortality and life expectancy at birth, and of tackling the underlying determinants of heath and inequalities, prompted the Department of Health to make the issue a priority in the NHS operating framework from 2006/2007 and a mandatory indicator through Local Area Agreements (LAAs), between PCTs and LAs from April 2007. Since much emphasis is being placed on health inequalities, PCTs and LAs have a major responsibility in taking this forward at the local level. The Walsall Borough Strategic Partnership (WBSP) - the Local Strategic Partnership (LSP) - has responsibility for strategic direction and for developing and performance monitoring the LAAs. One of the LAA objectives is to close the gap in performance by focusing on reducing inequalities. A proposed re-modelling of existing structures will result in a Health Inequalities Partnership Board (HIPB), whose role will be to performance manage relevant LAAs and the life expectancy project, and implement the Health Inequalities Strategy.

The role of Local Government

Local authorities aim to improve the health of their communities and to tackle health inequalities by working in effective partnership with the NHS, other public sector bodies, and the private, and 'third' (voluntary and community) sectors. LSPs are key for this aim; their work brought into focus by LAAs. Each LAA is a 3-year agreement that sets out the priorities for a local area, agreed between central government and a local area, represented by the local authority and LSP. The agreement is made up of outcomes, indicators, and targets aimed at delivering a better quality of life for people, through improving performance on a range of national and local priorities. There are several examples of programmes which impact on social exclusion.

Examples of national programmes that address the underlying determinants of health and which can help tackle social exclusion

- Child Tax Credit.
- Communities for Health (C4H).
- Community Legal Service.
- Connexions.
- Creative Partnerships.
- Crime and Disorder Partnerships.
- Drug and Alcohol Action Teams.
- Healthy Living Centres, sustained (former Lottery Programme).
- Homelessness Act (2002).
- Hospital Travel Costs Scheme.
- Job Centre Plus.
- Learning and Skills Councils.
- Low Pay Commission.
- Making the Connections: Transport and Social Exclusion (2003).
- Minimum Income Guarantee (replaced by Pension Credit, 2003).
- National Alcohol Harm Reduction Strategy.
- National Drugs Strategy.
- National Minimum Wage.
- National Strategy for Neighbourhood Renewal.
- Neighbourhood Management.
- New Deal.
- New Opportunities Fund (now replaced by Big Lottery Funds).
- Positive Futures.
- Regional Development Agencies.
- Skills for Life.
- Sure Start and Children's Centres.
- Sustainable Communities: building for the future (2003).
- Sustainable Development Commission.
- UK Fuel Poverty Strategy.
- Valuing People: a new strategy for learning disability.
- Working Tax Credit.
- Youth Offending Teams.

One particular initiative relevant to social exclusion is Communities for Health (C4H), which aims to identify and promote local projects that engage communities, especially hard-to-reach groups, in improving their own health, thereby reducing health inequalities. This programme serves as a vehicle for testing new, innovative initiatives. LAs work in partnership to strengthen disadvantaged communities and empower individuals, many of whom are socially excluded, to ensure that within 10 to 20 years, no one is seriously disadvantaged by where they live.

Local authorities will be assessed as part of the Comprehensive Performance Assessment (CPA) on the action they are taking to reduce health inequalities, through the ongoing LAA process. Important programmes include those tackling child poverty, homelessness, teenage pregnancy, and neighbourhood renewal. A practical guide was produced on creating healthier communities, to help drive forward local health improvement and tackle health inequalities (Office of the Deputy Prime Minister 2005). Tackling the underlying determinants of health, such as housing, education, and work, is clearly fundamental to sustained and long term success in addressing health inequalities. Local authorities and wider partners, such as Housing and 'Third Sector' organisations, have a key role to play.

As much as addressing inequalities will impact on social exclusion, more specific action is still required. This was recognised by the creation of a special taskforce.

Cabinet Office Social Exclusion Taskforce

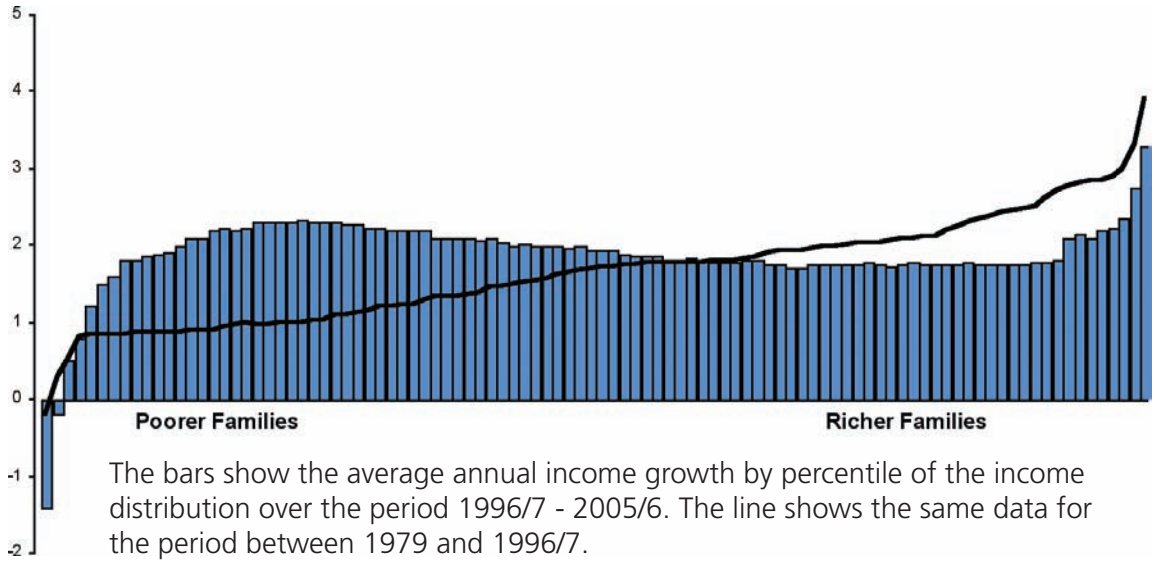
The taskforce has shown the Government's commitment towards better public services, plus measures such as the minimum wage and welfare changes through the tax and benefit system have enabled people to prosper and secure better outcomes for the most disadvantaged groups. However, a minority have not benefited and are caught in a cycle of disadvantage; standing out starkly and comprising most of the socially excluded. The taskforce is charged with a focus on social exclusion in a more specific and targeted way, especially to help and support the most vulnerable families and children facing the most complex problems and barriers.

Number of Socially Excluded People in Walsall

Those in poverty often overlap with those who are excluded; a complex web where a poor neighbourhood is usually a common factor. Within this complex are those in a state of deep and persistent exclusion. The taskforce estimates that this socially excluded group comprises between 2 to 3% of the population (Social Exclusion Task Force 2007). Around 80% of the population live above the poverty line, with around 20% comprising the working or coping poor, and resilient families. The 2 to 3% are found within this 20% of the population. They can be classified as 'poverty plus' and usually contain those with multiple problems such as people with mental health issues, drug users, young offenders, and children in care. It is estimated that Walsall, with a population of around a quarter of a million residents, has up to 7,500 people who are in a state of deep and persistent social exclusion. It is probable that at least 10,000 Walsall people can be defined as socially excluded or at risk of being so.

The taskforce progress report (2007) presents a chart which compares average income growth rates for different groups from 1996/97-2004/05 and 1979-1996/97. The poorer income groups are represented to the left of the chart and the better off ones to the right. For 1996/97-2004/05, each vertical bar represents a percentile of the population. The data for 1979-1996/97 are represented by the line. In contrast to the highly regressive picture from 1979-1996/97, during the last decade lower income groups have seen their incomes rise faster than the richest group of families.

Figure 1. Average annual income growth by percentile of income distribution

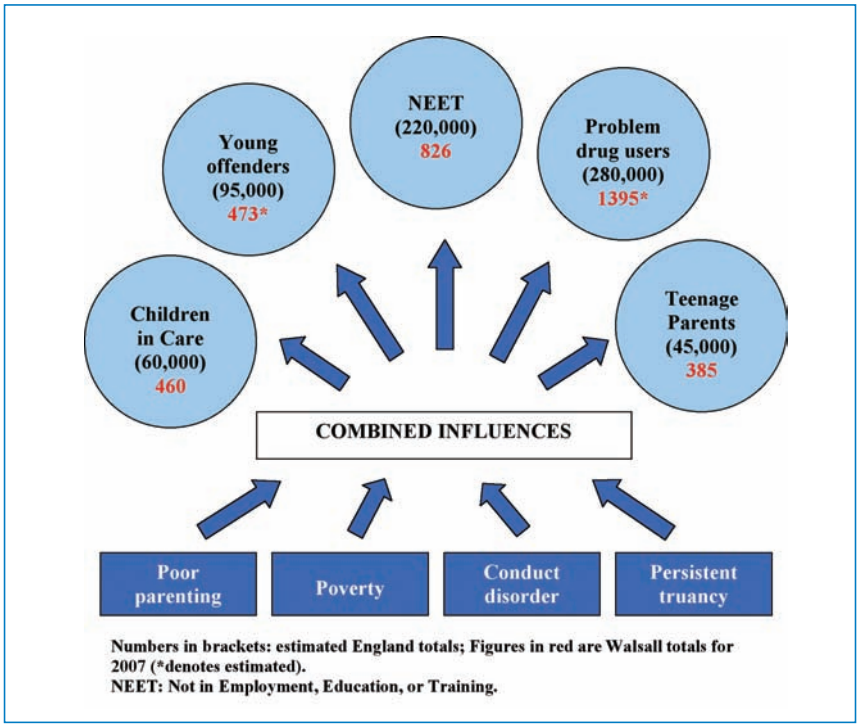


The bars show the average annual income growth by percentile of the income distribution over the period 1996/7 - 2005/6. The line shows the same data for the period between 1979 and 1996/7.

Source: Social Exclusion Taskforce (Cabinet Office), 2007.

Many people may be poor, have a long-term illness, or struggle with basic literacy, but this does not necessarily mean that they are socially excluded. Certain protective factors, such as supportive parents for children, can ensure that outcomes in later life are much more positive. The taskforce report (2008) proceeds with the factors that may result in social exclusion, by looking at young people in particular. Specifically looking at a small group of people who face multiple intractable problems that, when combined, result in social exclusion. This is illustrated in the diagram.

Figure 2. Groups at risk of social exclusion



Source: Walsall data: Children in Care (Care Plus, NHS Walsall); Teen Parents (Care Plus, NHS Walsall); NEET (Prospects).

Later childhood and youth is a key transition point that can determine a young person's future life chances. Those who are at risk of a lifetime of social exclusion, such as young offenders or those not in employment, education, or training (NEET), often have common characteristics which can be seen as risk factors; for example, growing up in poverty or with poor parenting. People who fall into certain groups at this life stage experience poor outcomes and are at risk of facing a lifetime of social exclusion; for example, teenage parents, young offenders, and problem drug users. Many of these groups overlap; for example, 74% of teenage parents are also NEET.

A significant change is intended for ways that social exclusion will be addressed:

- Government will work harder to identify those at risk and intervene, despite the high costs, since these will be matched by the benefits of a better quality of life, leading to contributions to society and less damage to local economies.
- Performance management systems will need to be sufficiently attuned to identify when people are being missed. The most excluded families do badly on a range of outcomes, but may not be detected in conventional datasets; the same few families are failing to be picked up in different service areas.
- More must be done to promote multi-agency working. Services need incentive to personalise services around the needs of the individual and the family.

The Social Exclusion Task Force is working across departments to consider how to develop a cross-government PSA which could help both adults and families.

Chapter 2: Deprivation and social determinants of health

Chapter content at a glance:

Description of the social determinants of health and their link with deprivation and social exclusion; Walsall deprivation data; Life expectancy and inequalities; Social Exclusion Task Force.

Social exclusion examples:

Poor and Relatively Deprived People

While the poorest people in society have the poorest health, a gradient of ill health and mortality operates across all the socio-economic strata. This gradient persists despite the long tradition of research into inequalities in the UK (Davey Smith *et al* 2001). In England for the period 1986 to 1999, all-cause mortality fell in all classes, but the class gradient was persistent. For males, the social class gap actually widened (White *et al* 2003). A concept closely identified with social exclusion is relative deprivation, which refers to the disadvantaged position of a person, family, or group relative to the society to which they belong. This is the basis of the Townsend index of deprivation, which is a composite of indicators such as unemployment, housing, car ownership, and overcrowding (Townsend *et al* 1988). Material conditions are the underlying root of ill health (Davey Smith *et al* 1994; Shaw *et al* 1999). Living in a relatively deprived area can drive a person into extreme poverty and/or social exclusion, along with associated poorer health (Shaw *et al* 2006; Haan *et al* 1987; Langford and Bentham 1996; Shouls *et al* 1996; Davey Smith 2003). Blackburn (1991) asserted that poverty also affects health through psychological processes; or example, living on a low income means a lack of control over family health, so that mothers will often sacrifice their own health in favour of their children. Graham (1995) found that high smoking rates among poor women were related to coping mechanisms in caring for their families. Therefore, poverty and constraints on everyday life can readily explain unhealthy behaviours.

As summarised by Shaw *et al* (2006), increases in poverty and inequality across Europe have resulted in deteriorating health among deprived communities. Those areas of England and Wales, between 1984 and 1994, with the greatest gains in prosperity, had the greatest gains in life expectancy, (6.7 years for men; 4.7 years for women) compared to negligible improvement in deprived areas (Raleigh and Kiri 1997). Poorer health outcomes have been heavily influenced by smoking, poor diet, and a lack of exercise (Cockerman 1997). A great proportion of the increase in mortality among males has been due to accidents and homicide, many being alcohol related (Ellman 1994). Recent incidence rises of tuberculosis in the UK have been linked with deprivation and concentrations of socially excluded groups such as ethnic minority communities (Darbyshire 1995; Kumar *et al* 1995). Worsening conditions experienced by the poor and socially excluded have led to social stress, declining marriage rates, and soaring crime rates.

There is a strong relationship between income and health within all developed countries, although there is no relation between gross national product per capita, as an indication of average living standards, and death rates (Marmot and Wilkinson 2001; Wilkinson 1997). In other words, health among the most affluent countries such as the UK is a reflection of social position and relative income, rather than exposure to differences in living standards alone. This is clearly obvious among most socially excluded groups living in conditions of relative deprivation. Animal experiments, in which social position was manipulated, showed clear stress effects of social position (Shively and Clarkson 1994). Social gradients seen in these animals were similar to those found in humans. Social status is closely correlated with the amount of control people have. Low control at work explains a significant part of the social gradient in health seen in the Whitehall studies (Marmot *et al* 1984, 1991). Empowerment is all important for good health. Feelings of being subordinate, if sustained, are associated with chronic stress and ill health. Indeed, low control is commonly accompanied by feelings of hostility (Williams *et al* 1997). Bitterness, anger, and hostility are frequently experienced by people who are socially excluded.

In summary, social exclusion is mainly associated with relative deprivation. Social determinants of health, such as a deprived upbringing, poor education, lack of employment, inadequate housing, and a lack of social support or relationships, are strongly related to an impoverished existence. However, underpinning all these factors are the fundamentals of social position and empowerment. Deficiencies in these two important areas are a source of chronic stress, and this is the basis for much ill health among the deprived and socially excluded people living in our society.

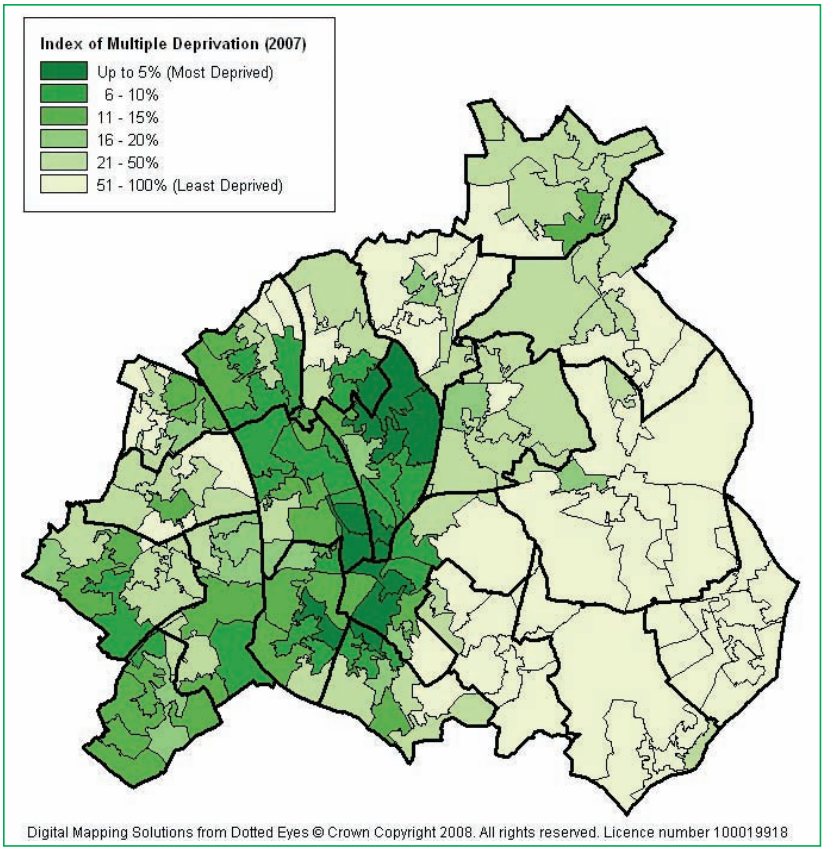
The Influence of the World Health Organsation (WHO) on Health Inequalities, Deprivation and Social Exclusion: The Latest Initiative - Commission on Social Determinants of Health

- WHO's most recent launch is the Commission on Social Determinants of Health. Its Commission Chair, Michael Marmot, has outlined its work and background findings (2007): Health equity is central to the work of the Commission . . . which focuses on the fundamental structures of social hierarchy and the socially determined conditions these create in which people grow, live, work, and age . . . The outcry against inequity has been intensifying for many years from country to country around the world . . . forming a global movement. The Commission places action to ensure fair health at the head and the heart of that movement.
- A major thrust of the Commission is turning public health knowledge into political action. It has an endpoint, the end of 2008, by which it will report to, lean on, and lobby governments (60 years after WHO's creation).
- WHO is becoming better at getting governments to invest in addressing health inequalities; something we are already seeing in the UK.
- The Commission will suggest more to tackle social exclusion, especially pointing the finger at those countries who are lagging behind on the inequalities agenda - this will include the UK, which is ranked 12th in health from among 21 rich countries.

Walsall

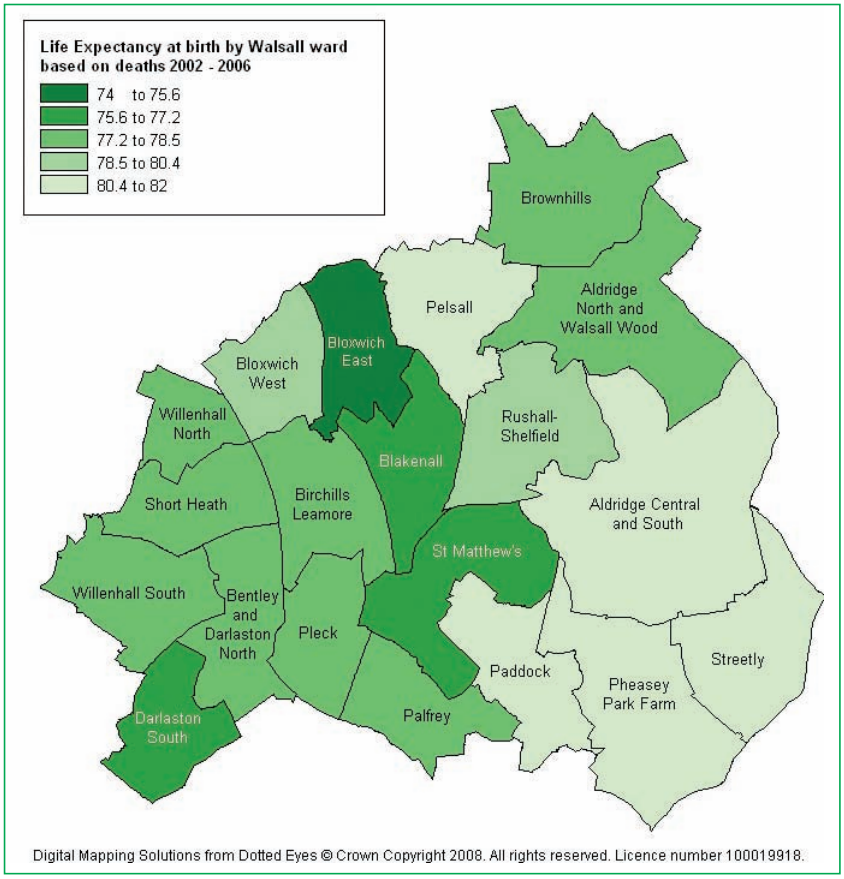
Around a quarter million people live in Walsall, the densest population occurring in the north, west, and south, in close proximity to the M6. The south-west has a high ethnic minority population (14% of total; 19% of primary school children), largely South Asian, with a youthful age profile (Griffiths 1999). Wards located in the west and centre, along a north-south axis, are more deprived. Young people, age ≥ 19 years, account for 27% (68,000) of the borough population (253,500), with those < 16 years ranging from 17% in the less deprived Paddock and Pheasey to > 25% in the more deprived Blakenall, Palfrey, Birchills Leamore, and St Matthew's (Walsall HA 2002). The more deprived wards have the highest proportion of births to one-parent households, with Blakenall the highest at 29% (compared to Streetly with none). Map 1 shows that neighbourhoods in some central and northern parts of Walsall are among the most deprived (top 5%) in England. These include centrally located neighbourhoods of Alumwell, Caldmore, Pleck and Walsall Central, and more northern neighbourhoods of North Blakenall, Leamore, Goscote and North Walsall.

Map 1. Deprivation by Lower Super Output Area in Walsall (IMD 2007)



Source: Index of Multiple Deprivation 2007

Map 2. Life expectancy at birth (persons) by Walsall ward 2002-06



Source: Office of National Statistics (ONS)

People living in Bloxwich East have the lowest life expectancy in Walsall (74.5 years). Blakenall, St Matthews and Darlaston South also suffer from much lower life expectancy than other wards. In contrast, people in Streetly, Pelsall, Aldridge, Paddock and Pheasey can expect to live up to 7 years longer (Streetly 81.9 years).

The DH and Association of Public Health Observatories (2007) have produced health profiles (www.community-healthprofiles.info). Walsall maps of income inequalities, based on the most income-deprived fifth of areas, highlight the following wards: Birchills Leamore, Blakenall, Palfrey, Pleck, and St Matthew's. The next most deprived wards were: Bloxwich East, Bloxwich West, Bentley and Darlaston North, Darlaston South and Willenhall South.

The data showed that

- 18.8% of Walsall residents were dependent on means-tested benefits (England avge 12.9%).
- Child poverty (percentage of children living in low income households, 2001) was high at 27.1% (England avge 21.3%) – 14,887 total children.
- However, there was a below average rate of homelessness (% age of households on LA housing register who were statutorily homeless, 2004/05) at 4.0% (England avge 7.8%) – 486 total homeless.
- Violent crime was high (crude rate per 1,000 population, 2005/06) at 22.1% (England avge 19.8%) – total 5,599 reported incidents.
- Compared to England averages, educational attainment was lower, while teenage pregnancy rates were higher.
- There were worse than average rates for disease: 4.8% prevalence of diabetes (England avge 3.7%), early deaths from heart disease and stroke (104.9 per 100,000; England avge 90.5), and from cancer (130.8 per 100,000; England avge 119.0).
- Infant mortality was above average at 8.4 per 1,000 live births for 2004 (England avge 5.1), while male life expectancy was lower at 75.7 years for 2003/05 (England avge 76.9), as was female life expectancy at 80.7 years (England avge 81.1). Relevant to relative deprivation and social exclusion is closing the life expectancy gap between wards, since the gap between the worst and best is 11.1 years for men and 8.8 years for women.

Chapter 2: Deprivation and social determinants of health

Walsall Borough Strategic Partnership (WBSP) commissioned Public Management Associates to produce a report on increasing life expectancy by reducing inequalities (2005). Ward based data were required on 14 priority factors that impact on life expectancy: low birthweight, breastfeeding, teenage pregnancy, sudden infant death, accidental injury, healthy eating and physical activity, secondary prevention of CHD and stroke, smoking cessation, diabetes, access to services, benefit uptake, housing, educational achievement, adult basic skills and employment. These were then included among a wide range of indicators: such as deprivation scores; demographic data on age, gender, and ethnicity; income; child poverty; crime rates; fear of crime; access to vehicles; disability; limiting long term illness; etc.

In total, **45** significant indicators were computed and subjected to detailed statistical analysis. Of the total 20 wards in Walsall, 10 wards had 25 or more indicators scoring worse than average; they were all located in the western, more deprived part of the borough.

These 10 deprived wards (and number of indicators scoring worse) were: Birchills Leamore **(41)**; Pleck **(40)**; Bentley and Darlaston North **(39)**; Darlaston South **(38)**; Bloxwich East **(37)**; Bloxwich West **(37)**; Blakenall **(36)**; Willenhall South **(33)**; Palfrey **(27)**; St Matthew's **(25)**.

The remaining wards were: Brownhills **(19)**; Short Heath **(15)**; Hatherton Rushall **(14)**; Willenhall North **(10)**; Aldridge Central and South **(9)**; Pelsall **(9)**; Paddock **(7)**; Pheasey **(6)**; Aldridge North and Walsall Wood **(3)**; Streetly **(2)**.

Appendix 3 summarises the key findings of the 10 worst scoring wards in Walsall.

Community engagement in Walsall

The engagement of community and voluntary groups is key to improving life expectancy and reducing inequalities. Up to 30 Community Associations (CAs) operate across Walsall, some such as at Palfrey and Blakenall having access to a good range of facilities, and being at the centre of community activities. They struggle after initiatives such as Healthy Living Centres and Neighbourhood Renewal came to an end. There was a boom in community engagement during the time of Health Action Zones (HAZ) from the end of the 1990s, but then only the most resilient organisations continued. With exceptions, especially around the town centre, the most deprived areas have the least well established organisations. Recognising the power and potential of CAs, Local Neighbourhood Partnerships are well placed to coordinate meeting community needs. The buzz associated with the time of HAZ has to be regained.

Addressing inequalities in Walsall

Walsall produced a detailed action plan for the period 2007-2010 to increase life expectancy (Walsall Borough Strategic Partnership 2007), after noting the short term, high impact actions that would help to meet the various 2010 targets (Chapter 1). There was need for ward-based health interventions to reduce or address:

- Early deaths in the older population by
  - Reducing smoking rates (1)
  - Preventing falls (2)
  - Managing long term conditions (3).
- Smoking in pregnancy (Maternal and child health, 4).
- Teenage conceptions (5).
- Housing (6).
- Accidents (7).

The plan was structured around these seven key action areas, along with the wider determinants such as reducing poverty, tackling crime, improving education, and increasing employment.

The plan targeted priority wards, largely based on deprivation and poor health indices. A key development by Walsall tPCT has been that of practice based commissioning (PBC) groups, which have responsibility for local services to improve health. Walsall Council launched nine local neighbourhood partnerships (LNPs), aimed at engaging local communities in decision making around local issues. The PBC groups and LNPs will have a major role to play in tackling health inequalities and increasing life expectancy. Each of the nine LNP areas was prioritised for action according to the above seven key areas. For example, one of the most deprived LNP areas, Blakenall and Bloxwich, was prioritised for all seven areas. There were a number of defined actions, each with a designated Walsall ward location, a nominated lead or responsible person, an identified guideline document (usually strategy, plan, or pillar type), and an indicator (for tracking from baseline, through from 2006 to 2010). Actions included: smoking cessation interventions; falls prevention initiatives for housing, residential and nursing care; long-term conditions management, such as uptake of the influenza vaccine; promoting breastfeeding and avoiding sudden infant death; teenage pregnancy efforts to increase availability of emergency hormonal contraception (EHC) and condoms; housing improvements such as home fire safety checks, installation of free smoke alarms, and affordable warmth schemes; and accident prevention to reduce deaths and serious injury from road traffic accidents.

Challenge for Walsall Borough Strategic Partnership

A major challenge for WBSP is overcoming boundaries as arbitrary determinants, *eg* around wards, school and primary care catchment areas, housing services. It is fundamental that energy be directed at deprived areas, to improve their health outcomes at a greater rate than their more privileged neighbours; otherwise it will be wholly untenable to even touch on the problems of the socially excluded. It is clear that not all agencies have developed joint working in their services. Many are stand alone and unconnected from social policy. WBSP needs to sort this out. To which can be added the need to share data and make sense of it through proper intelligence.

Health Trainers and inequalities

Health trainers are recruited locally and deployed by the tPCT in communities with the highest need of action to tackle health deprivation and reduce inequalities. Their function is to help people make positive behavioural changes to improve their health, and to help them access health information and/or services. Two national awards based on health trainer competences have been developed. The Walsall Health Trainer Service is one of very few in the Region and has recognised good practice (Beacon status is pending). It provides one-to-one support, utilising motivation to meet goals guided by personal health plans, with signposting to mainstream services. It aims to counteract deprived and socially excluded people's poor and late uptake of health and social services. The workforce is flexible, and supports people to attend appointments, especially in accessing primary care prevention. There are over 25 community locations for health trainers across Walsall, including Sure Start, Children's Centres, Health Centres, and Libraries. Referrals are received from, for example, Primary Care, Pharmacies, Infertility and Antenatal Clinics, and Mental Health. Self referral is increasingly being encouraged. The destinations for referrals include: Community Dieticians, Weight Watchers, Smoking Cessation Team, Physical Activity Team, Walk Leads, Community Groups and Clubs, and specific Primary Care. Health Trainers continue to target Walsall's deprived areas, from which the majority of referrals originate; two trainers specifically operate in the New Deal for communities footprint. From January 2007 to May 2008, 2,659 referrals were made to the Health Trainer service. The service is proving increasingly popular.

Clearly there is scope to expand into other areas. There is current work on a pilot with Community Mental Health to increase access to patients. Access times will be extended to target working populations during Saturdays. Home visits are planned to increase access to people with long term conditions. The potential is enormous and holds particular promise in accessing socially excluded groups of people in Walsall.

Social Exclusion Task Force: what we should do

The taskforce action plan, *Reaching out* (2006), referred to five guiding principles in order to better tackle social exclusion:

- **Better identification and early interventions.** The aim is to identify early those at risk of persistent exclusion and intervene and more effectively support those most in need before disadvantage becomes entrenched.
- **Identifying what works.** This will ensure effective adoption of best practice, to help build the capability of providers and commissioners.
- **Multi-agency working.** Coordination between services must be improved, since excluded groups face multiple problems, requiring a variety of agencies.
- **Personalisation, rights, and responsibilities.** Services must fit around needs, rather than multifaceted problems having to fit around services, and there must be more persistence and follow-up in dealing with problems. Excluded groups will be accorded the support of a trusted third party working on their behalf (*eg* health trainers), and they will be made aware of their rights and responsibilities as citizens.
- **Government intervention.** This will happen when there is underperformance.

The action plan considered the early, childhood, and teenage years, which will be referred to in Chapter 3. This section will focus on aspects of the adult years.

Programmes to support adults with severe and multiple disadvantages have offered support in relation to housing and homelessness, mental health, substance misuse, the criminal justice system, skills development, and employment. For example:

- **Pathways to Work** and the **New Deal for Skills** have helped getting people back into the mainstream, such as employment for disabled people. Access is secured to specialist incapacity benefit personal advisers in Jobcentre Plus, along with financial incentives to return to work and health focused support.
- **Supporting People** has enabled vulnerable people to live independently, through Government sponsored outreach teams supporting hard-to-reach people with mental illness living in the community. Multi-disciplinary contact and assessment teams (CATs) have been deployed to known rough sleeping areas, providing hostel bed spaces and addressing needs such as drug abuse.
- **Hostels Capital Improvement Programme** has helped address the needs of former rough sleepers.
- The **Care Programme Approach** provides systematic assessment of the needs of people admitted into secondary mental health services.
- The **Reducing Re-offending Delivery Plan** and the **National Offender Management Service** to improve services available for adult offenders.
- The **Drug Interventions Programme (DIP)** integrates interventions to help drug-misusing offenders move out of crime and into treatment.
- **Multi Agency Public Protection Arrangements (MAPPAs)** require the police, prison and probation services - supported by housing, health, and social services - to manage the risks from dangerous offenders in the community.
- The **Prolific and other Priority Offenders (PPO) programme** tackles the relatively small, hard core of offenders who commit a disproportionate amount of crime and cause disproportionate damage to their communities.
  However, there are major problems in most areas in coordination between services.

All is not well: the problem of stand alone services

No one agency has an overview. For example, drug users without housing have difficulty with treatment, while those leaving custody with no home to go to are more likely to re-offend. Some local mechanisms, such as the Care Programme Approach, aim to resolve wide ranging problems, but this can be very time consuming and often ineffective. With some adults in contact with up to 10 agencies, costs can be high. In the midst of this chaos, Government acknowledges the considerable gaps in our knowledge about what works. These need to be closed. The taskforce has launched scoping exercises that will feed directly into pilot approaches. Solutions are awaited. Consider the following local area case study.

Local area case study (Cabinet Office Social Exclusion Task Force 2006)

People with chaotic lives and multiple needs have a wide range of input from statutory agencies; this is illustrated in the summary below by the percentage breakdown of the services used by a small sample (n=36) of the clients of one voluntary sector agency. The average annual cost to services is £23,000 per case.

Area	Service	Average % spend by statutory services per adult
Benefits	Benefits Employment support	36%
Health and Social care	Primary care Hospital Mental health services Alcohol services	21%
Housing and Homelessness	Supported housing Homelessness services	19%
Criminal Justice System	Policing Probation Prison Courts	18%
Drug Misuse	Drug Services	6%

Walsall's opportunity to address social exclusion

There is an opportunity for the WBSP to establish its own Walsall Social Exclusion Task Force (how about WALSET!), as an integral part of a Health Inequalities Board. The recent development of a robust Health Inequalities Strategy (WBSP 2008), built around a model that places the health inequalities focus much closer to the WBSP Board, will provide the necessary platform to investigate communities much closer and with an innovation to address social exclusion. This model has been urged by Grant Thornton (2008), the appointed auditors of Walsall tPCT and Walsall Council, following a rigorous review of health inequality work across the borough.

Government admits failure in addressing social exclusion!

First of all, this statement merits explanation. In *Reaching out* (2006), the taskforce lists progress from several programmes, but highlights a group of people with complex needs who are still not benefiting from services because their lives are too chaotic. They continue to experience deprivation and lack of work, to engage in offending and substance misuse, and to have mental or physical health problems and poor family relationships. The reality is that services are geared for delivering to the majority and are not well established to address the needs of those with more complex problems. While individual agencies do generally focus on improving outcomes for the neediest within their service, they often miss those with multiple needs but who require less help from any one service. In summary, people may not meet the threshold of any given agency to trigger a fuller intervention, despite the scale of their problems or the harms caused to the communities in which they live.

A further incentive to do more in tackling social exclusion will arise from a new duty conferred on LAs and PCTs to develop Joint Strategic Needs Assessments (JSNA). This has implications for better joint commissioning and planning of services in Walsall, and for stronger partnership working with community engagement. The JSNA will be an ongoing process. If done effectively, it will facilitate a better detection of families at risk of social exclusion, and so enable prevention and intervention. A Walsall briefing paper is available to inform, in particular, leaders of public health, social care, adult and children's services (Laverty and Robinson 2008), along with Department of Health guidelines (DH 2007).

The Lyons Inquiry

Small, incremental changes to the way that local government is run can make a difference to poorer residents. For example, the Lyons inquiry (2007) looked at the future of LAs, although the report attracted undue attention to council tax. This was all about fairness, and at least the proposals would seem to ease the burden on low income groups, pensioners, and others struggling to pay their council tax. They included rebates being given automatically to those entitled to council tax benefit, ensuring that millions of pounds in unclaimed benefits would find their way to the poorest households. Sir Michael Lyons wanted more emphasis on place-shaping, whereby LAs would be willing to work more closely with residents and other parts of the local community, to establish clear local priorities, and especially to shape public services to local needs and preferences. The relevance of this to the issue of tackling socially excluded and deprived families is all too clear.

We can conclude that the very existence of poor and relatively deprived people underpins all the necessary ingredients for the state of social exclusion, but there are a range of complex and multiple problems that are not so easily addressed by individual services or by the health inequalities strategy. The latter can raise the general well-being of poor people, and can assist those on the margins of society, but for families - and even small communities - enduring a deeply entrenched socially excluded experience, we have to await solutions and funded initiatives from Government. Without a major political shift to a more egalitarian society, it is difficult to envisage any sustainable improvements in the short term.

What about Brownhills?
Birchills Leamore: do wards make sense?
Joint Strategic Needs Assessment: what can it offer?

Brownhills was just outside the 10 most deprived wards in deprivation and inequality. However, there certainly exist areas of deprivation, as do small pockets within more affluent wards such as Paddock and Pheasey. Again, Birchills Leamore as a ward does not adequately describe its residents, there being a high proportion of BME groups in Birchills, in contrast to the predominantly White population of Leamore, whose issues are more in keeping with those of nearby Blakenall. Accordingly, a major task of addressing social exclusion will require teasing out the data on affected families at the small communities level. As repeated earlier, there is need for a greater sharing of information between services, for socially excluded families to be identified. The Shared Partnership Information Resource (SPIR) is a move towards this, and it is to be hoped that the Walsall JSNA will progress matters even further.

From April 2008, each LA was required to establish a Local Involvement Network (LINk) as an essential component of the JSNA. LINks are new bodies designed to engage local people in shaping health and social services. LINks will investigate issues of concern, demand information, enter and view services, and refer issues to the Overview and Scrutiny Committees. Walsall has good locality based examples of collaborative working across services, and so LINks are to be welcomed to progress partnership working further. The obvious need to pick out families at risk of social exclusion will represent prevention at the very highest level. This will need to be demonstrated as a pilot within Walsall, say in Adult Social Care as an example, to show the added value of JSNA. Ward based data is a little bland. The need for more small community data is difficult. The mass of data requires more intelligence and more effective linkage, often to address mounting community problems that tend to get dumped in the difficult tray.

Information relating to JSNA can be found through the Department of Health (2007), and in relation to the *Local Public Involvement in Health Act* (HM Government 2007), the *Commissioning Framework for Health and Well-being* (DH 2007), and *Creating Strong, Safe and Prosperous Communities* (Communities and Local Government 2007).

Chapter 3: Life course and social gradient

Chapter content at a glance:

Social structure, health, and the life course; Low birthweight and early life; Teenage pregnancy; Education; other Walsall information on social exclusion examples; Task Force initiatives.

Social exclusion examples:

Families with Low Birthweight Babies
Teenage Parents
Children in Care

A most important category of psychosocial influences on health and the life course are those occurring in early life, including prenatal and postnatal factors. People who were smaller as babies are more likely to experience heart disease, diabetes, stroke, raised blood pressure, and central obesity in later life. The original hypothesis about the unique period of 'growth before birth' being an opportunity for vital organ and tissue development has been called the biological programming hypothesis, because it asserts that the foetus responds to under-nutrition with permanent changes in physiology, metabolism and structure (Barker 1998). The chronic stress associated with a deprived existence perpetuates the likelihood of disadvantage in a baby at the very outset, even before childhood begins. This is in keeping with the psychological view that early childhood experience has significant influence on personality development. Low birthweight is associated with reduced chances of upward social mobility. The life course implies a continuity of social circumstances from parental social class to social conditions during childhood and adolescence and, eventually, to adult socioeconomic position. Low birthweight babies tend to concentrate in deprived communities, and to remain there throughout childhood. They further tend to be captured within a poorer standard of education, and to drift into a manual type of employment, with attendant higher risks of redundancy and chronic illness. Add to this the increased risks of poor health programmed from birth, and it is clear to see the disadvantage experienced by people living as a part of a deprived community. Indeed, entire groups or communities may feel socially excluded, and may particularly lack self esteem, freedom, and empowerment.

The life course perspective has important implications for social policy making in relation to health. Bartley *et al* (1997) have drawn on the biological concept of critical periods, when if anything goes wrong, permanent damage can result. These periods include the move from primary to secondary school, labour market entry, establishing own residence, occupational change, onset of chronic illness, and retirement from paid employment. Redundancy and divorce, also, can be especially damaging, while mental or physical disability may arise from such critical periods. These life course events are highly relevant to many socially excluded people, whose plight may be precipitated by such critical periods or whose existing excluded state may be worsened. A better social policy could actually do much to address social exclusion.

Our social policy may be flawed

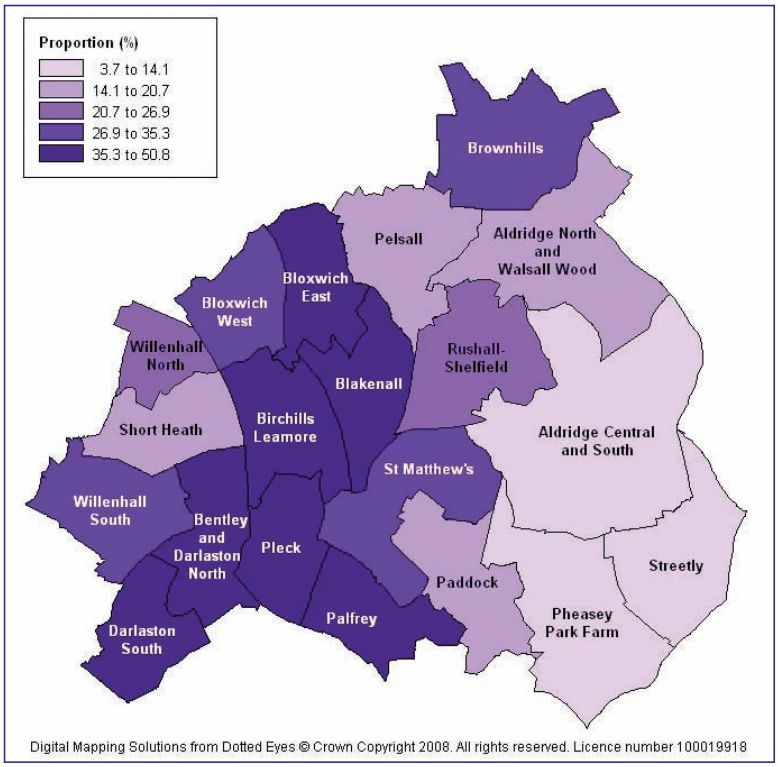
As stated by Blane (2006), in the past, social policy has assumed that critical periods are distributed randomly and that, over the long term, approximately equally among the population. Therefore, that protection can be financed by social insurance . . . A life-course perspective identifies the flaw in this 'safety net' approach to social welfare. Those at greatest risk of misfortune, eg from redundancy and unemployment, are least likely to have previously enjoyed stable employment and hence are least likely to have accumulated sufficient insurance contributions to finance the welfare benefits that they require (Sinfield 1981). As a result, those most in need of a safety net are least able to provide one. Blane (2006) continues: the life course perspective identifies a further limitation of the traditional 'safety net' approach. Adversity is not randomly distributed; it tends to cluster and to accumulate present on top of past disadvantage. Consequently, any single misfortune tends to identify the most vulnerable individuals who have accumulated the greatest number of previous handicaps. What is required is a modernised social policy; not so much a 'safety net' but a 'springboard' which also repairs damage caused by past disadvantage.

Child Poverty in Walsall

A national indicator used to measure child poverty is the proportion of children who live in families where out of work benefits are received (National Indicator 116). In 2007, this proportion was 25.7% of Walsall children below 16 years of age (14,000 children), substantially higher than the England average (19.7%). Moreover, of the 34 local authorities in the West Midlands Region, Walsall ranked 5th highest on this measure of child poverty, where rates ranged from Bromsgrove (8.5%) to Birmingham (32.1%). Within Walsall, the proportion of children living in families on benefits ranged from 2.9% in Streetly to 43% in Blakenall, although there were also a further six wards where the proportion was over 30%.

A broader measure of relative child poverty is the Income Deprivation Affecting Children Index (IDACI), which includes children living in low income families as well as those in families receiving out of work benefits. On this measure almost 30% of children in Walsall were affected by deprivation in 2007, about 16,000 children.

Map 3. Proportion of children affected by deprivation (IDACI) by Walsall ward, 2007



Source: Indices of Deprivation for England, 2007

In Blakenall and Birchills Leamore one in two children were affected by deprivation (about 3,500 children), whilst Palfrey, Pleck, Darlaston South, Bentley and Darlaston North, Bloxwich East, St Matthews all had more than one in three children affected by deprivation. In the more affluent wards of Streetly, Pheasey, and Aldridge Central and South the proportion of children affected by deprivation ranged from 3.7% to 11.4%, although this nevertheless represents over 500 children.

Child Poverty and Inequalities in the UK

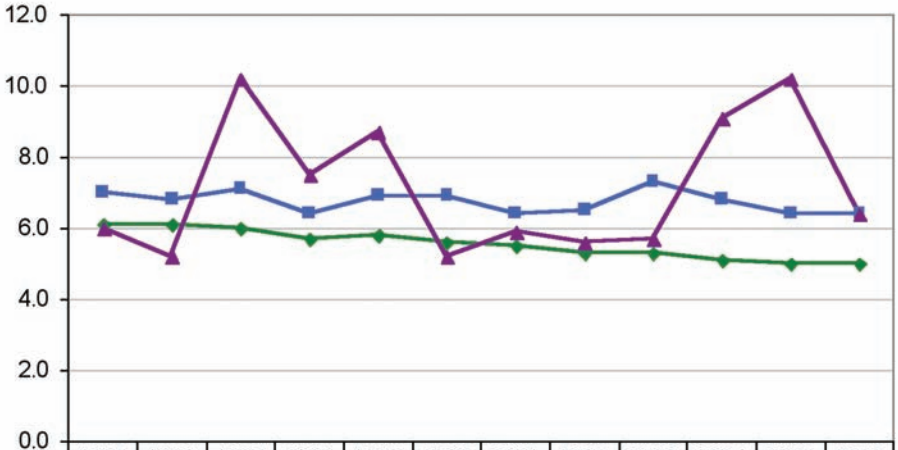
A UNICEF report ranked the wellbeing of children in 21 rich countries (Unicef Innocenti Research Centre. *Child poverty in perspective: an overview of child wellbeing in rich countries.* Florence, 2007). The UK was in the bottom five countries for five of six dimensions, and was ranked 12th in health. It was clear that inequalities affect child wellbeing and that poverty kills as effectively as any disease. Governments need to invest more in children. Pickett and Wilkinson (2007) analysed the report, along with US data, suggesting that children's responses to inequality are remarkably similar to those found in adult populations. Data on peer relations and violence among children ran parallel to those on social capital, trust, and violence among adults. Fighting, experience of bullying, and the proportion of children not finding their peers kind and helpful, correlated closely with inequality variables. Improvements in child wellbeing might depend more on reductions in inequality than on further economic growth. Attempts to reduce the proportion of children in relative poverty are urgently required.

Low birthweight among deprived communities is associated with high maternal and infant mortality, and unplanned pregnancy. There are clear links between teenage pregnancy, social disadvantage, and later social exclusion. Teenage pregnancy is linked to lower parental social class and poor educational attainment (Wellings *et al* 2001), which in turn predicts future teenage pregnancy (Bonell *et al* 2003). Where prevalent, teenage pregnancy is a good marker for socially excluded communities, which produce the majority of children taken into care; often precipitated by drug or alcohol misuse problems, as well as truants and exclusions from school. Family breakdown is frequent, and often follows repeated incidents of domestic violence.

Early life and the Walsall review

Infant mortality is a good indicator of the overall health of a society. During the period 2004-06, there were 5.0 infant deaths per 1,000 live births in England, with 43% in the Routine and Manual group (DH 2007). Each avoidable death is one too many and the number of preterm babies is still too high; the reason being that surviving babies are left with long term health conditions, causing misery to families. There are also huge financial implications for affected families, as well as for society and government. The infant mortality rate among the Routine and Manual group was 17% higher than in the total population in 2004-06, compared with 18% higher than, and 19% higher than, for 2003-05 and 2002-04 respectively. However, the target to narrow this gap by at least 10% by 2010 is clearly a challenging one.

Figure 3. Infant mortality rates per 1000 live births in Walsall, West Midlands and England 1994-2006



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
England & Wales	6.1	6.1	6.0	5.7	5.8	5.6	5.5	5.3	5.3	5.1	5.0	5.0
West Midlands	7.0	6.8	7.1	6.4	6.9	6.9	6.4	6.5	7.3	6.8	6.4	6.4
Walsall	6.0	5.2	10.2	7.5	8.7	5.2	5.9	5.6	5.7	9.1	10.2	6.4

Infant mortality in Walsall was close to the national average from 2000-2003 but rose substantially during 2004 and again in 2005, when the rate was double the national average. (Walsall 10.2, England 5.0). In 2006, the Walsall infant mortality rate fell back to the regional average, although this nevertheless remains above the national average.

Source: Vital Statistics, ONS

A national implementation plan has been produced for reducing health inequalities in infant mortality, including actions to address mortality associated with teenage pregnancy and ethnic minority groups (DH 2007). Walsall has 3,600 babies born each year; more than 99% survive past their first year, but less than 50 per year are stillborn or die in infancy. This prompted a review of perinatal and infant mortality, based on 161 stillbirth and infant deaths at the Manor Hospital between 2001 and 2006 (Walsall tPCT 2008). The findings were consistent with experience elsewhere, and it is clear that preventing infant mortality is a task not just for health professionals, but also for families, communities, their leaders, and other organisations concerned with providing services to ensure economic and social wellbeing.

Areas of concern in the review were:

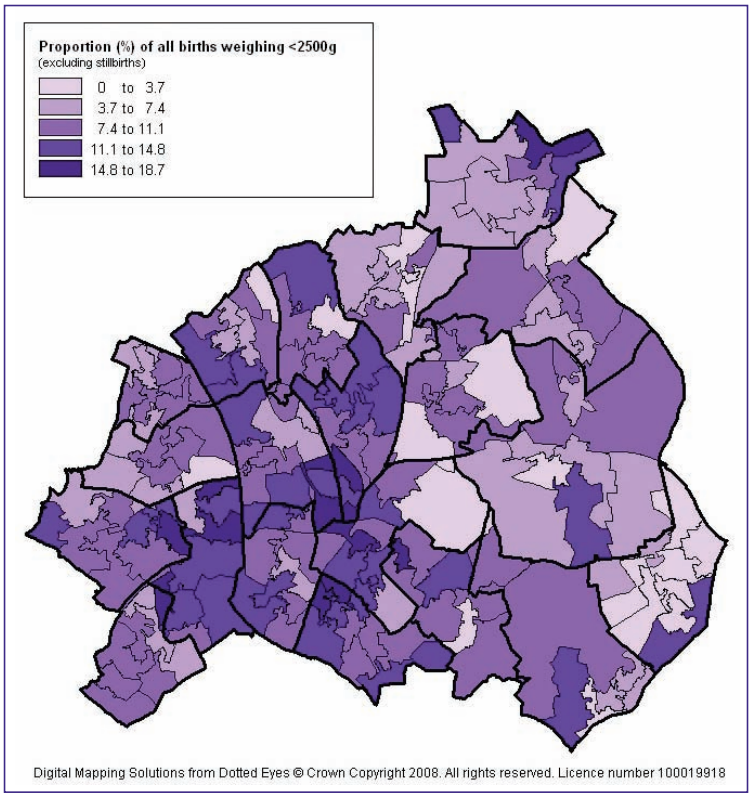
- Smoking in Pregnancy. The risk of stillbirth and infant death among White mothers who smoke in pregnancy was 2.9 times higher than for those who did not smoke in pregnancy.
- Ethnicity, Religion and Consanguinity. The risk of stillbirth and infant death in consanguineous marriages (predominantly in the Muslim community) was over three times higher than in non-consanguineous marriages.
- Socio-economic deprivation. Very strong links with parental deprivation.
- Obesity. Body mass index was recorded at booking and followed up.
- Maternal age and gestation. Correlations with under 20s mothers, deprivation.
- Low birthweight, which was associated with two thirds of stillbirths.
- Deaths of babies with congenital abnormalities.

Strategies to tackle infant mortality were identified:

- Intensify the targeting of antenatal health care resources on mothers in deprived socio-economic groups.
- Promote cessation of smoking.
- Tackle consanguineous marriage sensitively.
- Partnership working, especially joint commitments to tackle smoking.
- Careful monitoring of stillbirths and infant deaths.

Given the very strong links with deprivation, it is apparent that maternal and child health issues - such as low birthweight, smoking in pregnancy and teenage pregnancy - are an effective means of identifying socially excluded families, that in all probability have a range of other health and social care issues that could be a focus for joined up partnership action.

Map 4. Low birthweight babies (weighing less than 2500gms) as a proportion of all live births in Walsall 2001-2007



Source: ONS, Public Health Birth Files.

Mothers in neighbourhoods in some western, central and northern areas of Walsall are more likely to deliver low birthweight babies. The highest proportion of low birthweight babies in 2001-07 were born:

- In the western neighbourhoods of Bentley, Birchills Reedswood, Darlaston Central, Rough Hey and South Willenhall.
- In central neighbourhoods of Walsall Central, Chuckery, Palfrey and North Walsall.
- In Central Brownhills.

The Significance of Victoria Climbié

The social and environmental background faced by families living in socially excluded and deprived communities has encouraged focus on the wider determinants of health. This focus was sharpened in 2000 by 8-year old Victoria Climbié, who came into contact with a range of service providers - such as health, social care, and police - who failed to recognise and prevent abuse that led to her death. This led to the Children Act, Every child matters (HM Government 2004), and the National Service Framework (NSF) for children, young people and maternity services (DH 2004), to create a culture of integrated health, family support, childcare, and education services so that children get the best possible start in life. Sure Start programmes would expand, with payment according to means, supported by tax credits. The Department for Education and Skills (DfES) would provide greater help with and support for childcare, and the Treasury looked to welfare reform and public service changes for stepping up advances towards halving child poverty by 2010, and so on. Walsall was well primed to respond to these changes and recognise the need for stronger partnership working, as outlined in the DPH annual report on children at that time (Walsall HA 2002). Clearly further work is required given the recent events in Haringey surrounding Baby P.

Actions to address early life inequalities in Walsall

Actions to address early life issues are undertaken through membership of Walsall's Children and Young Person Strategic Partnership, which includes the tPCT, the Manor Hospital, Social Services, and Education, to oversee a wide range of actions and initiatives:

- Closer working and integrated budgetary support for children in care, child protection, and Child and Adolescent Mental Health Services.
- Strengthening education and welfare staff to reduce truancy and, jointly with police, target young people to prevent crime.
- Further strengthen maternity services, which are doing well to maintain perinatal mortality well below national and regional averages.
- Step up initiatives on smoking in pregnancy and breastfeeding; more recently, a strategy is being developed to tackle consanguinity.
- Improve access for health visitor interventions to help families in need.
- Support development and training for Walsall's youth service.
- Maintain Walsall's well performing childhood immunisation programme.

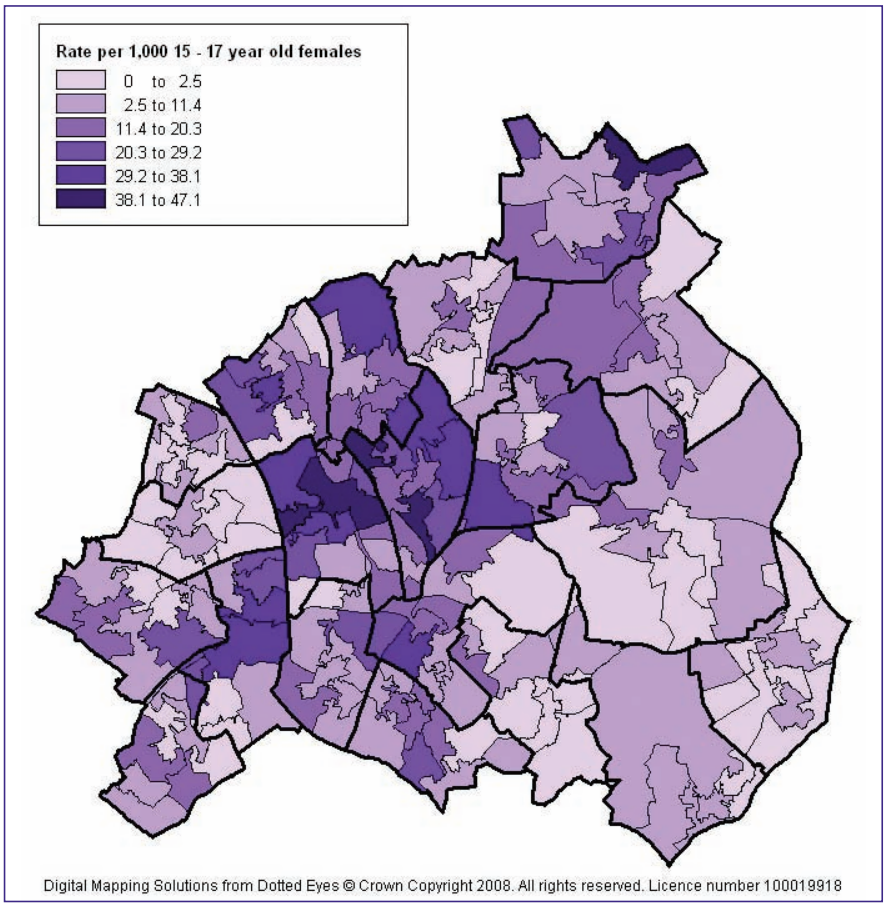
Teenage pregnancy

Teenage pregnancy is a result of a complex interaction of a number of factors:

- Low expectations and education achievement; associations with truancy, school exclusion, and lack of participation in training or employment.
- Ignorance about sexual health, relationships, and parenting.
- Peer pressure to view sexual activity as the norm.
- Living within deprived or socially excluded backgrounds.
- In or leaving care, homelessness, mother who was teenage parent, close associations with young people involved in crime.
- High likelihood of receiving income support and relying on benefits alone.

Health outcomes are poor, arising from late antenatal care, smoking, and low take up of breastfeeding. There are higher rates of pregnancy complications, maternal and infant mortality, low birthweight, physical ill health, depression or other mental ill health during pregnancy or within one year of child birth.

Map 5. Teenage conception rate by Lower Super Output Area in Walsall 2003-2007



The highest rates of teenage pregnancy are found in a band of adjacent neighbourhoods including North Blakenall, Beechdale, Bentley, Leamore, Darlaston, Goscote, Rushall and Ryecroft/Coalpool. In addition, the neighbourhoods of Caldmore, Bloxwich, Mossley/ Dudley Fields and Central Brownhills share these high rates.

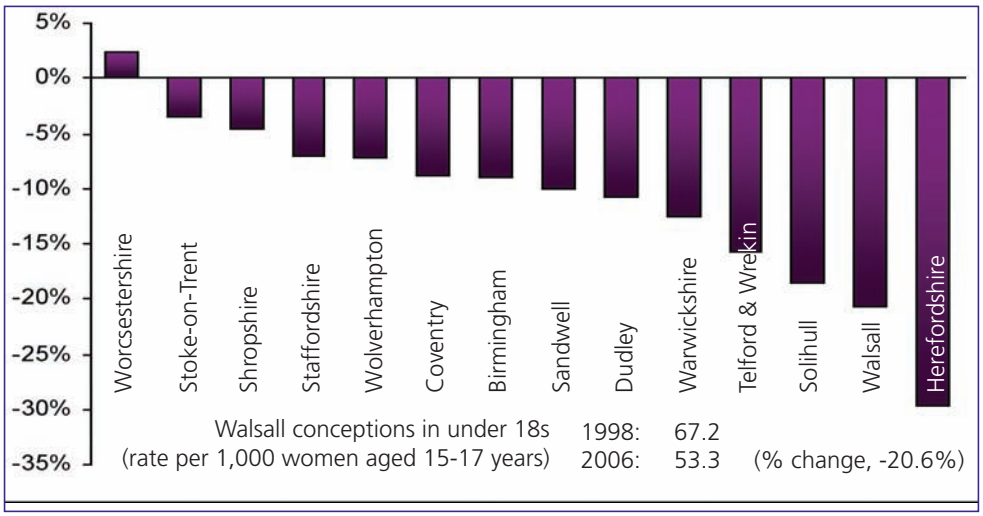
Source: NHS Walsall, Community Births system.

Walsall's teenage pregnancy strategy, a required 10-year approach, was issued in 2001. One main goal was an expectation to meet the health inequalities PSA target of reducing the under-18 conception rate by 55% by 2010. That is an ambitious target, despite achievements made over the period 1998-2006. However, the other main goal is that of reducing the risk of long term social exclusion for teenage parents and their children, by supporting young parents (a target of 60%) in education, training, and employment. Work is guided by the Department of Health's Teenage Pregnancy Unit to ensure joined up action at national, regional, and local level. Local strategies are led by local Teenage Pregnancy Coordinators, supported by dedicated TP partnership boards, comprising social services, education, housing, the tPCT, Connexions, and other key voluntary sector agencies.

Connexions is a government support service for 13-19 year olds, to provide integrated information, advice and guidance.

Sure Start Children's Centres are a key initiative, working to promote the physical, intellectual, and social development of babies and young children, particularly those who are disadvantaged. Walsall currently has a network of 15 Sure Start Children's Centres and a further three are planned for the third and final phase of the development programme.

Figure 4. Change in conception rate in under 18's 1998-2006



Under 18 conceptions in Walsall fell by over 20% from 1998 to 2006, which was the second largest reduction in the West Midlands during this period. The 2006 rate (53.3) was the same as in Birmingham but lower than Wolverhampton and Sandwell. The highest rate in the West Midlands was in Stoke-on-Trent and the lowest was in Hereford county.

Source: ONS, Public Health Birth Files.

Hot spot areas for teenage pregnancy in Walsall generally coincide with areas of higher deprivation. The under 18 years teenage conception rate per 1,000 for 2002-2004 showed the following wards with the highest rates (deprivation scores in parenthesis): Blakenall 104.8 (53.8); St Matthew's 84.0 (45.5); Birchills and Leamore 81.9 (42.9); Bloxwich East 81.7 (36.7); Bloxwich West 76.2 (34.8). Accordingly, the strategy to tackle teenage pregnancy includes targeted work in deprived and socially excluded localities, across three key areas: (1) better access to services, (2) better sex and relationships education, and (3) better support for teenage parents. The actions are extensive across a range of agencies, including the following broad approaches:

- Provision of youth services and teen clubs in high rate areas, along with the promotion of free condom uptake and emergency hormonal contraception (EHC), through Young People's Advice clinics and signposting in secondary schools. Pregnancy testing and counselling services must be enhanced.
- Schools in high rate areas are targeted by the Walsall Community Arts into Health programme, using a participatory approach deemed highly successful. Secondary schools should ensure continued activity of holders of Personal, Social and Health Education (PSHE) posts.
- Making properties available for teen parents, especially in the Blakenall and Leamore areas, among numerous housing support initiatives.
- Schemes operate to allow the reintegration of teenage parents into education, including cash for childcare and sponsored child minders.
- Programmes to offer advice on breastfeeding, with community nurse support, and smoking cessation, including nicotine replacement therapy.
- Sex and relationships education (SRE) through secondary schools is supported by Family Planning and Genitourinary Medicine advisers.
- Active marketing of milk tokens in Sure Start Children's Centres facilities, and promotion of calcium supplementation to reduce preterm births and low birthweight.
- School governor induction programmes, faith issues, BME considerations.

Walsall's TP Partnership Board has produced a detailed, comprehensive action plan for 2006-08 (2006). Secondary schools in high rate areas will be a focus for 2008-09.

Family Nurse Partnership

Walsall is one of ten first wave pilot sites in England testing out the Family Nurse Partnership Programme; an intensive parenting programme specifically for young vulnerable/ disadvantaged women, developed in the USA,

the aims of which are to:

1. Improve pregnancy outcomes
2. Improve child health and development and future school readiness and achievement
3. Improve the economic self-sufficiency of parents.

Evidence from the US studies show that the FNP can deliver benefits for the children (and their mothers) who receive it; some of these are long term, including:

- Improvements in women's maternal health.
- Reductions in children's injuries.
- Fewer subsequent pregnancies.
- Greater intervals between births.
- Increases in fathers' involvement.
- Increases in employment.
- Improvements in school readiness.
- Less involvement with the criminal justice system in later life.

The Walsall FNP programme is for women aged under 20 years having their first baby. The structured programme is delivered via frequent home visits, utilising a strengths-based approach, delivered by registered nurses who receive intensive additional training.

Currently the Walsall team has four Family Nurses plus a part time Supervisor, specially trained to deliver this programme under strict licence with a maximum of 25 clients each. The first year evaluation carried out by Birkbeck shows many positive elements regarding the introduction of the programme, notably its acceptability to parents – including fathers and the level of engagement with young women. Although these are early days and the numbers are small, there is an encouraging trend in that fewer women on the programme are smoking, only a few reported alcohol use and two-thirds had initiated breastfeeding. The involvement of fathers is highly encouraging, as research identifies this as a key to children performing better emotionally and academically.

Audit of Walsall's Teenage Pregnancy Strategy

This was carried out by Grant Thornton (2008). Teenage pregnancy was regarded as an area of strong joint working between the tPCT and Council. The New Deal project in the Bloxwich area attracted praise in promoting new initiatives. Also, the pilot of a whole school approach to reducing teenage pregnancies in two secondary schools and two primary schools; here, four newly appointed young people's advisors work closely with parents and school governors. Another scheme is the peer mentor service, which has 15 teenage mothers to speak to children through PHSE programmes. There were three main concerns: (1) BME teenage conceptions could increase if there is a copy of other teenage behaviours; (2) the need to address some faith schools, eg Catholic, which are reticent about engagement; and (3) doubt over achieving the 55% reduction target and potential damage to morale (need to consult Government).

Education

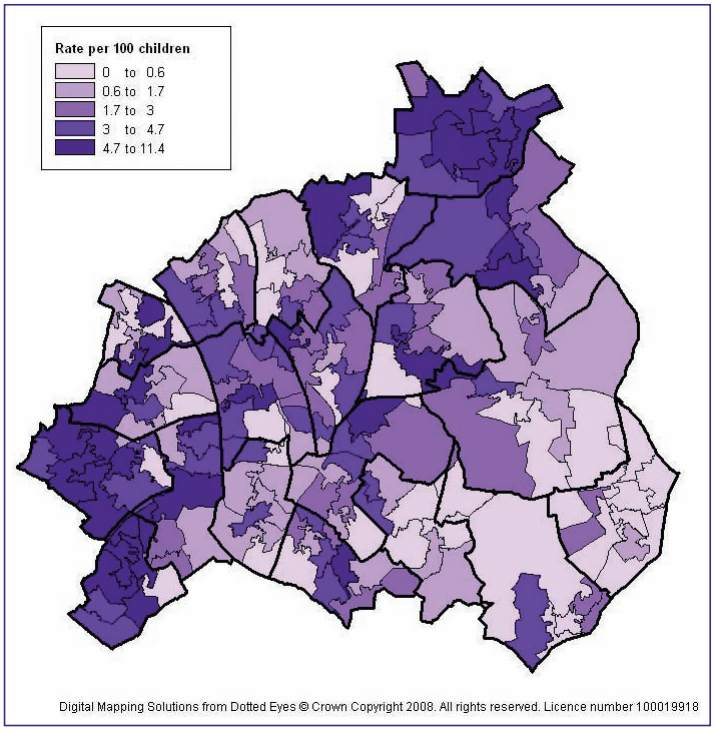
The policy implications of education are immense in fostering health and development early in life, particularly among people in poor social and economic circumstances. Parents need to be involved in education and understanding of their children's emotional needs. Pre-school programmes are now known to improve reading, stimulate cognitive development, reduce behaviour problems in childhood, and promote educational attainment, occupational chances, and healthy behaviour in adulthood. Parental involvement in such programmes reinforces their educational effects and reduces child abuse. There should be increased opportunities for educational attainment at all ages, since education is associated with raised health awareness and improved self care. The persistent problem of low achievement among pupils in deprived areas, and the growing problem of social exclusion, were identified in the 1997 White Paper, Excellence in Schools. A number of factors included: lack of preparation for school among the very young; lack of pupil aspirations and motivation; poor behaviour from

poor parenting; truancy and exclusion from school, often from drug taking or crime; poor provision for pupils with special needs; lack of fluency in English, especially among BME groups; higher proportions of schoolgirl mothers; erratic attendance among children in care; problems around refugees and asylum seekers; and difficulty in retaining school staff, social workers, and educational welfare workers. To address these issues, a number of policy initiatives have been introduced:

- Local Authority (LA) role in promoting high standards, with support and early preventive intervention, including that of improving under performing schools.
- Effective deployment of School Improvement Partners to support schools to audit standards and agree targets.
- Implementation of the National strategies (Foundation Stage, KS1-5) with an emphasis on literacy and numeracy.
- Support for the management and effective use of Information and Communication Technology to support personalised learning.
- Excellence in Walsall initiatives to support schools in pockets of deprivation.
- Playing for Success is an initiative among 7-14 year olds to motivate pupils through sport centres.
- Healthy Schools Programme designed to improve health awareness and the environment within schools.
- Connexions and other services to encourage 17+ year olds into further education and training. There is support for this through a Learning and Skills Council, while the Excellence Challenge aims to increase the number of children from poorer backgrounds into higher education.
- Government measures to support the recruitment of teachers and local implementation for succession planning.
- Monitoring the use of ethnic minority attainment grant and giving support when required.
- Raising the attainment of children in care, through LAs adhering to a Children's Services Plan.

It can be seen from this list of initiatives how families at risk of social exclusion can be identified, along with other markers such as truancy, exclusion from school, teenage pregnancy, and low birthweight.

Map 6. Percentage of Walsall children excluded from school in autumn and spring terms 2007-08



Source: SERCO

In 2005/06 there were 1,337 fixed period exclusions of children from Walsall (maintained) secondary schools, representing 6.4% of the secondary school population. This was lower than the England average (10.4%) and West Midlands average (9.7%).

Exclusions from school are concentrated predominantly in neighbourhoods in north and west Walsall. This includes parts of: Brownhills, Walsall Wood and Clayhanger, Pelsall, Mossley/ Dudley Fields, Beechdale, North Blakenall, Hatherton, Rushall, New Invention, North and South Willenhall, Darlaston Central, Dangerfield, Moxley, Bentley, Birchills/ Reedswood, Delves.

Walsall's progress on educational initiatives

There is active engagement in numerous areas, coordinated by and conforming to a Schools Improvement Plan, entitled Excellence in Walsall. There is a strong focus on the Healthy Schools Programme, including adoption of the Choosing Health agenda, with particular attention to healthy eating (pre-school breakfast facilities in high priority wards, and all round balanced school lunches), physical activity, obesity, smoking, and drugs and alcohol misuse. Health advisers have a coordinating role while health trainers, referred to in Chapter 2, can offer more support. Sure Start Children's Centres offer: high quality play and early learning, family health and outreach services, child care, access to education, training, and employment through JobCentre Plus.

Free school meals are provided to pupils whose parents receive income support or income related Jobseeker's Allowance. Around 13% of pupils have English as a second language, reflecting the ethnic diversity in Walsall and requiring special inputs. Seven special schools serve children with mild learning difficulties or behavioural and emotional difficulties; almost half are eligible for free schools meals, suggesting a much higher level of deprivation among the parents of these pupils. Bullying is widespread in Walsall, as elsewhere, and is attracting increasing attention and need for incisive strategies. Susceptibility to bullying goes hand in hand with scoring of self esteem and wellbeing.

The Educational Welfare Officers team has been strengthened to tackle truancy and, with the police, to address persistent offenders. Attendance panels exist to ensure prosecutions are a last resort. While truancy is generally not a problem, high priority areas remain a challenge. School focus teams have also been established to identify issues such as truancy, bullying and teenage pregnancy for professional support. Led by an Educational Psychologist and advisory teachers from Serco, each team comprises an Educational Welfare Officer, a Headteacher, a School Health Adviser and a Special Educational Needs Coordinator.

Table 1. Proportion of pupils achieving 5 or more A*-C GCSEs by Walsall ward 2005-06

Key Statistics	A*- C grades
Aldridge Central & South	66.67
Aldridge North & Walsall Wood	57.50
Bentley & Darlaston North	36.31
Birchills Leamore	41.62
Blakenall	32.83
Bloxwich East	43.31
Bloxwich West	46.71
Brownhills	43.75
Darlaston South	27.68
Paddock	71.82
Palfrey	46.83
Pelsall	63.70
Pheasey Park Farm	56.14
Pleck	38.01
Rushall Shelfield	55.22
Short Heath	56.76
St Matthew's	55.47
Streetly	67.65
Willenhall North	37.10
Willenhall South	47.57

Source: SERCO

Less than half the children in nine of Walsall's wards achieved 5 or more GCSEs at grade A*-C grade, with the least successful living in Darlaston South, Bentley and Darlaston North, Blakenall, Willenhall North and Pleck. This compares with Paddock, Streetly, and Aldridge Central & South where more than two thirds of children achieved this benchmark.

Other important life course issues, and children in need or care

Domestic violence

Domestic violence is widespread, significantly under reported, and certainly not associated with socioeconomic status. Repeated and serious incidents can drive women and children into a state of social exclusion, with frequent severe health and social consequences. Children may end up in care, and when neglect is an issue in precipitating referral to child protection, domestic abuse is frequently associated. A concerted focus on domestic abuse is therefore an important action in tackling social exclusion. The incidence of domestic violence in Walsall is discussed at the end of this section. With respect to children in care and children on the child protection register, numbers are expected to reduce with time as a result of strategies to address domestic abuse.

The Walsall Domestic Violence Forum (WDVF), which is responsible for providing specialist services, takes the lead on domestic abuse across the borough. In recent years, the Forum has been strengthened by the creation of a Domestic Abuse Response Team (DART). The DART is a multi-agency group made up of representatives from the statutory and voluntary services, who act as a single point of information sharing, contact, assessment, and intervention for all domestic abuse incidents referred to the police. It comprises an Operations Manager, two Independent Domestic Violence Advocates, and a Specialist Social Worker: together they make initial contact with the majority of victims. They are supported by the rest of the team, comprising a Social Worker from Children's Services, a Health Visitor, a Domestic Abuse Police Officer, an Information or Research Assistant, and an Administrative Assistant. Additional input is received from Witness Care (providing updates of cases in the Criminal Justice arena), Addaction (to address drug or alcohol concerns), and the Homeless Needs Unit (to deal with accommodations issues or arrange referral to the Sanctuary Scheme). Efforts are currently underway to seek participation of Adult Services and Education.

WDVF and the role of the Walsall DART have received high praise from the police, who are now better able to divert resources to offender based work to increase conviction rates. Partnership assessment of all cases at the earliest opportunity has resulted in earlier interventions by the most appropriate services, leading to a reduction in the numbers of cases needing to be referred to MARAC (Multi-agency Risk Assessment Conference). MARAC was established in Cardiff in 2003, and has since been adopted by Walsall as a model of intervention in all reported cases of domestic abuse, to identify those people and households at highest risk of personal harm and domestic disruption. It has promoted the multi-agency approach and has established itself as a template for good practice. Already in Walsall, Children's Services have noticed a significant reduction in referrals to their Initial Response Team and acknowledge that many referrals are now being assessed by the DART Social Workers.

There is a growing openness about domestic abuse and an increasing realisation by victims that action can be taken to stop the violence. Accordingly, there has been a dramatic increase in the numbers of referrals for victims and children requiring support, with consequent increasing telephone support from crisis centres. Affected young people in Walsall are now receiving support from different services such as the Family Support Team, the Teenage Support Service, and School & Youth Programme Officers. To gauge the volume of reported incidents in Walsall, data was collected and analysed over the last 19 weeks in 2007 (approximating to 3,000 incidents per year). Key results for this 19 week period were:

- Total 1305 referrals, 88% female, 12% male.
- Most were aged 19-50years with a peak in two age bands - under 25 years and 31-40 years.
- Ethnicity - White 65%, unassigned 23%, and BME groups 12%.
- Most referrals (72%) involved intimate relationships (spouses, partners, ex-partners), 9% involved other relationships (eg siblings), while 19% were unclassified.
- Following the DART intervention, 9% and 14% were considered very high and high risk respectively, for consideration by MARAC.
- Repeat rates during this period of study: once 68%, twice 19%, three 6%, four or more 7%.
- 1,059 children were exposed to the domestic abuse going on among adults, of whom 501 were 7 years or younger.

Forced marriages

This is another issue in some cultures (reportedly not prominent in Walsall), again enslaving women, often with dire consequences for children. Social policy is in place to salvage desperate situations such as these during the life course, which are a feature of some disadvantaged and socially excluded families and communities.

Child Services Social Care

The need to protect children from abuse or neglect, and to improve services for children looked after by the LA, was addressed in Walsall by the Children's Taskforce, established in 2000. It had several components including the Quality Protects programme aimed at reforming children's social services. The drivers behind this project now exist as part of the Local Authorities every day work. Safeguarding Children aims to ensure that children, especially those in care, are properly looked after and protected from abuse. In addition, Walsall has a multi-agency strategy to deliver continuous improvement in services to support children and young people who have a disability and their families.

Children referred to Walsall Children's Services as needing protection are recorded as children who have a child protection plan, which runs at below 200 children per year (below 30 per 10,000 children aged under 18 years), but higher than the national rate of around 25 per 10,000. The commonest category of registrations is for neglect, frequently with associated issues such as domestic violence and parental substance misuse. There is a strong link with socioeconomic status, most of the children being from the deprived and socially excluded communities.

Children in care

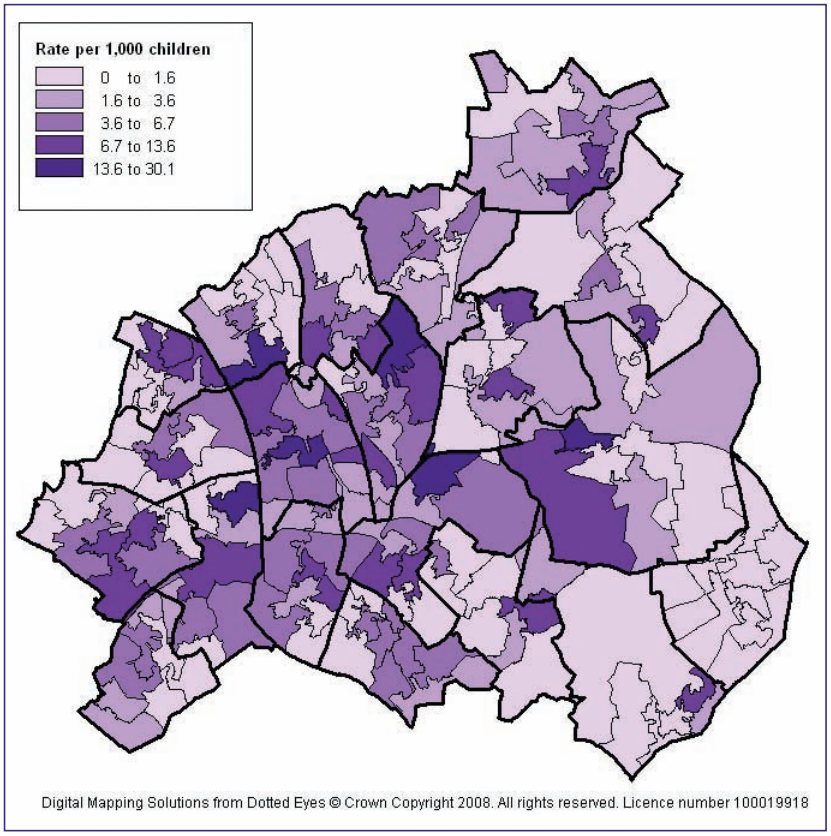
The number of children looked after by Council runs at around 440. A key indicator of quality of care is to reduce the percentage of looked after children who move home three or more times in a year. There have been improvements and this is now below 15%. A high priority is children leaving care, who tend to be disadvantaged in their physical and mental health, education, employment prospects, housing, and social status. They have higher rates of substance misuse and teenage pregnancy, and are at high risk of social exclusion. Looked after children tend not to have a single person familiar with their life course, and many of the manifestations that can lead to exclusion escape notice. This has been addressed by a Transition and Leaving Care Team who provide support, advice and guidance to all care leavers up to the age of 21.

The health care team specifically:

- Establish a detailed register of all looked after children.
- Ensure that they are offered regular and appropriate health need assessments.
- Ensure access to the required services so that needs are met.
- Develop accurate record keeping systems to track progress of all children.

The aim is to ensure high, at least 90%, compliance with a range of assessment indicators. Some children in care arise following domestic violence, accounting for as much as 40% of those made unintentionally homeless. The Women's Refuge in Walsall caters for such mothers but their service is continually stretched.

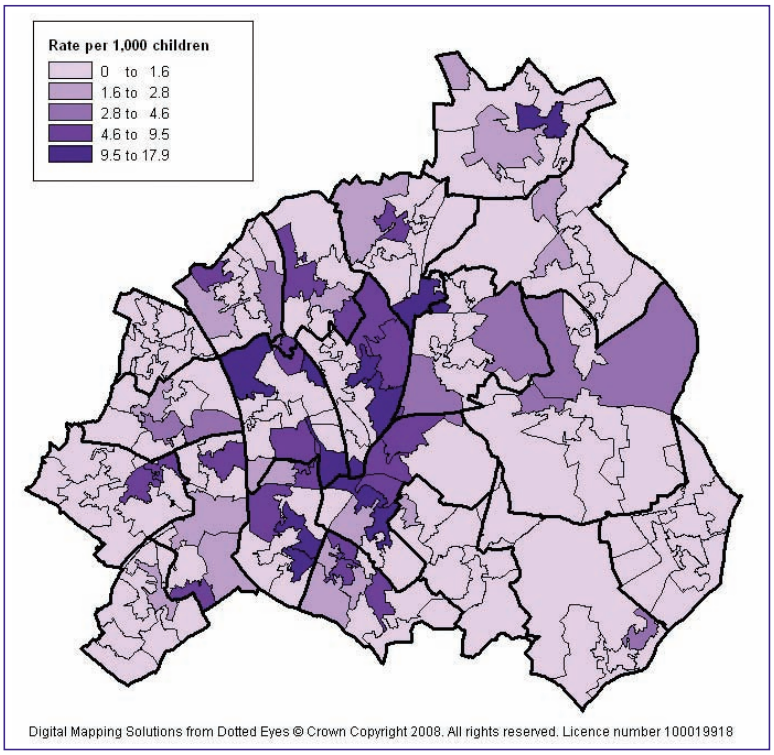
Map 7. Children in care in Walsall (earliest known address), October 2008



Source: NHS Walsall Care Plus system.

The highest rates of children in care in Walsall are of children who earlier lived in neighbourhoods in North Blakenall, Beechdale, Bentley, Mossley/Dudley Fields, Hatherton and Brownhills. Rates are also relatively high in parts of several other neighbourhoods in central and west Walsall.

Map 8. Children on the Child Protection Register in Walsall (earliest known address), July 2008



The highest rates of children on the Walsall Child Protection Register lived in a band of adjacent neighbourhoods comprising Goscote, North Blakenall, Ryecroft/Coalpool, Hatherton and Walsall Central. Rates are also high for children living in parts of Central Brownhills, Beechdale, Willenhall and Bentley.

Source: NHS Walsall Care Plus system.

Walsall Successful in Bid

The Big Lottery has funded the 'Living Well' programme. This is a cross sector partnership initiative that is addressing common mental health issues such as anxiety and depression in young South Asian girls. A range of innovative approaches have been developed.

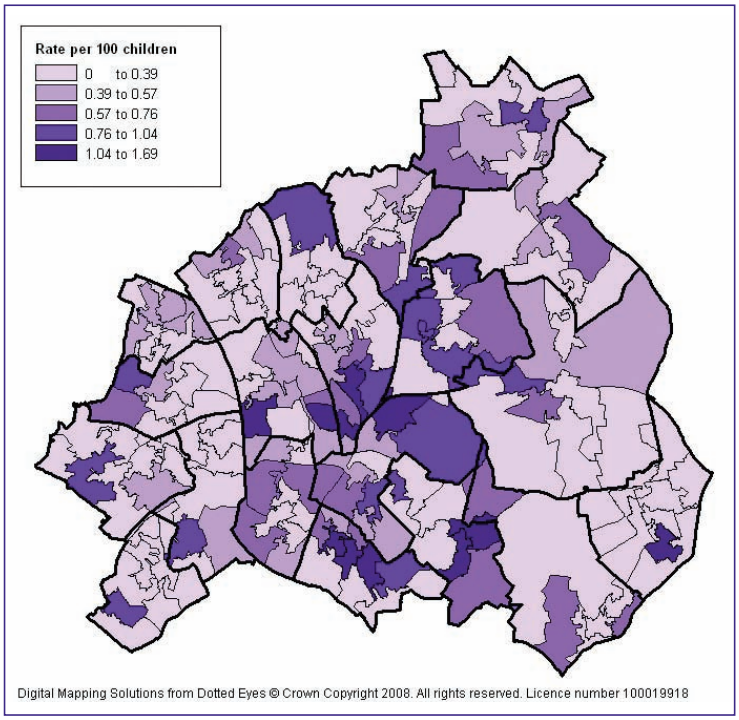
NICE Guidance on Depression in Children

The National Institute for Health and Clinical Excellence highlighted the high prevalence of depression in children and young people, often going undetected, unsupported, and untreated (2007). The emotional and economic costs are high. NICE recommends that Child and Adolescent Mental Health services (CAMHS) should work with health and social care professionals in primary care, schools, and other community settings such as the voluntary sector, youth offending, and criminal justice systems to provide training; also to develop ethnically and culturally sensitive systems to assess, support, and refer those young people who are depressed or at risk of becoming so.

The tPCT maintains a database of around 1,500 children with disability: physical, hearing, vision, language, behaviour, and learning. The latter predominates (around 40%) and 10% of these children have severe learning disabilities. Physical, language, and behavioural disabilities each account for around 15-17%, with almost half of the physically disabled being severely affected. The total number is an underestimate since children with behavioural disorders may remain hidden due to stigma. More than two thirds of known disabled children are boys. The Walsall Child Development Centre at Shelfield provides assessments and interventions for the severely disabled, including around 140 with cerebral palsy and 70 with Down's Syndrome. A Disability Living Allowance is accorded families who care for children under 19 years requiring continual supervision, the total number claiming running at over 1,300.

Walsall has a well established multi-agency strategy to deliver continuous improvement in services for children who have a disability and their families which has recently been reviewed to encompass the requirements of *Aiming High for Disabled Children 2008.*

Map 9. Proportion of children on the Disability Register, August 2008



Map 9 illustrates the clustering of children on the disability register across Walsall. Although the highest rates are found in some of the relatively deprived neighbourhoods (for example, Birchills/ Reedswood, Palfrey, Delves, Ryecroft/Coalpool, Hatherton, North Walsall), the highest rates are also found in relatively affluent neighbourhoods such as Park Hall and Streetly.

Source: NHS Walsall Care Plus system.

Social and Emotional Aspects of Learning (SEAL)

Government has developed this whole-school programme, supplemented by small group work for certain pupils. By creating positive social and emotional learning environments, and training approaches, SEAL can improve behaviour, attendance, attainment, and long term outcomes for children most at risk. So far, SEAL has shown dramatic decreases in classroom aggression and increases in pro-social behaviour. This approach cannot be underestimated because society and employers place high value on good relationship skills among young people.

National and local initiatives on social exclusion

Problems for young people are exacerbated by employers wanting high level social skills, enabling good team working, communication, and negotiation. These are developed in good home environments but may be lacking for the most excluded children and young people. So far, Government spending on socially excluded groups has been directed at managing the problems of entrenched exclusion, whereas there is now a need to shift towards prevention, to break the cycle of disadvantage. Large investments are made in tackling child poverty through the tax and benefit system, and through services such as Sure Start Children's Centres.

Walsall successful in Family Pathfinder bid

International evidence has suggested that intensive health-led home visiting can radically improve outcomes for both mother and child, especially for the most excluded. Pilots are underway to test interventions for childhood mental health problems using Multi-systemic therapy (combining family and behavioural therapy with intensive family support services). Fifteen LAs in England are participating in the DfES Early Intervention Pathfinder programme for parents of 8-13 year olds at risk of negative outcomes. This is a £16 million Family Pathfinder programme, to test and inform the implementation of the 'think family' approach, to offer disadvantaged and vulnerable families intensive help and support. The 15 LAs that successfully bid to become a Family Pathfinder were: Blackpool, Bolton, Brighton and Hove, Durham, Gateshead, Islington, Leeds, Salford, Somerset, Southampton, Southend, Sunderland, Walsall, Warrington, and Westminster.

Public services struggle to support very high need families because they are harder to reach. More advantaged families are often the most likely to ask for help, while those with more complex problems may not know that help is available or may even decline it. Local area data help in allocating and prioritising resources within geographical areas, but systematic and more rigorous tools are required. Closely related to this is the issue of information sharing. Some agencies can be reluctant to share information needed to identify at-risk households with other agencies who may also be able to help them. This stand alone service attitude simply has to stop.

The taskforce *Reaching out* document (2006) refers to the 'Incredible Years' parenting programme, which has demonstrated impressive sustained impacts on maternal health, child development, and reduction of conduct problems. Dramatic results have been achieved in 11 Sure Start centres in Wales and the Scottish Borders, whereby families with a child aged 3 or 4 years with significant behavioural problems attended 12 group sessions and were tracked for 18 months. The intervention families showed significantly increased positive parenting and marked decreases in quantity and intensity of child problem behaviours. This approach is now being piloted in England. Government intends to support the up-skilling of midwives, health visitors, and commissioners to promote early-years interventions, through guidance and spread of good practice. The future for tackling social exclusion at the early years level is first identify affected families by better data intelligence, coupled with information sharing, followed by health-led home visiting programmes and health-led parenting support. Recently appointed health trainers could play a role in this approach.

Impact of social exclusion on life outcomes

Despite programmes to support socially excluded families, problems remain:

- 1 in 3 children in care ends up not in employment, education or training.
- People with no qualifications are 7 times more likely to be unemployed and 5 times more likely to be low paid than those with higher education.
- Children from the 5% most disadvantaged households are more than 100 times more likely to have multiple problems at age 30 than those from the 50% most advantaged households.
- 1 in 4 adults in prison experienced being in care at some point as children.
- 65% of children with parents in prison go on to offend.
- Boys with a convicted father are 3.3 times more at risk of being convicted of a crime than those with a non-convicted father.
- The daughter of a teenage mother is twice as likely to become a teenage mother compared with a daughter of an older mother.
- Only 15% of young people from unskilled backgrounds begin higher education by the age of 21 compared with 79% of young people from a professional background.

Numbers of children in need in England, West Midlands and Walsall

	England *11,000,000*	**West Midlands** *1,100,000*	**Walsall** *59,000*	**Description**
All children				
Vulnerable children	3,000,000	300,000*	16,100*	Disadvantaged children who would benefit from extra help from public agencies to make the best of their life chances.
Children in Need	386,000	38,600*	2,070*	Vulnerable children who are unlikely to reach a satisfactory level of health and development without the use of services.
Children in Care	61,000	6,100*	290	. Children looked after by LAs, due to significant harm (65%), or on a voluntary basis (35%).
On Child Protection Register	26,000	2,600*	170	Children who are at risk of significant harm. They have a Protection Plan, where specific professionals have responsibilities to the child.

* denotes regional and Walsall estimates based on national figures from DfES (DfES, 2005 data)

Three million children in England are considered vulnerable, as defined by living in households with less than 60% of the median household income (DH 2000). They contain children in need of services support, which can result in LAs taking over care. An even smaller proportion are at risk of significant harm and require a Protection Plan. At risk children display a low level of social and emotional skills early on, such that 10-year-olds are over 40 times more likely to experience significant problems by the age of 30 compared with lowest risk children of the same age.

Much has already been done in Walsall to promote the education and wellbeing of the young:

- Improving education attainment, with greater investments.
- Joining up children's services through the Children's Act 2004 (HM Government 2004).
- Reforming the youth justice system with a focus on preventing offending, through the establishment of multi-agency Youth Offending Services (YOSs), bringing together criminal justice and children's services.
- Improving parenting in families through Sure Start Children's Centres.
- Addressing anti-social behaviour and offending through the Youth Justice Board working with YOTs to provide parenting support interventions, where necessary through parenting orders.
- Narrowing the gap between outcomes of children in care and other children.
- Continuing progress on teenage pregnancy.
- Implementation of the Child Concern Model and Common Assessment Framework, supported by multi-agency training and a small support team to enable earlier identification of concerns and a co-ordinated provision of services to support the child and their parents.

It is argued that much more needs doing to tackle mental health problems in children and young people, and to address at-risk children to prevent them going into care.

Future national and local initiatives

After the taskforce *Reaching out* document (2006), a second report was produced, called *Think family* (Social Exclusion Task Force 2008). This set out a next steps vision for a local system that improves the life chances of families at risk and helps to break the cycle of disadvantage. It includes a £16 million pathfinder programme, of which Walsall is a part, led by the Department for Children, Schools and Families, to find solutions on the ground. In a system that 'thinks family', services would:

- **Have no wrong door.** Frontline staff would be alert to wider risk factors, and arrange referral to other agencies as required.
- **Look at the whole family.** Here, practitioners consider the ways in which different family members and their problems interrelate, addressing parental problems whenever possible, eg through a family learning programme.
- **Build on family strengths.** This builds on the capacity of family members to support each other, promoting resilience, and supporting them to build up aspirations and capabilities. Strong families improve the life chances of individual family members.
- **Provide support tailored to need.** The Family Interventions Project has developed effective and intensive support to challenging families engaged in anti-social behaviour; while the Family Nurse Partnership programme provides effective support for first-time mothers with complex needs.

The WBSP can play a key role in strategic planning for families at risk. Partners from adult and children services must collaborate, and make more efficient use of limited resources, to manage the shift from crisis to prevention. The WBSP can draw partners together through existing bodies such as the Local Safeguarding Children Board and adult safeguarding arrangements, which will already include many of the key agencies. Joint strategies for families at risk can also be embedded in other local plans such as Children and Young People Plans, Local Parenting Strategies, Local Delivery Plans, and Community Safety Plans. Joint commissioning can target resources more effectively at families at risk, and this can arise from the Joint Strategic Needs Assessment (JSNA).

Chapter 4: Unemployment

Chapter content at a glance:

Unemployment, selection, and health; Links with poverty and stress; Job insecurity and quality. Walsall unemployed and initiatives.

Social exclusion examples:

Unemployed People

Unemployment remains a feature even of developed economies and tends to be concentrated particularly in deprived areas, with growing numbers of long-term unemployed, and young people who have never worked. Unemployment carries a risk of premature mortality over and above pre-existing social class. This has been shown by Drever and Whitehead (1997), with excess mortality among the unemployed being 25% for men and 21% for women. Such differences persist even after adjusting for smoking and alcohol consumption (Morris *et al* 1994). Job insecurity is also damaging for health (Bartley *et al* 1996), and so is temporary work compared to permanent employment (Kivimaki *et al* 2003). However, health does not necessarily decline during a period of unemployment, since those who are ill may be more likely to lose their jobs and find it harder to regain work because of their illness. This is known as selection (Valkonen and Martikainen 1995) and there is no doubt that ill health is a risk for job loss and re-employment. Nevertheless, when an entire workplace closes down, so that job loss affected by health is taken out of the equation, increases in illness are found in those made redundant (Kivimaki *et al* 2000). Two factors are at play: causation, where unemployment contributes to ill health, and selection, where ill health contributes to unemployment. Montgomery *et al* (1999) found that recent rather than total unemployment was the prime factor that led to risk for subsequent deterioration in mental health. This suggests that interventions need to be targeted at those who have recently lost their jobs, when the decline in mental health may be steepest. This acute effect of unemployment on health has been reviewed by Bartley *et al* (2006), who consider three reasons: (1) poverty; (2) unemployment as a stressful life event; and (3) changes in health-related behaviours at the time of job loss. Of course, retention programmes to prevent unemployment are also important.

The Reservation Wage

Bartley *et al* (2006) state: If the pay at which the unemployed will accept new work - the 'reservation wage' - is too high, employers will not take them on. If benefits are too high, the state is raising the reservation wage and contributing to high unemployment. In the UK, benefits were cut from the early 1980s, followed by a decrease in the real value of the lowest wages and a general redistribution of income away from the poorest sections of society, so that between 1979 and 1991, while the average household experienced an increase in real income of 36%, that of the poorest 10% fell by 14%. In 1981, households in the lowest 10% of the income distribution shared out 4.1% of the total income (including benefits and net of direct taxation) in the population between them (this had fallen to 2.9% by 1993), while the richest 10% shared out 21.3% in 1981 and 26.2% in 1993.

Household ownership is compromised in a situation of threatened redundancy. Those in rented housing are increasingly at risk of homelessness. Victims of such a downward spiral following job loss are certainly candidates for joining the socially excluded, with all the attendant ill effects on health. This illustration is one prime example of the widening inequalities in the UK today. Many unemployed adapt to their new circumstances, since there appears to be little further deterioration in psychological wellbeing after a period of 12 to 18 months (Warr and Jackson 1985), lending weight to the case for early intervention to support the newly unemployed. In summary, financial problems associated with the sudden experience of poverty is a main reason for the acute effects of unemployment on health.

Another reason is that job loss has been shown to be a highly stressful life event. It appears that work provides a number of non-financial benefits for psychological health. Warr (1987) has developed a 'vitamin theory' of the benefits of work, which include physical and mental activity, use of skills, decision latitude, interpersonal contact, social status, and a motivation to go from one day to the next. These are lost with unemployment. A third reason for health damage after unemployment is the appearance of new behaviours. Many are self destructive, and include suicide. This is not surprising given that spells of unemployment are also associated with loss of home and marriage breakdown. New behaviours include alcohol dependency, and it is easy to understand how job loss can be so acutely traumatic and damaging that a person can rapidly move towards a socially excluded state.

Unemployment and job insecurity

As the proportion of working-age men with jobs has declined in the UK, the proportion of women in paid work has risen sharply, but as summarised by Bartley *et al* (2006): the majority of these jobs are part-time and do not pay a wage sufficient to maintain the living standard of a single individual. A single adult or sole breadwinner could not afford to accept many of these jobs, as the resultant income would be lower than the level of welfare benefit, given that benefits cover the cost of housing.

As wages for lower-paid jobs drop relative to housing costs, it becomes dangerous to give up benefits in order to accept a job. Especially if the post is insecure; weeks without pay could end in eviction and homelessness. London has one of the largest number of unfilled vacancies for unskilled work and one of the highest unemployment rates in the UK. However, housing costs are so high relative to even the average wage in London, that many workers cannot actually afford to accept the lower-paid jobs that they are offered. An inadequate differential between low pay and benefit levels, together with loss of benefits as income rises, may therefore lead to voluntary long term unemployment.

Bartley *et al* (2006) have summarised how much the nature of the labour market has changed over the years, and how there is a greater sense of job insecurity than before; that the job for life factor is fast disappearing. Therefore, many in work may also endure chronic stress, as with the unemployed; 'Mac-jobs' are a good example:

- These are jobs available to those without advanced education and training, nicknamed after the McDonalds catering empire (Ritzer 1993).
- They are commonly found in the fast food industry, consisting of relatively unskilled work in preparing and serving such meals.
- Mac-jobs are at the lower end of an increasingly polarised job market, the upper end requiring high levels of education and skill in high-technology industries, and in services such as banking, law, and health.
- They are an example of how employers demand good health in employees.
- They are more likely to involve close supervision and contact with the public.
- Mac-jobs do not support the individual, who has to bear the burden of training costs (this has seen the disappearance of apprenticeships and the appearance of student loans, critical illness policies, and private pensions).
- These jobs contribute to the numbers of people who have become economically inactive, which far exceeds the increase in the numbers officially unemployed.
- Mac-jobs are actually insecure and low-paid, and their increasing share of the job market goes hand-in-hand with the increase in numbers of people dependent on long-term sickness benefit.
- They have had the effect of sharpening overall inequality of income.

This scenario of how the job market has changed in the UK serves to illustrate how people at the lower end of the socioeconomic spectrum do not necessarily have to be unemployed to experience chronic stress that is damaging to health. Similarly, you do not necessarily have to be unemployed to be socially excluded.

The unemployed face barriers and problems in taking up job opportunities, including:

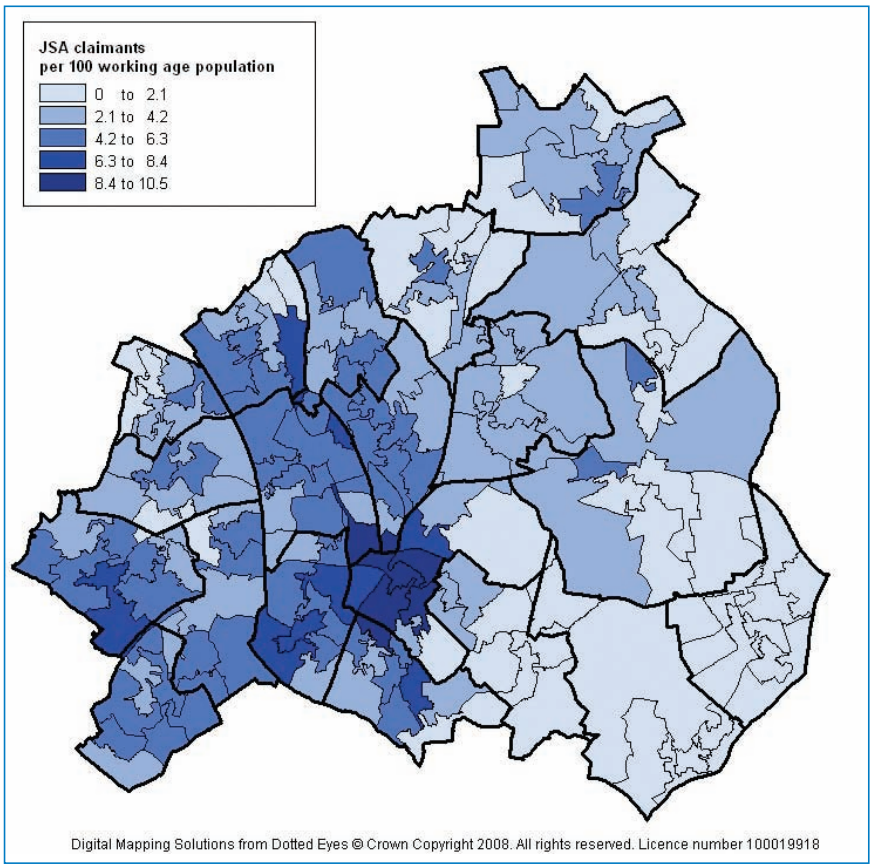
- Care for children and other family members.
- Cost of transport or difficulty in access to available employment.
- Training or education courses to address social and basic skills.
- Lack of information, confidence, and poor job search skills.
- Poor presentation and interview skills.
- Lack of recent work experience.
- Behavioural problems, including mental illness and substance use.
- Record of offending.

Accordingly, an overall package of actions is needed to help disadvantaged and socially excluded people into work. These have been addressed nationally by various initiatives, such as New Deal or Welfare to Work programmes, targeting: Young People, People aged 25 Plus or 50 Plus, Disabled People, Lone Parents, and Partners of unemployed benefit claimants; Government policies such as Tax Credit, Child Maintenance Bonus, and Back to Work Bonus; and other national schemes such as Single Regeneration Budget, Employment Action Zones, and Job Action Teams.

Unemployment in Walsall

The WBSP report (2005) identified that around 17% of households in Walsall contain nobody working, while one child in five was growing up in a workless household. Among ethnic minorities, Black, Bangladeshi, and Pakistani people had the highest unemployment rates. The ratio of BME unemployment to White rose from 1.7 in 1988 to 2.4 in 2000.

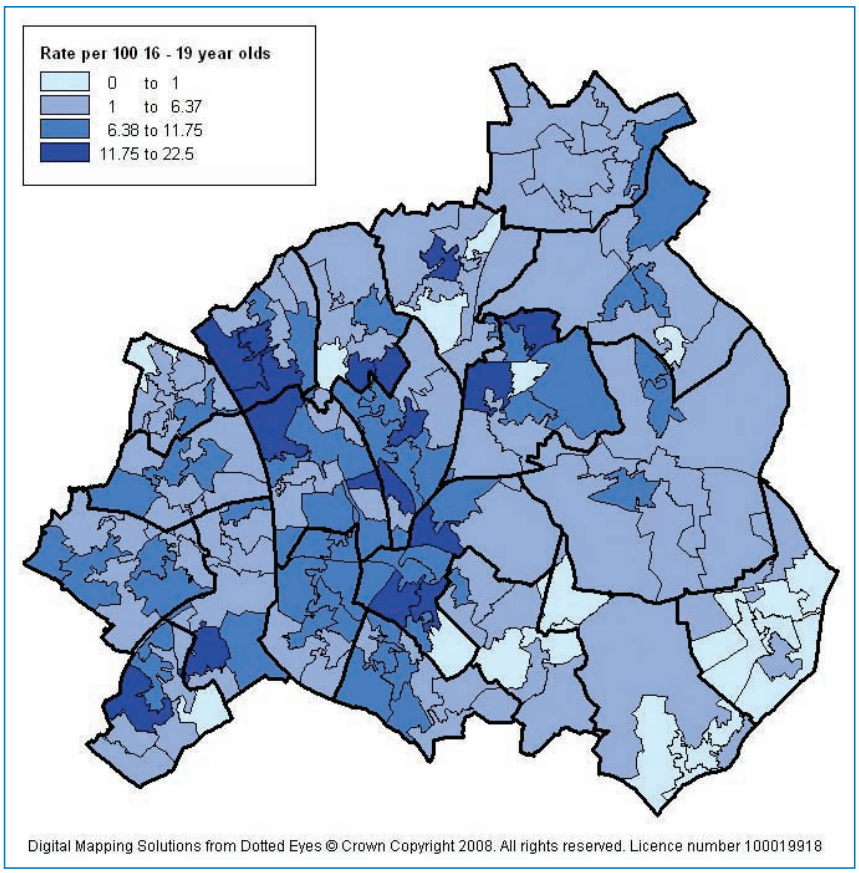
Map 10. Proportion of adults in Walsall claiming Job Seekers Allowance (JSA), February 2008.



In February 2008 there were 5,600 people in Walsall claiming Job Seekers Allowance (4,100 men and 1,500 women). The proportion of the working age population claiming JSA varies markedly across Walsall, with substantially higher rates (up to 10%) in the west of the borough. The highest rates (more than 6%) are in South Willenhall, Bloxwich, Beechdale, Pleck, Ryecroft Coalpool, Walsall Central and North, Birchills Reedswood, Caldmore, Palfrey, Delves and Hatherton.

Source: Department for Work and Pensions.

Map 11. Proportion of 16-19 year olds in Walsall, who are not in education, employment or training (NEET), July 2008



Source: Prospects.

In July 2008 there were 826 people aged 16-19 not in education, employment or training (NEET) in Walsall. Map 11 illustrates the wide variation in rates of NEET across Walsall. The neighbourhoods with the highest rates (up to one in five) are in the west of the borough including Birchills/ Reedswood, Caldmore, North Blakenall,Darlaston Central, North Walsall, Hatherton, Pelsall, Rushall, Shelfield and Mossley/ Dudley Fields.

Walsall initiatives

Walsall has deployed a number of initiatives to address unemployment:

- New Deal has a high profile in the Blakenall, Leamore and Bloxwich areas.
- The Local Pension Service has developed joint team working to improve uptake of pension credit and disability benefits. This includes addressing those with learning disabilities; more than half are in supported employment.
- The Civic Centre provides an extensive provision of benefits advice.
- The Anti Poverty Unit particularly addresses hard to reach, excluded groups and has achieved a Department of Work and Pensions (DWP) good practice award. Welfare rights officers visit homes and help with applications, they provide training to health care staff to identify need and take referrals, and they survey households to identify likely benefit need.
- The Walsall College of Arts and Technology (WALCAT) is active in its Skills for Life programme, including literacy, numeracy, and teaching English for speakers of other languages (ESOL). Over 1,000 students enrol each year: 45% are from BME groups and 90% are from deprived areas.
- A multi-agency borough wide Worklessness Steering Group has been established, which has produced Neighbourhood Employment and Skills Plans (NESPS) examining key issues contributing to worklessness for nine key deprived wards. This work has identified particular issues relating to the prevalence of high rates of incapacity benefit claimants with common mental health issues such as stress and depression. The tPCT is developing a range of interventions in response, supported by key partners, which will refer individuals and support them through a menu of options to help them become job ready.

The key action now is rolling out availability of the Citizens Advice Bureau and Anti Poverty Unit in such venues as Children's Centres and Primary Care Centres in deprived, high priority wards, and at the Manor Hospital. Another key is to make widely available a multi-benefit assessment centre in all high priority wards, and to adopt the outreach approach of the Anti Poverty Unit with linkages across services.

There is a new Socially Excluded Adults PSA which aims to increase the proportion of socially excluded adults in settled accommodation and employment, education, or training. A particular focus is on four client groups:

- Care leavers.
- Offenders under probation supervision.
- Adults with secondary mental health problems.
- Adults with moderate to severe learning disabilities.

Adults with multiple needs are typically in contact with a range of services, but tend to benefit less from the support they receive because their engagement with these services are too chaotic. Effective inter-agency working is crucial in ensuring a more coherent and personalised response to their wider needs. Performance management to meet National Level Indicators is relatively easy to effect, based on the proportions for each client group. At least six delivery partners are involved in this PSA: Department of Communities and Local Government (DCLG), DWP, Ministry of Justice (MoJ), Department for Children, Schools and Families (DCSF), DH, and Department for Innovation, Universities and Skills (DIUS).

Social Exclusion: The 2007 Comprehensive Spending Review

Addressing unemployment and accommodation

The Social Exclusion Task Force considers that the problems of the socially excluded require joined-up solutions across several government departments, summarised in an approach that follows 5 principles:

1. Early intervention.
2. Identifying what works.
3. Multi-agency working.
4. Personalisation, rights, and responsibilities.
5. Supporting achievement and managing under-performance.

Socially excluded adults are now prioritised in the 2007 Comprehensive Spending Review (CSR), containing a new PSA (reflecting Government's high-level priorities, and being one of only 30 agreed across the whole of Government) targeting the most vulnerable adults.

The CSR includes PSAs which aim to:

- Narrow the gap in educational attainment between children.
- Improve the health and wellbeing of children and young people.
- Halve the number of children in poverty by 2010.
- Promote greater independence and wellbeing in later life.
- Reduce the harm caused by illegal drugs and alcohol.
- Reduce crime and anti-social behaviour.
- Maximise employment opportunity for all.

The new addition, called the Socially Excluded Adults PSA, aims to ensure that socially excluded adults are offered the chance to get back on a path to a more successful life, by increasing the proportion of at risk individuals in:

(1) settled accommodation; and (2) employment, education, or training.

In summary, the PSA flags up a job and a home as being the core foundations of normal, everyday life which most people take for granted. To socially excluded people, a settled home and a stable job can seem totally out of reach.

Chapter 5: Housing and neighbourhoods

Chapter content at a glance:

Homelessness; Neighbourhoods; Housing conditions; Transport. Travellers, Gypsies. Walsall information on housing, neighbourhoods and health initiatives.

Social exclusion examples:

Homeless People
Travellers

Homeless people have poor health outcomes. A British study of people using hostels, bed and breakfast accommodation, and those rough sleeping showed that they were more likely to have health problems, usually multiple, than the general population; especially respiratory and musculoskeletal problems, along with higher rates of fits or loss of consciousness, usually associated with drug and alcohol misuse (Bines 1994). Homeless people have high rates of tuberculosis (Ramsden *et al* 1988; Darbyshire 1995) and, associated with injecting drug use, higher rates of HIV and viral B or C hepatitis, plus higher rates of skin complaints including scabies, pediculosis, fungal infections, and impetigo (Raoult *et al* 2001). Other health problems include a range of mental health issues (Gill *et al* 1996), schizophrenia (Folsom and Jeste 2002), alcohol and drug misuse, with associated overdoses, accidents, thrombosis, and abscesses (Meltzer *et al* 1995), and suicide (Baker 1997; Desai *et al* 2003). The homeless are 35 times more likely to kill themselves than the general population and 150 times more likely to be fatally assaulted (Keyes and Kennedy 1992; Grenier 1997). The average age of rough sleepers in Britain was found to be 42 years Grenier (1997). Preceding events are illuminating, as found by the Bines study (1994) of homeless people:

- 12-20% had previously stayed in a psychiatric institution.
- 9-21% had been in a young offenders' institution.
- 15-24% had been in a children's home.
- Over 50% had been resident in some kind of institution.

While some health problems precede homelessness, being without a home certainly compounds matters, be they of a material, psychosocial, or health nature.

Homeless Feelings . . . a sense of isolation and loneliness, feeling worthless, a failure and uncared for, lacking hope for the future, feeling trapped and powerless to change things, despised, rejected and marginalised by society, feeling frustrated, betrayed and misunderstood (Baker 1997).

Walsall's homeless people

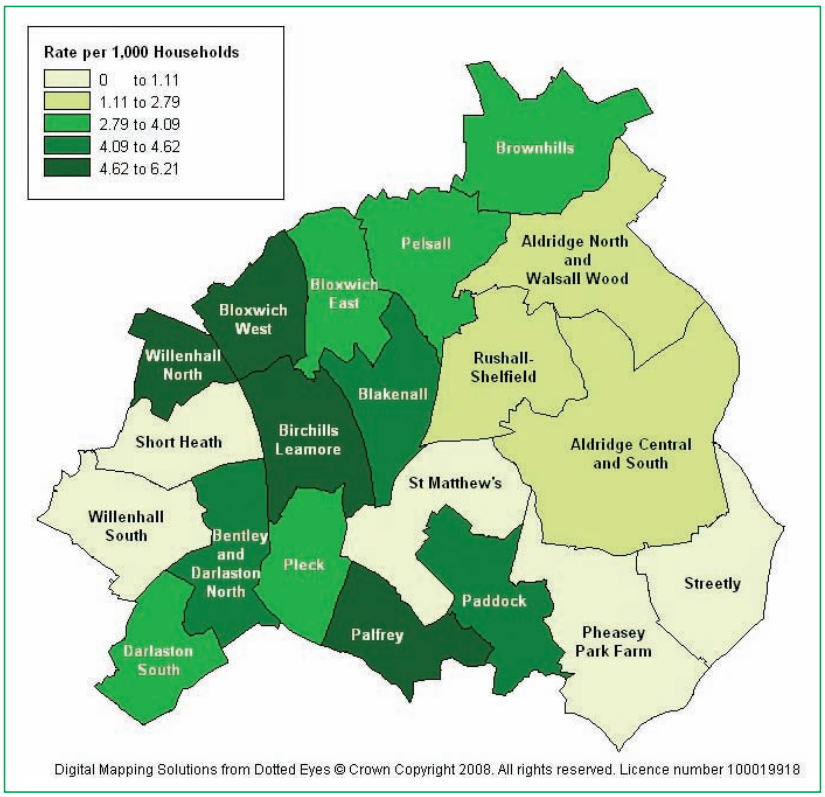
Rough sleeping is not a prominent issue in Walsall (no rough sleepers following street counts between 2005 and 2007) but over the years, TB cases among the White community have tended to occur among the deprived and often homeless, usually with drug, alcohol, or offending problems. However, over the last decade in Walsall, TB has predominated among South Asian people (in 2007, only 4.9% of cases occurred in White groups), often associated with travel among family members, but with no clear links to deprivation. Being homeless, and leading a chaotic lifestyle, has been associated in Walsall with morbidity from injecting drug use; arising from needle sharing (poor access to needle-exchange) and low standards of hygiene, leading to skin infections, abscesses, and blood borne viruses, notably hepatitis C (rates of 15 to 30% among injectors, depending on age and duration of injecting). Walsall injectors mainly derive from White deprived areas (Chapter 7).

Walsall has produced a homelessness strategy document, which shows a progressive reduction in 794 homeless applications in 2003/04 to 503 in 2006/07 (Walsall Council 2007). The principal reasons for applications are relationship breakdown, usually associated with domestic violence (showing year on year increases), and loss of privately rented accommodation. Mortgage and rent arrears may feature as another leading reason in the next few years. The Council acknowledges that data is based on the statutory homeless, who seek formal assistance, but there is little information about the hidden homeless. Bed and breakfast accommodation is only provided in emergencies. The Council oversaw an average length of stay of eight weeks in 2004/04 reduced to one week in 2006/07. Walsall's achievements have relied on a number of initiatives, including:

- Introduction of housing options and choice based lettings.
- Establishment of a rent deposit approach with Walsall Rent Guarantee Scheme.
- Walsall Interagency Sanctuary Project to enable victims of domestic abuse to remain in their own homes.
- Assistance from the Walsall Mediation Service.
- The opening of Rivers House, a supported housing project.
- A dedicated resettlement project to minimise repeated homelessness.

The underlying ethic has been that of addressing inequality, poverty, and social exclusion. More efforts are now being developed to encourage better partnership working, with a stronger focus on prevention and identifying those vulnerable people at risk of homelessness.

Map 12. Homeless households in Walsall, per 1,000 households (2007/08).



Source: Index of Multiple Deprivation 2007

Map 12 shows the number of homeless households expressed as a rate per 1,000 households in Walsall in 2007/08. In this period there were 290 homeless households (comprising one or more persons) in Walsall. The highest rates of homeless households were predominantly in the west of Walsall including Bloxwich West, Willenhall North, Birchills Leamore, and Palfrey. Perhaps unexpectedly, relatively affluent Paddock ward also had a higher than average rate of homeless households.

Travellers, gypsies

As stated on the Contents page, there will be little consideration in this report of people who freely choose a socially excluded lifestyle. However, this is not entirely true of all travellers or gypsies. In partnership with Dudley, Wolverhampton, and Sandwell LAs, a regional Gypsy and Traveller Accommodation assessment has been

commissioned to address the lack of data and needs concerning this population group. Walsall does have a Gypsy and Traveller Forum and a Gypsy and Traveller Community Strategy Implementation Group, who with Supported Housing, aim to promote the needs of these people, and those who desire to settle. Recent achievements have included the refurbishment of seven plots on Willenhall Lane caravan site, with plans to do so for a further 12 plots. Further details are available in Walsall's Gypsy and Traveller Community Strategy (Walsall 2006).

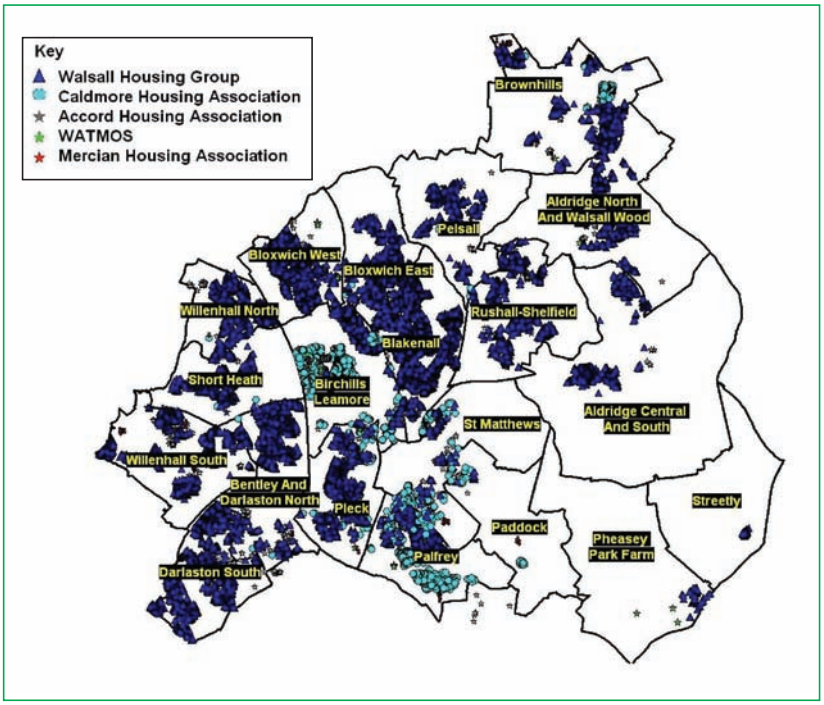
As a brief overview of travellers in Walsall, there were 44 counted Gypsy caravans in July 2005: four on unauthorised sites, 18 on Council sites, and 22 on private sites. A major issue is that there is a nationwide lack of permanent and transit sites, which may result in unauthorised encampments and the risk of tensions with settled residents. The Housing Act 2004 requires LAs to assess the accommodation needs of Gypsies and Travellers, and to develop a strategy to address these through public or private provision. Accordingly, Walsall became a member of the National Association of Gypsy and Traveller Officers, which enables access to training, good practice, and sharing of information. Council has listed requirements for caravan sites, including:

- Acceptable residential environment for occupants of caravans.
- Adequate access to schools and other local services (*eg* one key concern has been immunisation uptake, following traveller-associated measles outbreaks in other parts of the country).
- No unacceptable adverse impact on nearby residents.
- Suitable boundary treatment and screening.
- Provision of mains water, electricity, and drainage.

Housing and neighbourhoods

Housing is an important determinant of health. Poor housing can be damp, cold, and mouldy - conditions associated with respiratory disease, risk of fire and accidents, while overcrowding increases risk of infection and impacts on mental health through lack of privacy (Ineichen 1993; Shaw 2004). The Department for Environment, Food, and Rural Affairs (2004) states: *Everyone should share in the benefits of increased prosperity and a clean and safe environment. We have to improve access to services, tackle social exclusion, and reduce harm to health done by poverty, poor housing, unemployment, and pollution.* Housing has to counteract excess mortality each year in winter time and, in some years, also in summer time. However, studies of housing improvements show that while deprivation indices can improve, perceived quality of life, social relations, and mental health can deteriorate (Stafford and McCarthy 2006). Thus, the bigger picture of the entire neighbourhood, its services, and community safety has a more important role to play. Communities themselves are being socially excluded given the current trend of increasing residential segregation by social position and the widening social inequalities in housing conditions. This has been recognised by Government, so that targets have been set to narrow the gap, such that nobody should be seriously disadvantaged by where they live within 10 to 20 years (Cabinet Office 2001). Stafford and McCarthy (2006) have shown associations between residence in a multiply-deprived area and health indicators, violence and murder. The socially excluded are most likely to be found in the worst deprived neighbourhoods, where social cohesion and social capital assume importance in promoting a better quality of life and a health protective effect. Putnam (1993) defined social capital as features of social organisations - such as networks, norms, and trust - that facilitate action and cooperation for mutual benefit. The built environment is important since semi-private space, such as buffers between the house and public space, living at street level, and spaciousness are associated with better neighbouring. Also important are suitable meeting places, and local facilities for retired people, youth, and parents with young children. Suitable recreational areas are key for the teenager and young adult. This entire concept has been responsible for initiatives such as schemes supported by the Neighbourhood Renewal Fund.

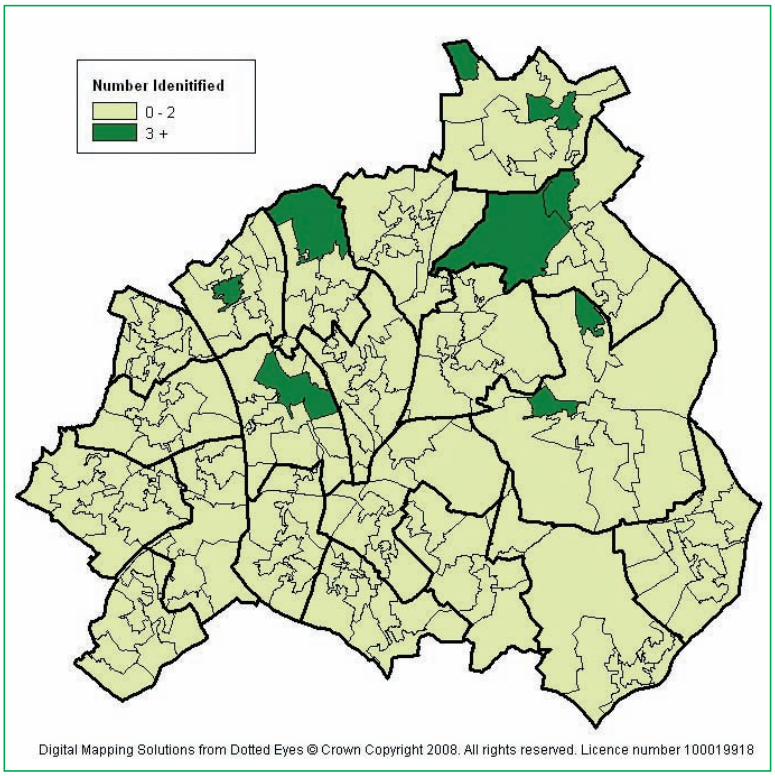
Map 13. Registered social landlord housing stock in Walsall



Source: Walsall Council, Strategic Housing

Walsall Council's Housing Needs and Demand Study Update 2007 estimated that there were about 103,200 households in Walsall, of which about 24% (24600 households) were in the social rented sector. Every ward in Walsall has some social housing stock but the distribution pattern broadly reflects relative deprivation across the borough, with most social housing located in wards in western, central and northern parts of Walsall.

Map 14. Areas of Walsall identified by Health Visitors as being risky, August 2008



Map 14 identifies areas in Walsall perceived as being risky by Health Visitors in terms of personal safety when making home visits. This includes in particular some neighbourhoods in Brownhills, Clayhanger, Walsall Wood, Aldridge, Bloxwich, Dudley Fields, and Beechdale. It can be seen by comparison with Map 13 that these risky areas represent a very small proportion of social housing in the borough and that some are in private housing areas.

Source: NHS Walsall, Children's Prevention Services.

Putnam's work on social capital

Among the 20 regions of Italy (Putnam *et al* 1993) and the states of the USA (Putnam 2000), community life involvement tended to be higher where income differences were smaller. There were remarkably similar time trends as social capital moved inversely with inequality during the 20th century. The first two-thirds of the century saw income inequalities narrow and social capital strengthen; but in the late 1960s, both reversed direction. America became less just economically and less well connected socially and politically.

Actions to address Walsall housing and neighbourhoods

The national housing policy was issued in 2000, and summarised in the objectives of the Department for Transport, Local Government and the Regions (DTLR) housing directorate, aiming to offer everyone the chance of a decent home to promote social cohesion, wellbeing, and independence. The focus of neighbourhood renewal is to:

- Raise the quality of social housing.
- Provide new affordable housing.
- Create new forms of tenure.
- Tackle social exclusion, eg: rough sleepers, vulnerable tenants in sheltered and supported housing, fuel poverty, travellers' sites, and anti-social behaviour.

LAs and Registered Social Landlords are set targets for social housing to meet standards of decency by 2010. Walsall is on track in this regard.

The Walsall Regeneration Company is active in the field of neighbourhood renewal, being funded jointly by the Council, Advantage West Midlands, and English Partnerships. The focus is around the town centre and surrounding employment areas, extending to locations such as Darlaston, Leamore, Pleck, and Bloxwich. A number of Housing Associations operate across Walsall, and the Council is involved in various initiatives including: Neighbourhood Renewal; New Deal for Communities; Decent Homes standards; and Housing Market renewal. Major regeneration and housing activity areas include the town centre, Bloxwich, Darlaston, and Willenhall. A major investment programme is underway, and is highly visible around the town centre and ring road developments. There are a number of other initiatives: housing management to address anti-social behaviour; a Walsall Housing Group strategy that also addresses health and education issues; a Council strategy on homelessness; Council support for affordable warmth schemes; provision of free smoke alarms; checks on home safety, including electricity and gas; replacing internal lead piping and asbestos material where feasible; and testing for Legionella in blocks of flats. Along with the Decent Homes standards, heating is a key objective, with numerous actions to address fuel poverty (proper insulation; remedying damp; removing mould; improving ventilation; constantly increasing the proportion of homes with central heating). Home safety also includes targeting the elderly population living in priority wards, referred to in Chapter 2, and providing child stair gates. Housing Associations are also active in replacing baths with showers, where appropriate. Neighbourhood safety improvements include traffic calming measures in residential streets.

Transport

Transport provision can potentially play an important role in influencing many of the outcomes that are enveloped by the concept of social exclusion since, in most instances, ***inclusion*** implies ***participation*** in processes and activities (*eg* labour markets, social services, social networks *etc*) and this participation will often in turn depend upon ***physical access*** to the relevant facilities. (Social Inclusion: Transport aspects; March 2006, Department for Transport).

Increasing geographical dispersion has resulted from the increasing dominance of the motor car; with two important effects on health:

- *Increased car-dependency,* as a more dispersed pattern of activity and residence is less easily served by public or non-motorised transport modes;
- *Increased social polarisation,* as the most affluent can move further away and the poorest people have become more concentrated in the areas already suffering the highest levels of poverty.

Individuals who are disadvantaged often experience serious difficulties in getting around and are much less likely to have access to a car. Moreover, regular and reliable public transport services are not available or at least readily accessible in every community; are often unaffordable for people on low incomes or do not take people to where they want to travel. Walking and cycling may not be suitable options for accessing (critical) services, such as health care, learning, shops and post offices, which are distant or in environments where traffic levels and accident rates are high.

Transport problems of this kind can therefore be a significant contributory factor to social exclusion. Such problems act to isolate individuals and prevent them from participating in a wide variety of every day activities, such as visiting friends and relatives. It affects the ability to get to sources of healthy foods and community services. These factors underpin both the promotion and maintenance of healthy lifestyles and mental wellbeing.

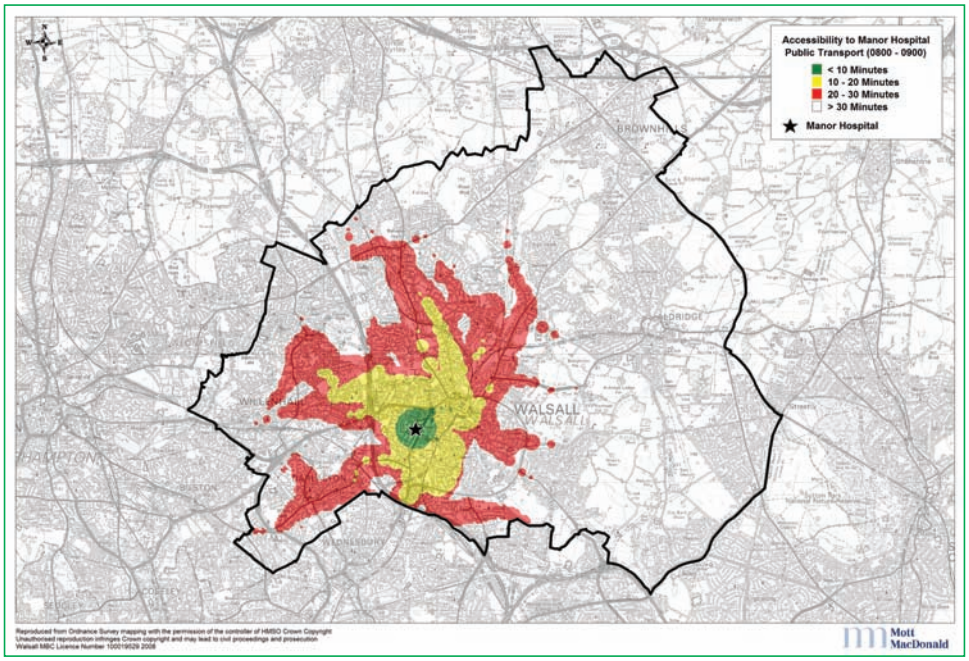
Lack of transport or access to transport services disproportionately affects the lower socio-economic groups, women, ethnic minorities, children, the elderly and those with impaired mobility. As an example, healthy foods are more readily and more cheaply purchased in large shopping centres, and the price differential between healthy and unhealthy foods is greatest in the shops used by poorer people.

The subject of transport has an intimate association with neighbourhoods. McCarthy (2006) has reviewed the complex issue of transport and health, particularly on heart disease and the role of exercise; on mental health and the role of traffic volumes and noise; on respiratory disease and the role of pollution; and on road accidents. In all these areas, socially deprived areas easily fare the worst. Policies for walking and cycling are discussed, although these are more easily implemented in greener and more pleasing environments. Policies for improving public transport and restraining vehicles are beginning to take effect. There is a long way to go and overall, socially deprived communities will be the last to benefit from the policies.

Many of the national transport indicators that have an impact on public health are generally applicable to the overall Walsall population, such as people and children killed or seriously injured in road traffic accidents. However, there are others that have a disproportionate impact on socially excluded communities, and these include: (1) access to services and facilities by public transport, walking, and cycling; and (2) working age people with access to employment by public transport. Walsall also has to comply with the West Midlands Local Transport Plan targets, the relevant ones for social exclusion being (3) to increase access to a main NHS hospital, and (4) increase access of households to a local or main centre that includes food outlets.

Walsall is compact from the perspective of the 15% most deprived wards, such that access to Manor Hospital, for example, is not unduly difficult (with the exception of Willenhall South and Darlaston in the extreme south west of the borough; and the small pocket of deprivation within Brownhills in the extreme north east). This can be illustrated by isochrone mapping (Map 15), showing bands of access by public transport from less than 10 minutes to over 30 minutes. Such mapping can also be applied to superstores, showing how less mobile and infirm people living in socially excluded communities are further disadvantaged, or to schools. Walsall Council has a well advanced Sustainable School Travel Strategy, although there is no specific focus on social exclusion. Road safety is an issue, and there is a lack of safe cycling or walking routes.

Map 15. Accessibility of Manor Hospital by public transport between 8.00-9.00am



Source: Mott McDonald

A revealing perspective on transport in Walsall arose during the tPCT-Council 2008 Health Inequalities conference. Important issues that were raised included:

- Teacher perception of health and safety concerns about public transport, while many children from deprived areas are disadvantaged over funds for transport.
- Personal safety on public transport, especially for lone women.
- Older people being isolated as bus services are withdrawn.
- Need for police support officers on public transport.
- Accidents in deprived areas – rat running, parking in residential areas.
- Merger of GP practices and many patients inconvenienced by more travel.
- More centralised health centres putting pressures on those without a car.

This suggests that bus transport is inadequate in terms of safety and cost to those living in deprived areas. At the same time, anti-social behaviour, more prevalent in those from socially excluded communities, is contributing to the safety concerns and fear of crime among passengers, and among those walking the streets in some areas.

Local Initiatives on Transport

Under the auspices of Walsall Strategic Borough Partnership (WBSP) a multi-agency working group was tasked with establishing the Local Accessibility Action Plan (LAAP) and then driving its delivery. In February 2008 the WBSP Board approved the LAAP and agreed to ensure partner "sign up", bring back changes for endorsement and hold partners to account on delivery.

For the Future

Using specialised software, maps of the borough and transport routes will be overlaid with census and non-census information and the location of key services. This will help service providers to assess more systematically whether people, and particular groups of people, can get to places of work, healthcare facilities, education, food shops, leisure and other destinations that are important to local residents. Solving accessibility problems may be about transport but also about locating and delivering key activities in ways that help people reach them.

Chapter 6: Social support and welfare

Chapter content at a glance:

Social support and - physical morbidity, mental health; Social cohesion.
Walsall information on social exclusion examples, and initiatives
(eg from Social Care Services).

Social exclusion examples:

Disabled People with Mental Ill Health, Carers
Elderly People
Chronically Ill People

Social support is beneficial to health and a crucial intervention for those who are socially isolated or excluded. It leads a person to believe that he or she is cared for and loved, is esteemed and valued, and belongs to a social network of communication and mutual obligation (Cobb 1976). There is a strong association between social support and mortality. For example, in a large study of social networks scored on the basis of marital status, number of contacts with friends and relatives, and group membership, low scorers had up to three times greater mortality over a nine-year period (Berkman and Syme 1979). There is a suggestion that the protective effect of social networks is greater in men than women. Much work on social support and social cohesion has been reviewed by Stansfeld (2006). There is also a strong association between social support and morbidity. Social support is beneficial for people with chronic illness (Lindsay *et al* 2001). Social isolation conveys a poorer prognosis after myocardial infarction. Socially isolated stroke victims fare worse, and those with chronic disabling and painful disease experience more physical symptoms and secondary depression. Links with psychological disorder are well known, as evidenced by bereaved adults who experience unexpected levels of illness and mortality in the year following the death of their spouse (Parkes *et al* 1969). Low emotional support is a risk factor for onset of depression following a variety of critical life events. Quinton *et al* (1984) showed how social support in adulthood may exert a beneficial effect on parenting problems, marital difficulties, and psychiatric disorder. Certainly, support for mothers with young children can help prevent social isolation from other adults, and is a recognised intervention to prevent onset of mental illness.

There is some evidence for a differential distribution of social support by social class in that, for example, there is more contact with friends among those with higher employment grades while there is more contact with relatives among those with lower employment grades (Stansfeld 2006). Social support operates at the community level, when we refer to social integration or social cohesion. Trust between people, as well as increased feelings of community cohesion and empowerment, seem to be of crucial importance for good mental health. This is related to the social organisation as well as the physical characteristics of any neighbourhood (Dalgard and Tambs 1997). There is a positive link between social cohesion and health (Wilkinson 1996). For example, Italians who settled in the USA retained low levels of coronary heart disease as long as they kept their traditional family-orientated family structure.

Mental Health and Deprivation

Suicide and psychiatric morbidity have been found to be associated with deprivation (Gunnell *et al* 1995; Hawton *et al* 2001; Bartlett *et al* 2004). In Scotland, between 1981 and 1993, the highest increases in suicide rates were for deprived young people, being approximately twice those of young people in affluent areas (McLoone 1996). Crawford and Prince (1999) found increasing suicide rates among young men in the UK to be associated with social deprivation, unemployment, and living alone. These are strong ingredients of the socially excluded state.

Forgotten socially excluded people?

Walsall's population of disabled people and those with mental health or chronic disease problems are not necessarily socially excluded. A large proportion benefit from the closeness of family members or carers, while only a minority experience disadvantage or exclusion through a combination of their disability or ill health and their deprived or socioeconomic circumstances. An even higher proportion of elderly people or pensioners enjoy an acceptable level of social cohesion, largely a function of close families and carers. A network of friends is crucial; social exclusion is more likely to arise in those sensing loneliness and desolation. This is accentuated among deprived communities, where fear of crime contributes to a sense of exclusion. Many older people experience stigma about their age. Increasing life expectancy has brought its own problems. Caring and compassion, and the human aspects that define it seem to be under increasing strain. Government has recognised these emerging issues. In May 2008, a six month consultation on the future of the care system was announced, that will lead to a Green Paper. Work is underway to *transform social care* through individual budgets; there will be an extra £520 million for councils over the next three years through the Social Care Reform Grant, aiming for more personalised and preventative care services, more power and control to service users and their carers, and a new closer relationship between PCTs and LAs.

Mental health in Walsall

This has been the subject of a DPH Annual Report (Walsall HA 2000). Many indicators of deprivation were not clearly associated with poor mental health, owing to the precision of available data, although community psychiatric nurse contacts across the borough suggested clear links. These included the correlation of severe and enduring mental illness with homeless people, housing problems, and deprived people from the African Caribbean community. Housing associations and a number of other facilities provide supported housing for people with mental health problems, but most users live in general housing. A user survey showed that most were satisfied with the general level of psychiatric service provision (particularly medication, in-home crisis services, counselling, family support, GP access, and help with transport), but:

- Most wanted to work and pursue further education and training.
- 25% had experienced abuse from neighbours.
- Nearly all BME residents had experienced racial abuse.

There have since been improvements to this situation with more organised support through Housing Benefit. Otherwise, there is a persisting problem following discharge from day hospitals and the Dorothy Pattison Hospital of a lack of continuing care, of feeling isolated, and of the family or carer being insufficiently informed.

Employment for people with severe mental health problems

Government has urged action in this area through its action plan on social exclusion (Social Exclusion Task Force 2006). Levels of unemployment are 89% for people with severe mental health problems, although most can and do want to work. They usually end up on long term Incapacity Benefit and suffer social exclusion in the form of deprivation, isolation, and physical ill health. There is need for a greater uptake of the Individual Placement and Support approach to vocational rehabilitation, but few incentives exist locally to support delivery of this best practice. In 2006, the DH and DWP issued guidance on commissioning vocational services for people with severe mental health problems.

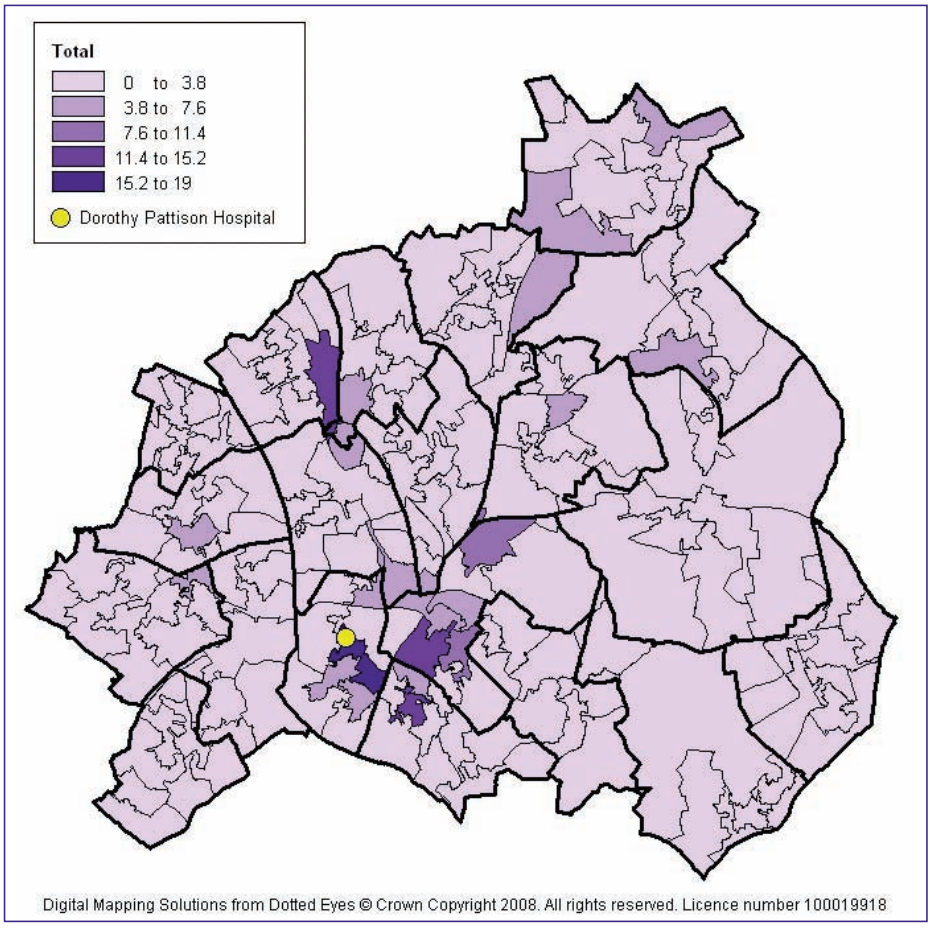
Government intends to support this commissioning further through dedicated teams within the Care Service Improvement Partnership Regions, working with Government Offices, and intends to refocus the Shift anti-stigma and discrimination programme. The DH and DWP will build on the Pathways to Work programme, exploring further incentives for agencies. Initiatives within the Skills for Life strategy will also be explored.

Walsall has an estimated 500 to 1,200 residents with schizophrenia, the same range for affective psychosis, 5,000 to 13,000 with depressive disorder, and 4,000 to 15,500 with anxiety states. Around 6,000 require specialist mental health services each year, of whom 1,500 will have severe and enduring mental illness. Suicides are few (around 20 per year), with no obvious links to social exclusion (Laverty *et al* 2008). People with dual diagnosis could reach at least 1,500; in line with Walsall's estimated 10,000 socially excluded population. People with dual diagnosis also have physical health problems, associated with poor diet, blood borne virus and other infections, risk of overdose and suicide, as well as social exclusion issues of unemployment and poor housing. Dual diagnosis is an important mental health issue since:

- Substance misuse among people with mental health problems is usual rather than exceptional.
- Treatment for substance misuse often improves mental health.
- Healthcare costs of untreated people with dual diagnosis are likely to be higher than for those receiving treatment.

However, the reality is that people with dual diagnosis may be excluded from both the separate services. They fall between them. Given the high prevalence of substance, and especially drug, misuse among socially excluded people, dual diagnosis provides a real opportunity for effective partnership working to identify disadvantaged Walsall families first, before addressing the challenge head on. Identifying families is key, since the children of those with dual diagnosis require just as much attention to their health and social care needs.

Map 16. Dorothy Pattison Hospital admissions of patients with severe and/or enduring mental illness for intensive care and rehabilitation 2003/4-2007/8



Map 16 shows the clustering of admissions to Dorothy Pattison hospital for intensive care and rehabilitation in 2003-07. The highest rates were in parts of Pleck/Alumwell, Walsall Central, Caldmore, Hatherton, and Mossley/Dudley Fields.

Walsall is currently producing a Dual Diagnosis Strategy to tackle this important area. This should have high impact on addressing the plight of its socially excluded people. Given the multiplicity of problems associated with dual diagnosis, the strategy will recommend an integrated approach and a radical rethink of the way services are organised. They will be structured around the user, and will entail a concurrent provision of both psychiatric and substance misuse interventions, with a strong focus on coordination and involvement of all other relevant services.

Source: Dorothy Pattison Hospital Admissions Data

Supporting people with dementia and their carers

The National Institute for Health and Clinical Excellence (NICE) has issued guidance on this topic in the context of health and social care (2007). There is increasing prevalence of dementia with age. It is progressive and largely irreversible, associated with complex needs and high levels of dependency and ill health.

- Health and social care managers should ensure the rights of carers to receive an assessment of needs is upheld, and that those who experience psychological distress should be offered appropriate therapy.
- Managers should coordinate and integrate working across all agencies involved, including jointly written policies and procedures.
- Care managers and coordinators should combine a plan for health and social care, and assign a named lead professional.
- Endorsement, with valid consent, of the care plan by the person with dementia and/or carers, and formal review, should be recorded in notes.

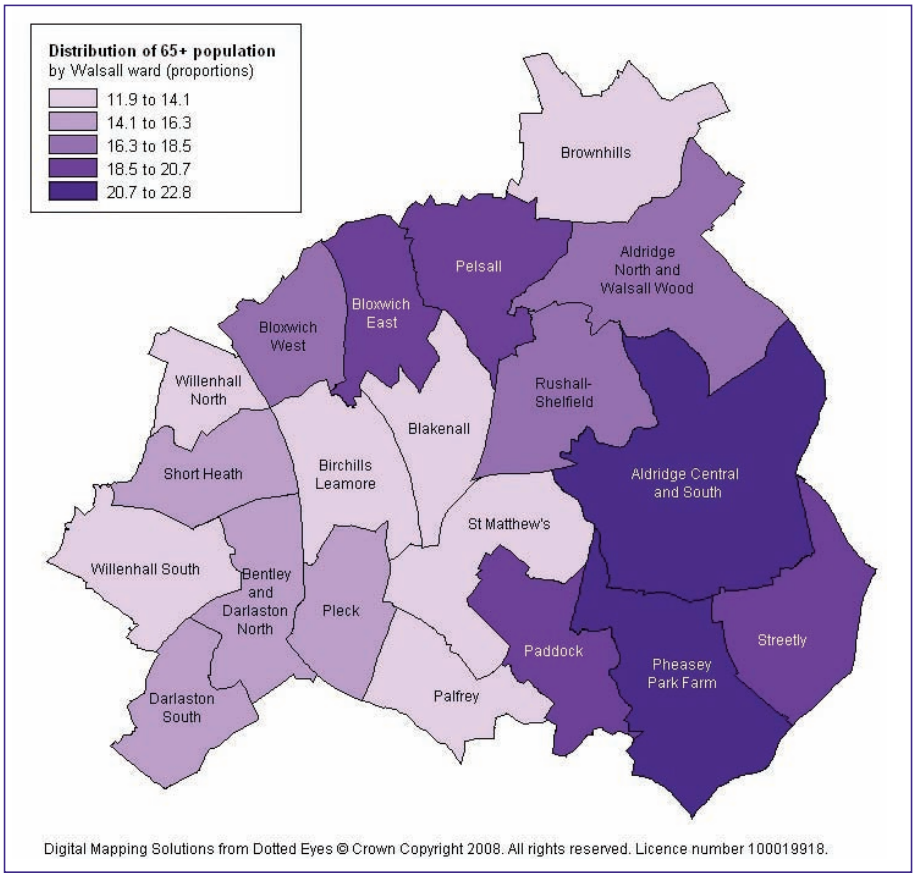
Sexually exploited and vulnerable young men in Walsall

A recent survey was undertaken in Walsall, through a number of agencies working with young men and boys, to determine vulnerability to sexual exploitation. A total of 31 young men were identified with a history of exploitation, and 71 were identified as being vulnerable to the risk of being so in the future. Both groups showed clear hallmarks of social exclusion. The exploited group were characterised by experience of financial difficulties, a previous history of being in care and of family disruption, current or previous substance misuse, and being sexually abused as a child. The vulnerable group also had problems around financial difficulties, family disruption, and substance misuse, together with episodes of running away from home, homelessness, and persistent low self-esteem. A very high proportion of both groups had mental health problems: 29 of the 31 exploited group, and 66 of the 71 vulnerable group. Identified problems were (exploited and vulnerable groups respectively): low self esteem, 12 & 25; self harm 8 & 21; insomnia 11 & 8; stress 8 & 7; depression 7 & 6; personality disorder 3 & 4; and anxiety 2 & 4. This is very early work in an attempt to assess need and better deliver services for these socially excluded groups.

Older people in Walsall, disability and chronic illness

The DPH Annual Report on older people describes many of the health and social care issues around older people and chronic illness (Walsall HA 2001). The proportion of older people aged 60 years or more varied from 12% to over 20% across Walsall wards. (see Map 17). However, many more older people living in socially excluded communities and locations within deprived wards endure poorer health and quality of life because of inadequate and inferior housing, lower income, greater fear of crime, and higher dependence on public transport. There is a major mismatch between expressed housing need and supply, with older people accounting for 1,600 of a housing list numbering around 14,000 in 2001. This compounds the problems of older people largely occupying poor housing in deprived areas. The same applies to crime against older people, domestic burglary and criminal damage accounting for 60% of crime against older people. The highest levels are in St Matthews, Blakenall, Palfrey, Willenhall South, Pleck, and Birchills Leamore.

Map 17. Proportion of older people in Walsall wards in 2001



Source: Census 2001

Older people with disability or long term illness can qualify for Attendance Allowance if they require varying degrees of care in the home, and can receive Disability Living Allowance as appropriate. Again, a significantly higher incidence of people receiving Attendance Allowance is found in the more deprived wards, and can amount to more than 10% of the total number of households in some areas. Generally, Walsall has a good provision of home care and sheltered housing for its older people. With the need to maintain independence of older people for as long as possible, much attention has been given to home aids and adaptations. Along with this, there is a well developed Falls Prevention programme. Intermediate Care has been well developed since 2001, aiming to provide faster recovery from illness and prevent unnecessary acute hospital admissions. Since 1991, the above initiatives have led to a decline in the number of pensioners requiring residential or nursing home care, which becomes necessary when health or social needs become too great to live at home. Palliative care is very well developed in Walsall, with the Macmillan team playing an active role. There is no data to suggest that older people from deprived or socially excluded communities are further disadvantaged in their access to all these facilities.

Chapter 7: Resulting behaviours, associated lifestyles

Chapter content at a glance:

Social determinants of health and relative deprivation, leading to social exclusion, often resulting in addictive and anti-social behaviours. Walsall data on social exclusion examples. Partnership initiatives.

Social exclusion examples:

Drug and Alcohol Misusers
Offenders
Gang Members, Sex Workers

There are very strong links between deprivation or social exclusion and substance misuse. Alcohol dependency is frequently a result of acute social breakdown and isolation, having a significant impact on mortality through accidents and violence (Makela *et al* 1997). Binge drinking is more frequent among socially excluded and deprived populations, often leading to hospital admission and sometimes sudden cardiac death (Kauhanen *et al* 1997). A recent Walsall public health report showed a higher prevalence of binge drinking in the most deprived wards, which also produced the highest rate of alcohol related hospital admissions (Walsall Teaching PCT 2007). There was a concentration of admissions from around the Blakenall New Deal for Communities area. Gang related behaviour probably had an influence in explaining certain patterns of admission from certain communities; for example, alcohol related injuries or medical emergencies among people from high street or park locations. Younger age groups accounted for 26% of alcohol related admissions in 2003. Drug misuse also shows strong associations with indicators of social disadvantage, often from within families with disturbed backgrounds, low self-esteem, and impaired psychological functioning. Drug misuse is immensely important in costs to society through crime and social disruption.

Walsall's providers of drug and alcohol services:

1. Lantern House, providing Tier 3 level community drug and alcohol services; comprises four teams – Generic, Shared Care with GPs, Criminal Justice, and Community Alcohol - giving specialised treatment for drug (mainly heroin) and alcohol misuse. Also responsible for placements in residential rehabilitation.
2. Addaction - a national charity providing Tier 2 level drug and alcohol services, including needle exchange, blood borne virus interventions, alcohol arrest referral, and point of contact for the Drug Intervention Programme.
3. T3 - part of the national charity Crime Reduction Initiative, providing substance misuse services for young people up to the age of 18 years.

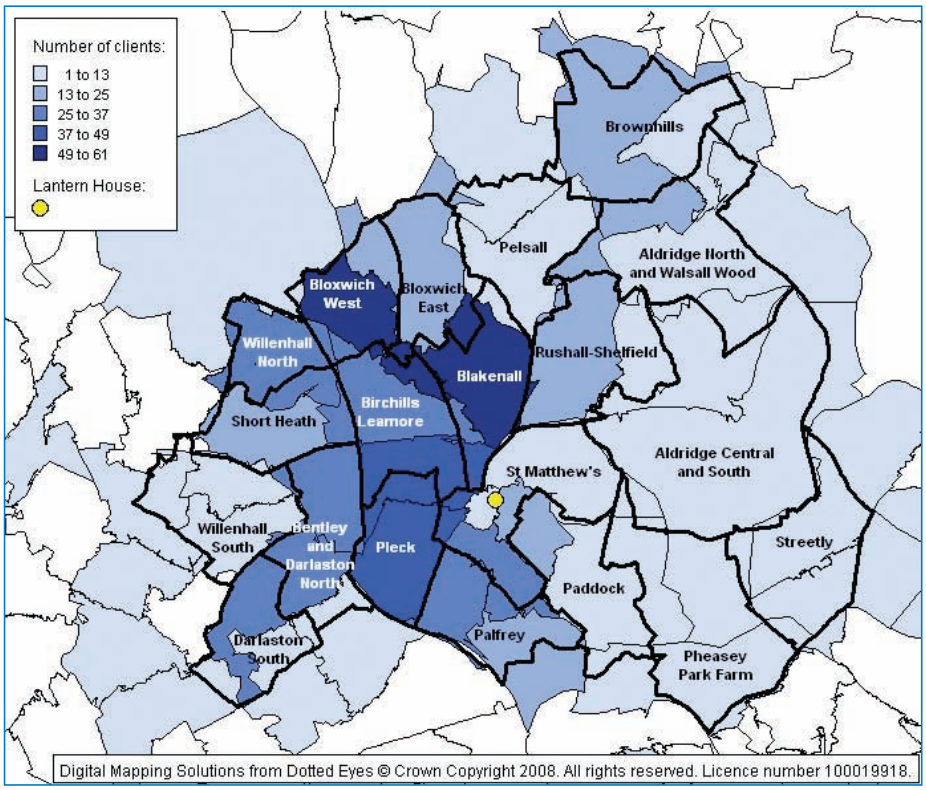
Substance misuse and crime in Walsall

Data for 2007-08 showed that there were 1,387 Walsall drug users (mainly heroin) in treatment, of which 501 had been new presentations; mostly from the crime 'hot spot' and deprived areas, indicative of social exclusion. Among the new users in treatment, 20% currently injected and 19% had previously done so. Walsall's Drug Intervention Programme (DIP) performs well in retaining cases in structured treatment, at over 90%. Around 50 to 80% of offenders identified by the DIP engage in treatment; above the national guideline of 40%. The DIP works closely with the drug and alcohol providers at Lantern House and Addaction, who increasingly engage social services and other support such as housing and employment. Addaction is involved with the recently implemented Alcohol Arrest Referral Scheme, whereby offenders (mainly committing alcohol fuelled assault or disorder) are brought into treatment. Referrals run at around 40 per month, mainly male and White groups living in hotspot areas.

Lantern House provided details of drug misuse clients (largely heroin) during the month of May 2008:

- Of the total 644 (male 448; female 196), 413 were self referrals, 143 were referred from other drug services, 45 from probation, and the rest from other sources.
- White British comprised 538, Pakistani 20, White/Caribbean 11, Indian 11.
- Their home locations could be mapped, based on information showing incomplete postcodes (neighbourhood level), to determine correlations with indices of deprivation and other markers of social exclusion (Map 18).

Map 18. Number of substance misusers accessing Lantern House services in Walsall, May 2008



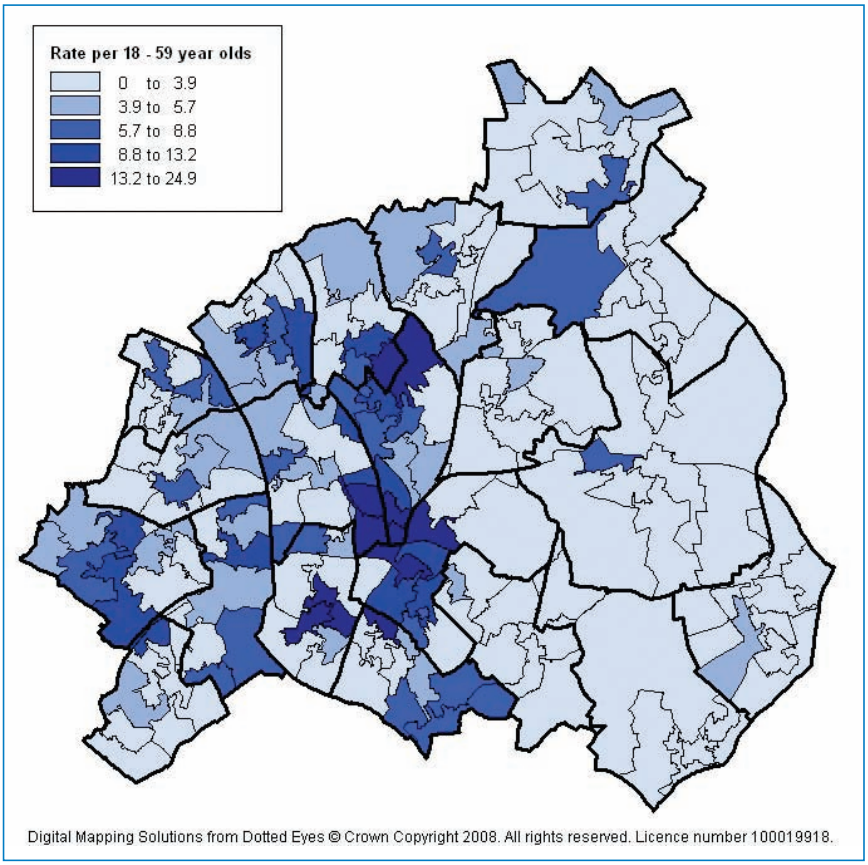
Source: Lantern House.

The majority of Lantern House clients are from neighbourhoods in parts of Bloxwich West, Blakenall, Pleck, Willenhall North, Birchills Leamore, Bentley, Darlaston North and South and Palfrey.

Addaction saw a total 939 clients (excluding for primary alcohol use, but including alcohol arrest referral) during May 2008 (male 753, female 180, non recorded 6).

- Again, the majority (450) were primarily heroin users (204 steroid users; primary crack cocaine users numbered 46, while there were 223 secondary users, usually to heroin).
- The DIP referred 376, while 310 attended for needle syringe exchange.
- Self referrals numbered 392, CARAT (counselling, assessment, referral, advice, and through care) prison service referrals 171, and Alcohol Arrest Referral 216.
- There were 720 White British clients, 37 Pakistani, and 33 Indian.
- Home locations were similarly mapped - but to first part of post code (a sample were hand searched to neighbourhood level) - to determine any matching to other markers of social exclusion.

Map 19. Substance misusers accessing Addaction services per 1000 16-59 year olds in Walsall, by Super Output Area, August 2008



Source: Addaction.

Addaction clients live predominantly in neighbourhoods in Blakenall, Leamore, North Walsall, Hatherton, Walsall Central, Caldmore, Palfrey, Pleck, Bentley, South Willenhall and Mossley/Dudley Fields. In these areas over 8.8 per 1000 15-59 year olds are Addaction clients.

NICE guidance on substance misuse among vulnerable young people

People who work with vulnerable and disadvantaged children in the NHS, LAs and the education, voluntary, community, social care, and criminal justice sectors (in schools, this includes teachers, support staff, nurses, and governors) should have access to screening and assessment tools to identify a substance misuse issue. There should then be a referral mechanism to services that offer family based structured support, and intensive support for those who need it, along with parent group-based training. Group-based behavioural therapy and motivational interviewing should be available and offered to children by trained practitioners. The new Walsall T3 Young People's service is a step in the right direction, but there is need for further resources to provide more of the above elements; akin to the Addaction structured day care approach to adults with substance misuse problems at the centre in the New Deal area.

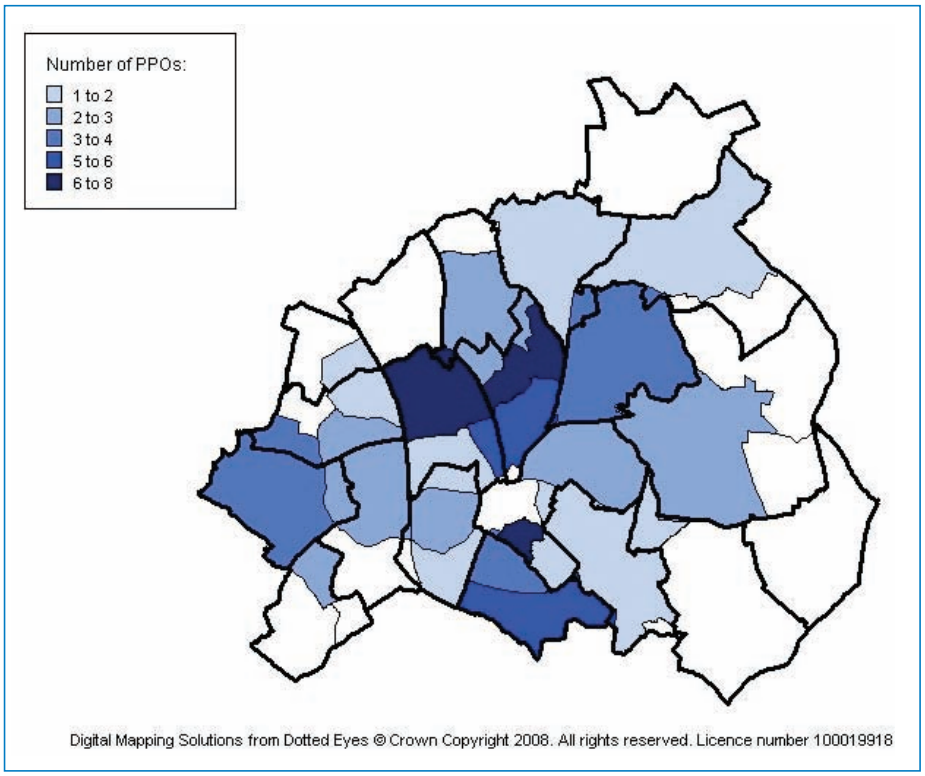
Crime in Walsall

Crime is heavily concentrated in deprived areas, and closely associated with drug and alcohol misuse. Reducing crime and addressing its causes led to the national Crime Reduction strategy of 1999, funding a number of initiatives including: use of CCTV; actions on burglary; preventive services to children aged 4-12 years at risk of criminal involvement; youth inclusion programmes to reduce offending, truancy, and exclusion in deprived

neighbourhoods; locks for older people; school interventions; and drug arrest referral whereby offenders can be managed and supported by drug agencies. Crime and Disorder Reduction Partnerships (CDRPs) followed in each LA, made up of key local partners, to develop Government guided action plans. Safer Communities Initiative funding helped CDRPs meet national crime reduction targets, supported by a range of programmes including New Deal, Neighbourhood Renewal, Street Warden programme, and Youth Offending Teams (YOTs), who coordinate the provision of youth justice and reduce offending by children. Walsall has been a beneficiary of all these initiatives, also applying other strategies to reduce crime: National Policing Plan, Safer and Stronger Communities, Alcohol Harm Reduction and Drug national strategies, Prolific and other Priority Offender (PPO) and Anti-social Behaviour national strategies. The Safer Walsall Borough Partnership was formed in 2004 to deliver crime reduction strategy, its work now being overseen by the WBSP.

Highly relevant to social exclusion were audit findings of a high proportion of Walsall crime occurring in a small number of neighbourhoods, so called 'hot spots' where most people receiving drug treatment also lived. The Town Centre was a hot spot associated with alcohol related crime, described in a recent DPH annual report (Walsall tPCT 2007). As a result, priorities and targets switched to: drug associated acquisitive crime; anti-social behaviour (ASB), including violence and prostitution; youth crime and ASB; community and road safety; domestic abuse; and fear of crime. Police resources were targeted to 'hot spots', helped by multi-agency hit squads that comprised community wardens and support officers, education welfare officers, etc. A Planning and Intervention Framework was developed to prioritise locations, persons likely to offend, and likely victims. The approach included education, protection and support of victims, management of offenders, engaging communities, and improving life chances. This strategy has been a success, with progressive reductions in both recorded crime and fear of crime. However, as experienced elsewhere nationwide, robbery, violence, and vandalism are persistent problems – albeit at lower levels – along with persistent concerns over drug and alcohol misuse.

Map 20. Number of Prolific and other Priority Offenders (PPOs) in Walsall in September 2008

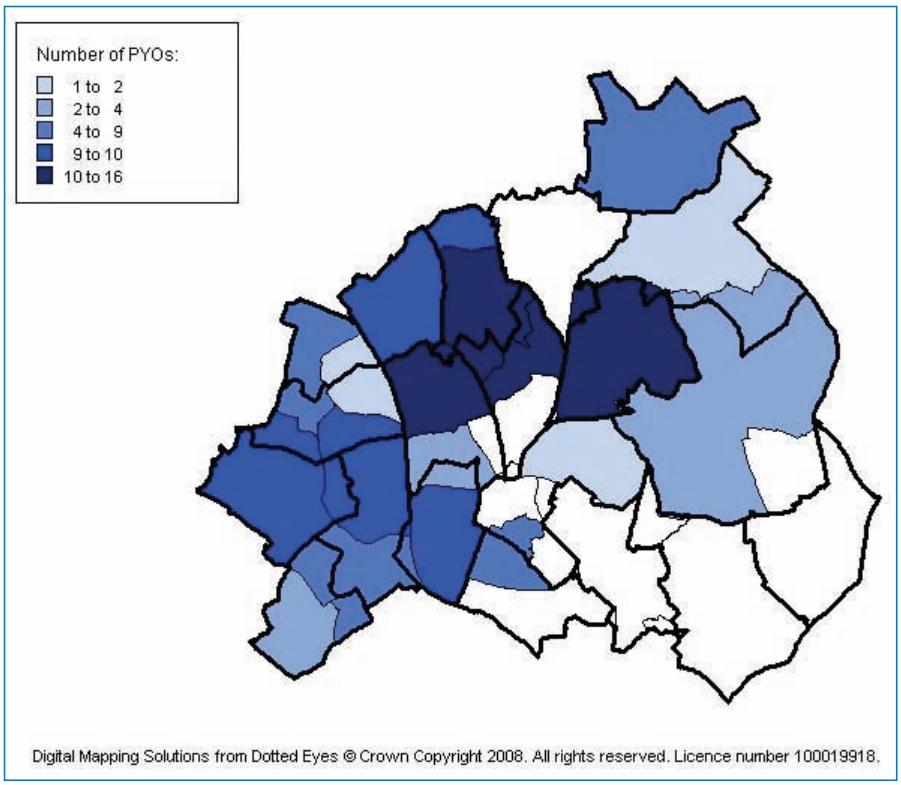


Prolific and other Priority Offenders are mainly concentrated in a relatively few neighbourhoods in the borough including Beechdale, Leamore, Goscote, Ryecroft/ Coalpool, North Walsall, Caldmore and Delves.

Source: West Midlands Police.

Youth offending in Walsall is mainly by males, again primarily from the deprived 'hot spot' locations. Around 50% of those brought to court are first offenders but 10% are persistent young offenders (PYOs). Ages tend to peak around 16 (range 13-17) years for the principal crimes of violence, reckless driving, burglary, arson, criminal damage, and theft or handling; the latter also committed by significant numbers of girls. There are strong associations with alcohol consumption and binge drinking. The T3 Young People's service was introduced as a specialised substance misuse agency in Walsall, specifically for affected youth. Already in the early years of its operation, alcohol remains the leading serious presenting problem of substance misuse.

Map 21. Number of Persistent Young Offenders (PYOs) in Walsall in September 2008



Young offenders are more widely spread across the western half of the borough, with the highest concentrations living in Beechdale, Leamore, Goscote, North Blakenall, Rushall/Shelfield, Bloxwich, Bentley, South Willenhall, Alumwell and Pleck.

Source: West Midlands Police.

The Social Exclusion Task Force is currently promoting Multi-systemic therapy (MST) as an intensive intervention for young people at high risk of being taken into care or custody. Many of these young people may have varying degrees of mental ill health and/or associated substance misuse problems. It is a short term treatment that supports the parent or carer. In the US, evaluations have found that re-arrest rates are between 25 and 75% lower among young people undergoing MST, compared with those who are not. It is being evaluated at 10 pilot sites across the UK.

Gangs and territorial groups

Gang related behaviour appears increasingly important in the UK, in parallel with an increasingly heightened fear of crime. Widening inequalities in the UK are fuelling this state of affairs, since evidence has shown that violence is reliably more common in more unequal societies (Hsieh and Pugh 1993). People are much less likely to trust each other when income differences are greater (Uslaner 2002; Kawachi *et al* 1997), while people are much more likely to be involved in community life when income differences are smaller (Putnam *et al* 1993; Putnam 2000).

The view of a consultant forensic psychologist

Young men who carry knives for protection does not convince. They may never have learnt principles of sharing and cooperation. Violence in the homes of those who offend is common. They receive low levels of warmth and family love, often suffering child abuse and learning to behave violently. Disaffection with school follows that of their parents, who are unable and unwilling to help. Persistent crime and violent behaviour quickly lead to exclusion. They fail to benefit from the school opportunities for social, emotional, and intellectual growth, and so gravitate towards anti-social peers and an environment where carrying knives is supported and reinforced. The answer is not to send more to prison, where they learn more about violent behaviour, nor to exclude them from the huge benefits of an education. If things are to change, we need long term actions that work. These are all to do with supporting families to promote consistent parenting, and supporting schools to work with children and families. It is the daily work of many unsung heroes, our teachers, social workers, foster carers, and those working in the criminal justice system. They need more resources. Government policy, Every Child Matters, is about achieving better outcomes for every child.

Zoë Ashmore works with the Youth Offending Service

The term gangs is a little strong as applied to Walsall, given its association with gun crime. However, irrespective of weaponry, youth in relatively deprived areas are intensely aware of their neighbourhood boundaries. Territorial groups are often used to describe members, rather than gangs. Walsall's groups are well defined. At one time, there was concern that Walsall youth attending Bluecoat School were being unduly influenced by Birmingham pupils. A glance at the 'Walsall Youth' website makes for uncomfortable viewing in the form of organised violence. As referred to earlier, disaffected youth are the angry and bitter face of social exclusion; they are a manifestation of our divided society in terms of inequality. In 2008, gangs are commanding high attention, but the underlying determinants are all too clear.

The theme of the 13th National Conference on management of drug users in primary care, held in Brighton 2008, was *Meeting the needs of diverse populations: hard to reach or easy to ignore?* An outstanding presentation was given by Martyn Glynn, a criminologist and advisor to the Birmingham DAAT, on gangs. He had experience a few years ago in the second city as mediator during outbreaks of street warfare. Several lessons can be learned. For example, imagine putting three new basketball or five-a-side courts into a ward area. They may end up within the territory of one particular gang, to the disadvantage of surrounding groups, whereas consultation with representatives of all concerned youth would ensure build locations that could better satisfy all. Disaffected youth are territorial and are actually excellent markers of their socially excluded areas. They may suggest that some services should be on wheels; that access could be better secured by mobile units. There are neutral areas; ideal locations for services that target youth. Walsall's youth was consulted when told that the new T3 Young People's service was coming to town. The feedback was unanimous in that location had to be the neutral Town Centre.

Sex workers in Walsall

Commercial partnerships constitute a small proportion of all sexual relations in high income countries. However, sex work is found in all strata of UK society. Women sex workers in the UK report high levels of condom use and have low rates of STIs and HIV infection. These women, and certainly those who engage in street prostitution, are at high risk of violence and rape, let alone a target for enforcement. The majority are also drug misusers, and many are forced into their activity through desperation and social deprivation. There are strong links with social exclusion. The most reliable information we have, certainly on street prostitution, followed research in Walsall by two acknowledged experts (O'Neill and Campbell 2004). Sifting data from the police, and two organisations that address the health needs of street workers in Walsall - Street Teams and the SAFE Project - they suggested that over 200 women were engaged in sex work; regularly so in around 40 women. Between 49-66% were from Walsall, some living in the Caldmore, Palfrey, and Pleck areas; while other women travel in from adjacent towns and cities. Most were aged in their 20s, 80% were White, and 60% mothers, two thirds of

whom had their children living with them. Over 40% reported previous experience of LA care. Over 50% reported current drug misuse, including injecting. This was clearly an underestimate owing to the attached stigma. Around 10-16% were under 18 years; 22% were homeless. Most had persistent problems of debt and issues of supporting housing and feeding needs. Most of these women had many of the hallmarks of social exclusion, but it was not possible for obvious reasons to identify the precise communities in Walsall where they lived.

The research made a number of recommendations that included addressing, minimising, and preventing the impact of prostitution on residential areas, and improving perceptions of community safety and the reputation of areas. The advent of CCTV has since seen a reduction in street sex working, and a shift to work indoors. The SAFE Project is commissioned to engage with sex workers to address their health needs, and facilitate a number of referrals into services. The project is especially active in encouraging contact with drug services, and others such as housing, and training. Street Teams has a main focus on youth, especially in prevention work to combat the sexual exploitation of young people. Both agencies, in their methods, are examples of numerous approaches to tackle elements of social exclusion in Walsall.

Sexual health

Johnson *et al* (2006) have described how social attitudes and expectations of sexual lifestyles have changed with time. Pregnancy outside marriage and single parenthood is no longer associated with the stigma and social exclusion of earlier decades. During the 100 years from 1840 to 1940, the proportion of births outside marriage was around 4 to 7%, but rose steeply from 1960 to reach 12% by 1980 and 40% by 2002. However, even if stigma has disappeared somewhat, teenage pregnancy and lone parents still tend to be associated with deprived and socially excluded communities, as described in Chapter 3, and in a previous Walsall public health report (Walsall PCT 2003). We are now in the midst of an epidemic of sexually transmitted infections (STIs) from the 1970s, and the emergence of the human immunodeficiency virus (HIV) causing acquired immune deficiency syndrome (AIDS) during the 1980s. Again, these are described in the Walsall report, with STIs tending to concentrate in the most deprived wards.

Chlamydia is a leading STI in the UK, and is certainly linked with deprived and socially excluded populations. This appears to be the case in Walsall according to recent evidence from the Chlamydia screening programme.

Chlamydia screening among socially excluded youth

The Black Country Chlamydia Screening Programme started screening for the STI, Chlamydia trachomatis infection, in Walsall from October 2007. It is part of the National Chlamydia Screening Programme, has been very well received, and has expanded with further team members in March 2008. Walsall tPCT has been commissioned by the other three Black Country Trusts to deliver the NCSP on their behalf and work together as a Consortium. The programme targets the sexually active population, aged 15 to 24 years, at a large number and variety of venues. The national average positivity rate for Chlamydia from screening is around 10%. So far in Walsall, the rate has been running above national average at around 14.4% overall.

Recently, the screening team has been working with socially excluded individuals, by targeting the Youth Offending Service, addiction services, and local hostels for the homeless. The positivity rate at these venues has varied between 14.1 to 25.0%. A screening event in May 2008 at a Walsall nightclub had a positivity rate of 22%. Young Persons Health Advisors working in YP hostels suggest that young people are frequently engaging in sexual activity with other residents on a casual basis, and the need for health promotion and risk reduction strategies is great. Recently, a resident positive for Chlamydia identified several other residents as contacts. In turn, these residents tested positive and identified additional residents as further contacts.

Along with the challenge of teenage pregnancy among socially excluded communities in Walsall, we need more specific and targeted sexual health initiatives to address infections among young people. Of course, there are other important STIs such as syphilis and gonorrhoea, but Chlamydia also carries significant potential morbidity in pelvic inflammatory disease, sterility, and tubal pregnancy.

Chapter 8: Affected people (distinct socially excluded groups)

Chapter content at a glance:

Social determinants of health and relative deprivation, often associated with special groups of people, who stand separately and who may be socially excluded on grounds of discrimination. Walsall data on social exclusion examples; equality and diversity initiatives.

Social exclusion examples:

Black and Minority Ethnic People
Asylum Seekers
Stigmatised Groups

Refugees and asylum seekers are at increased risk of mortality following their migration, not only from war-related injuries but also communicable disease, neonatal problems, and nutritional problems (Toole and Waldman 1997). There are associated stresses, ranging from post trauma, to loss of family and friends, to problems of adapting to a new environment or struggling with cultural identities (Bhugra 2004). Poorer migrants and minority ethnic people have worse health than the general population. For example, migrants from South Asia, Africa, Scotland, and Ireland have higher standardised mortality ratios (SMRs) than the general population in England and Wales, with the exception of those born in the Caribbean (Drever and Whitehead 1997). This may be explained by only the healthiest voluntarily migrating from the Caribbean, plus those returning to their islands shortly before death (Marmot *et al* 1984). This elevated mortality has also been found to extend to the children of migrants. Longer residence may not be protective, as evidenced by South Asian people resident in England and Wales having increased risk of cardiovascular and cancer mortality (Harding 2003). However, Nazroo (1998) has highlighted the importance of social position in determining the health of migrants. He asserts that variation in health by ethnicity can be explained by:

- Standards of living.
- Geographical concentration in certain areas.
- Experience of harassment and discrimination.

Nazroo (1998) warns . . . the ethnic classification we use does not reflect unchangeable and natural divisions within groups. Ethnicity does not exist in isolation, it is within a social context that ethnicity achieves its significance, and part of that social context is the way in which those seen as members of ethnic minority groups are racialised.

Data within the UK have been used to suggest that socioeconomic inequalities do not contribute to ethnic inequalities in health (Marmot *et al* 1984). However, Nazroo and Williams (2006) challenge this viewpoint, drawing attention to the complexity of inequalities faced by minority ethnic groups. In particular, the importance of assessing other risk factors related to ethnicity that may also affect health, such as racism and geographical segregation. Nazroo and Williams (2006) maintain that experiences of racial harassment and discrimination, and perceptions of living in a discriminatory society, contribute to ethnic inequalities in health. While the post-war migration of ethnic minority people into Britain was driven by a shortage of labour, the socioeconomic disadvantages faced by ethnic minority migrants in the UK was, and continues to be, structured by racism that has its roots in colonial history (Gilroy 1987; Miles 1982). In summary, social exclusion experienced by BME groups, including refugees and asylum seekers, is not only enhanced by relative deprivation but is fuelled by discrimination or a sense of not belonging.

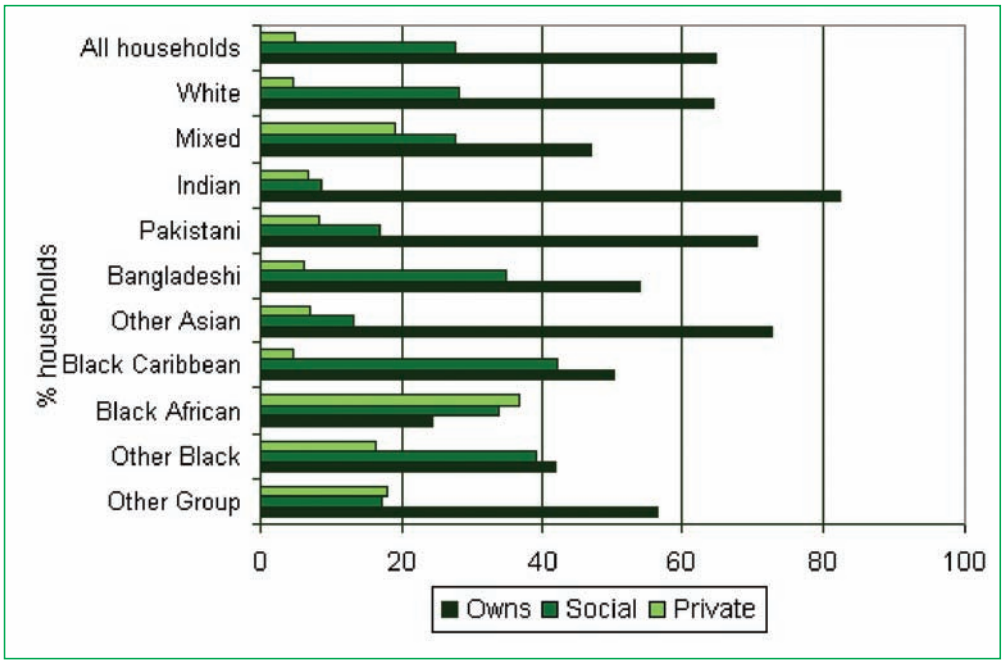
Ethnic minority groups and social exclusion in Walsall

The conclusions of a recent Walsall public health annual report on Black and Minority Ethnic (BME) issues (Walsall Teaching PCT 2005) agreed with Nazroo and Williams (2006) on racism and geographical segregation. Disadvantage in access to services experienced by BME groups in Walsall were interpreted as a proxy for racism, while socioeconomic factors clearly accounted for a large proportion of ethnic differences, given the concentration of groups in the most deprived wards. Younger members of Walsall BME groups tended to consider themselves totally integrated into society, and so it is likely that the socially excluded will predominate among the poorer and older people, notably those with English language difficulties. A summary of the key factors impacting on health among Walsall BME groups were as follows:

1. BME groups fared worse on employment, education, burglary, unfit housing and road casualties, although Indian pupils had the highest educational attainment.
2. Bangladeshi people were the most deprived of all ethnic groups, having very high levels of unemployment, the worst housing conditions and, along with Pakistani people, the least educational success.
3. There was a high unemployment rate among young Black and Asian people.
4. The growing population of BME pensioners face discrimination and little access to public services as they get older.
5. The highest concentrations of BME populations were in deprived areas, although there has been significant movement of certain communities to more affluent areas.
6. Variations in infant mortality and life expectancy have been related to the level of deprivation in an area, with more deprived areas showing the poorest health.

Home ownership and its positive influence on health is worth quoting from the 2005 annual report. The highest level of home ownership was seen among the Indian population, with 81.4% owning their own home compared to 82.4% overall across Walsall. The lowest level of home ownership was among the Black Africans, who tend to rent privately. Figure 5 shows the breakdown in Walsall. Almost 40% of all Asian households were in unsuitable housing, compared to only 10% of White households in 2001.

Figure 5. Tenure of Walsall households, proportion by ethnic group, 2001



Source: ONS 2001 Census.

Chapter 8: Affected people (distinct socially excluded groups)

Since the 2005 annual report, a survey of the health and lifestyle of Walsall's South Asians during 2006/7 (Walsall tPCT 2008) found that home ownership in this community had increased to over 90% and that overcrowding had reduced from 12% in 1995 to 4% in 2006/7. Another indicator that housing among this community has improved in recent years was that 95% of the survey sample said they had full central heating (vs 75% in 1995).

A final item worth quoting from the 2005 annual report concerns barriers to accessing health services:

- Although access was fine overall among BME groups, Pakistanis, Bangladeshis, and African Caribbean men experienced relatively low levels.
- Glaucoma among Africans and Caribbeans tended to be treated later.
- Black people with mental health problems were more likely to be given drugs alone rather than counselling.
- Bangladeshi women generally showed less than half the average rate of cervical screening uptake.
- The NHS has generally been slow to target services for sickle cell disease (impacts on BME groups) than for haemophilia.
- Problems of language and difficulties in navigating through the NHS system abounded among BME groups, who were also slower to demand choice and quality.

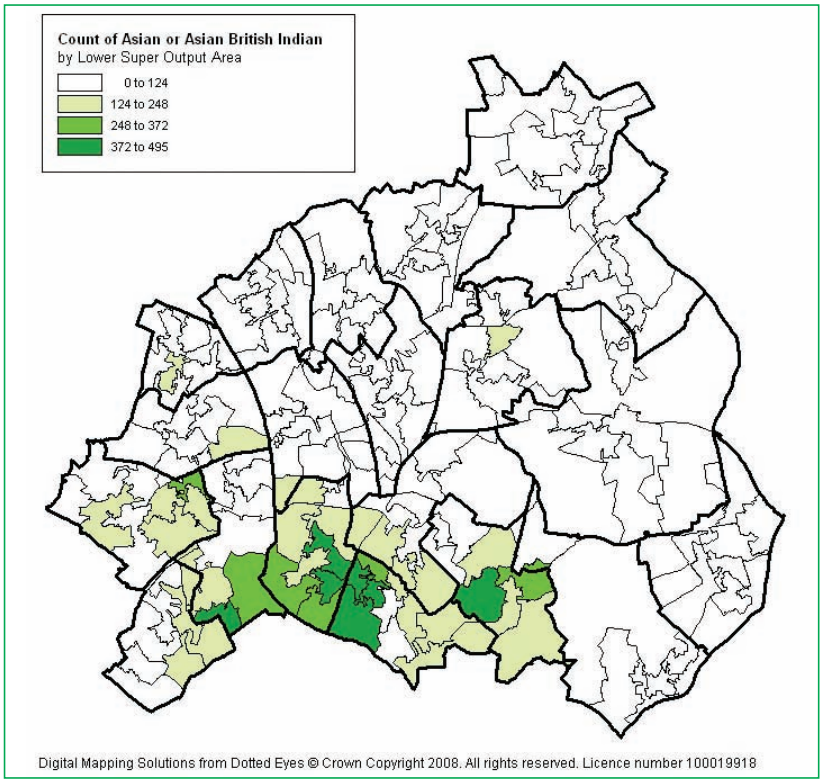
There was need for more BME coding for all diseases, services, etc as well as for employees and there was need for more community advocates.

There are persistent reports that older African Caribbean men who require services do not do so until very late, and that they are often perceived as an isolated group. For example, they may be over represented among those with severe and enduring mental illness, and among those requiring hospital admission; yet they are under represented among those seen by community mental health teams. However, cultural issues may be at play here, and this observation does not necessarily imply that they are socially excluded. Ethnic minority people who have mental illness or who are disabled, may endure racial abuse and discrimination, which in the case of those who are alone or with little family support, would often lead to a state of social exclusion; especially if they already experience socioeconomic deprivation.

Many South Asian people live in highly deprived locations, such as within Pleck or Palfrey, but may be supported by very close extended family networks, and may be sustained by a sense of social cohesion. In this situation, the state of social exclusion can be avoided. However, times are changing. As mentioned in the DPH annual report on ethnic minorities, younger people generally feel more integrated with their White counterparts (Walsall tPCT 2005). Yet the large extended family system is very slowly drawing to a close, and with it the strong sense of support and social cohesion that it offers. Thus, in time, BME groups will come to experience the same risks of entering social exclusion as the rest of the population.

Community Associations in some of the wards with high BME populations, such as Palfrey, provide strong social networking support to the various South Asian groups in particular. So do the mullahs through the mosques to the Muslim people and the priests through the temples to the Hindu people. Although women do not hold high profile community leadership positions, despite the emergence of a number of Women's Groups, they retain influential roles in many of the BME communities. Thus, traditional values contribute much in reducing the risk of social exclusion. However, the Bangladeshi and African Caribbean communities are perceived as being more fragmented, with high rates of smoking among men, and high levels of poor housing and unemployment. These two groups within BME communities in Walsall are perhaps the most deserving of an overall health needs assessment, along with Muslim people generally in the context of infant mortality and consanguinity.

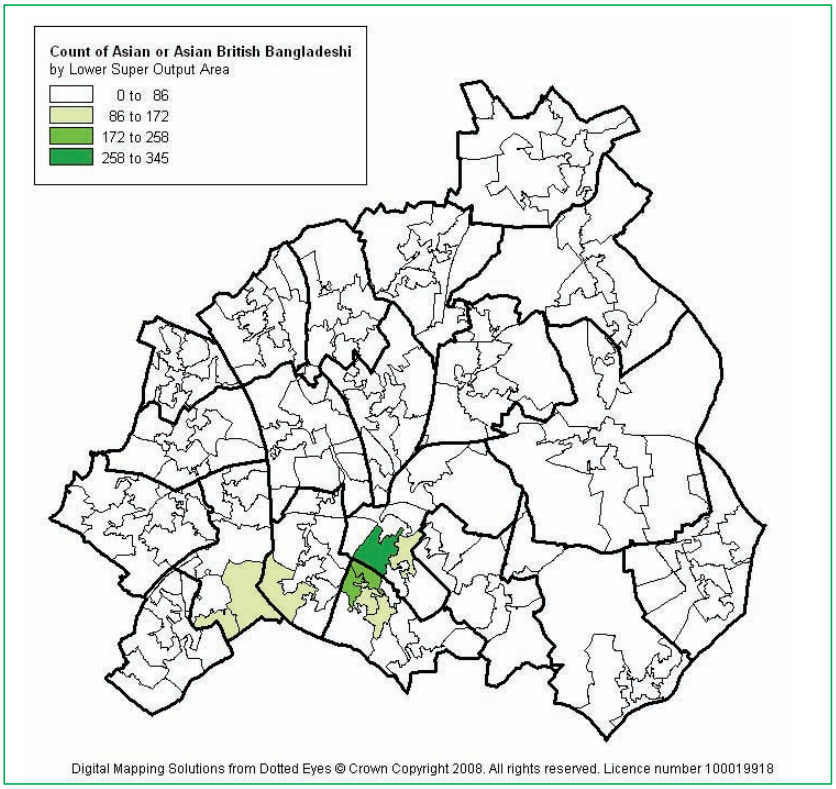
Map 22a. Indian population in Walsall 2001



Source: Census 2001

Walsall's Indian population is widely spread in neighbourhoods across the South and South West of Walsall. The largest concentrations are in the neighbourhoods of Pleck, Delves, Palfrey, Caldmore, Walsall Central, Darlaston Central, Fallings Heath Alumwell, South Willenhall, Park Hall and Chuckery.

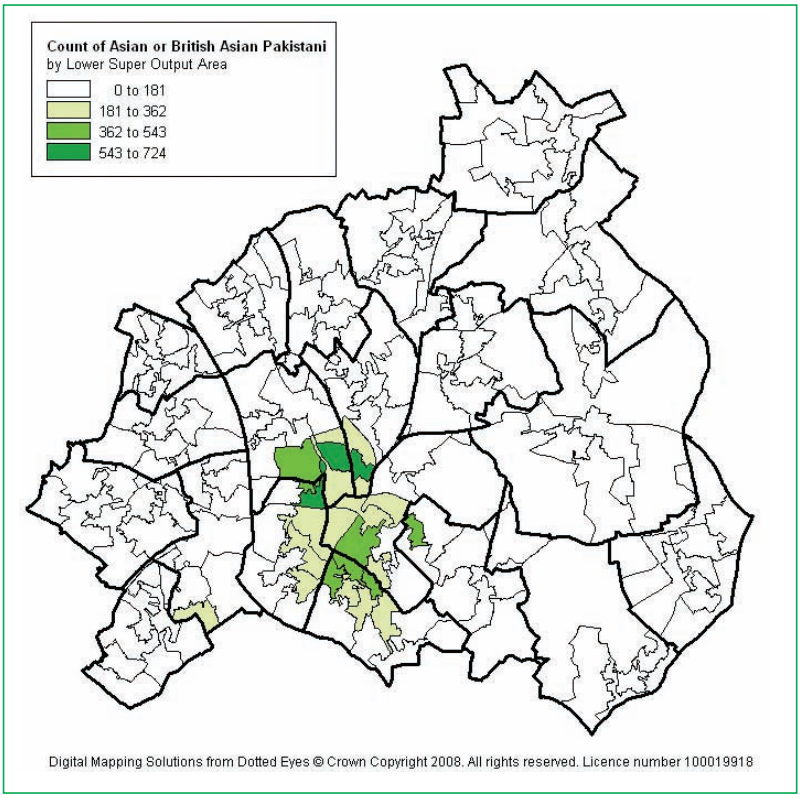
Map 22b. Bangladeshi population in Walsall 2001



Source: Census 2001

Walsall's Bangladeshi population is concentrated particularly in Caldmore and Palfrey and neighbouring districts.

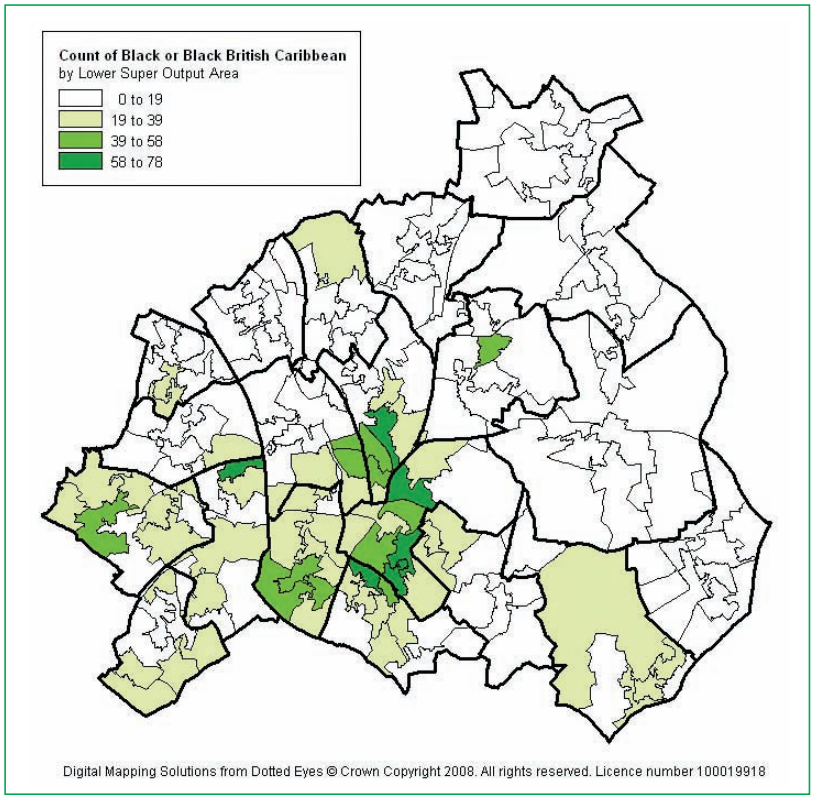
Map 22c. Pakistani population in Walsall 2001



Source: Census 2001

Walsall's Pakistani population is clustered in neighbourhoods around Central and South Walsall. The highest concentrations are in Birchills, North and Central Walsall, Alumwell, Chuckery, Caldmore and Palfrey.

Map 22d. Black Caribbean population in Walsall 2001



Source: Census 2001

Walsall's Black Caribbean population is more widely dispersed than other BME groups. There are concentrations in South Willenhall, Bentley, Pleck, Palfrey, Caldmore, Walsall North and Central, Rushall/Shelfield, Hatherton, Ryecroft/Coalpool, and Birchills Reedswood.

In conclusion, it is difficult to show that ethnic diversity leads to a breakdown of social cohesion. Indeed, diversity of origins is frequently a strength in contributing to many thriving communities. It would appear that the principal threat comes from injustice and inequality; the tensions that still arise from racism.

Walsall's new migrants

Walsall has about 4,300 overseas nationals, according to National Insurance number registrations for the period 2003-07. This is fewer within the region compared to Birmingham (43,500), Coventry (18,150), Sandwell (8,420), Wolverhampton (8,260), Stoke-on-Trent (6,760), and Herefordshire (6,380). The latter illustrates the importance of migrant workers to the agricultural economy in the region.

A look at the percentage of overseas nationals per LA area shows that Walsall is well down the list, at less than 2.9% (Coventry is highest at 6.0%). The bulk of these nationals are migrant workers. Their average length of stay in the region is estimated to be about 17 months. They are often highly skilled but tend to work in low wage sectors and occupations where high levels of vacancies exist. They are only able to access benefits once they have worked legally and paid taxes in the UK for one year. Many public services are delivered by migrants, including doctors, dentists, teachers, and care workers. Generally, their presence is temporary and based on choice; accordingly, they have attracted little attention in the context of social exclusion. While priority for health services, education, and social housing is based solely on need; and while there is no discrimination on the grounds of ethnicity or nationality, isolated incidents of inequality or racism continue to occur.

House of Lords Select Committee on Economic Affairs:
Report into the Economic Impact of Immigration (April 2008)

The Committee examined evidence on the economic impact of immigration on the (pre-existing) resident population in the UK. Among the findings were:

- Immigration has had a small negative impact on **wages** of the lowest paid workers in the UK. Resident workers whose wages have been adversely affected by immigration are likely to include a significant proportion of previous immigrants and workers from ethnic minority groups.
- Available evidence is insufficient to draw clear conclusions about the impact of immigration on **unemployment** in the UK. It is possible, although not yet proven, that immigration adversely affects employment opportunities of young people who are competing with young immigrants from the new EC accession countries. More research is needed.
- Immigration has very small impacts on **GDP per capita,** whether these impacts are positive or negative; there was no systematic evidence to suggest that net immigration creates significant dynamic benefits for the resident population.
- Rising net immigration leads to an increase in **population density,** which has potentially important economic consequences for the resident population, including impacts on housing, as well as wider welfare effects, especially in parts of England where immigrants are most concentrated.

The Committee recommended that the Government should review the implication of its projection of net immigration of 190,000 per year, have an explicit and reasoned target range for net immigration, and adjust its immigration policies in line with that broad objective.

Questions of social exclusion arise in relation to asylum seekers, but their numbers are small in Walsall. For 2007-08, numbers have ranged between 150 to 220 (at the present time, predominantly from the Democratic Republic of Congo, Zimbabwe, Iran, and Iraq). An asylum seeker is someone who has sought legal protection under the 1951 United Nations Convention Relating to Refugees in another country against persecution in their homeland. The UK hosts about 3% of the world's refugee population of around 9 million. Since 2000, asylum seekers have been dispersed to regional areas on a no-choice basis and often to areas of existing deprivation. Since 2002, UK asylum applications have decreased by over 70%. In Walsall, as elsewhere, new arrivals are planned, with careful consideration given to meeting their needs, ensuring there is no detriment to services for local people. However,

research has shown that asylum seekers not only tend to live in poverty, but also fear and ill health. They are not allowed to work. The majority are law abiding and are more likely to be the victims of crime and harassment.

Apart from Walsall, dispersal of asylum seekers in the region has continued to Birmingham, Coventry, Dudley, Sandwell, Stoke-on-Trent, and Wolverhampton. Most of Walsall's asylum seekers are family members, who receive accommodation on a no-choice basis and cash support. A smaller number are allowed to live with family or friends, and receive cash payments. Data is lacking on the eventual outcome of this category of migrants, although we are still in the early years of the UK scheme. Some of Britain's most successful entrepreneurs are refugees or came from families of refugees. Given the limitations of their situation, Walsall is organised to do its best to meet the needs of its asylum seeker population through a Council led committee and voluntary groups (churches have been especially active). Problems arise during failed asylum seekers applications, especially in relation to women in the late stages of pregnancy. This is a national problem, but everything is done to ensure the health of the family. Apart from local support, there is a scheme whereby a failed asylum seeker can apply for interim Section 4 support from the UK Border Agency, which is accommodation and £35 vouchers per week.

As with travellers, particular BME groups, and migrant workers in Walsall, asylum seekers have yet to receive the attention of a detailed health needs assessment.

Sexual preference and HIV in Walsall

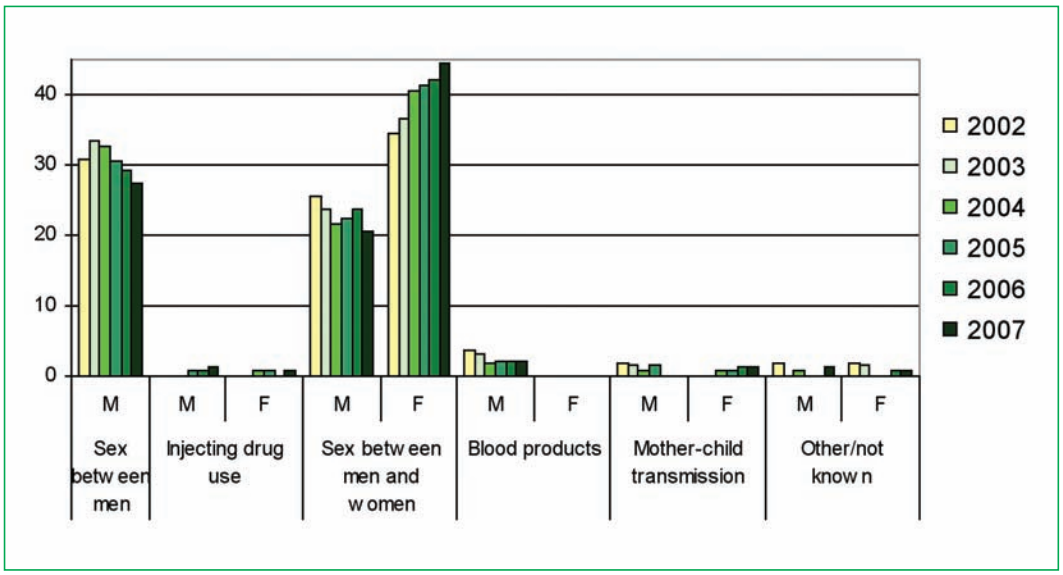
Sexual orientation is not an issue for social exclusion, as it was in the past, but men who have sex with men (MSM) still endure stigmatisation under certain conditions, and certainly if they have HIV infection. Sex between men was a criminal offence in the UK until 1967 and subject to heavy penalties. In 1974, it was removed from the list of psychiatric disorders by the American Psychiatric Association. Up until the late 1960s, only a small proportion of men had male sexual partners, and that prevalence was higher in London, where homosexuality was more widely accepted. Only since 1990 has there been a liberalisation of social attitudes to male homosexuality. Johnson *et al* (2001) have described:

- The proportion of men reporting that homosexuality was 'not wrong at all' increased from 21% in 1990 to 35% in 2000.
- This proportion among women increased from 26% to 49%.
- Over the same time period in the UK, the proportion of men reporting homosexual partnerships in the past five years increased from 1.5% to 2.6%.
- For women, the proportion rose from 0.8% to 2.6%.

Liberalisation of the law and social attitudes have been of strategic importance in the prevention of HIV infection early in the epidemic. However, risk behaviour has recently increased. During the early part of the epidemic, HIV infection leading on to AIDS was regarded as a death sentence, and served to encourage safer sexual practices as well as discourage multiple partners. More recently, there is a perception that HIV infection can be contained with modern chemotherapy, and so a renewed complacent attitude towards safer sex has emerged. This has been reflected by continuing incidence of new HIV infections and rising STI rates.

There is a disproportionate population burden of some STIs in certain population groups. This is particularly the case with HIV infection, gonorrhoea, and syphilis among gay and bisexual men, referred to as men who have sex with men (MSM). This group of men has been shown to have increased rates of partner exchange. Information on HIV infection and STIs in Walsall has been provided in a previous public health report (Walsall PCT 2003). Since that time, the focus of HIV in the MSM population has shifted. There were 142 persons in Walsall living with HIV in 2007. This number has increased from 55 in 2002 but the preponderance of new cases over the past five has been found in immigrant groups, largely from Africa. New cases since 1999 total 158 (2000, 6; 2001, 8; 2002, 24; 2003, 19; 2004, 47; 2005, 28; and 2006, 26).

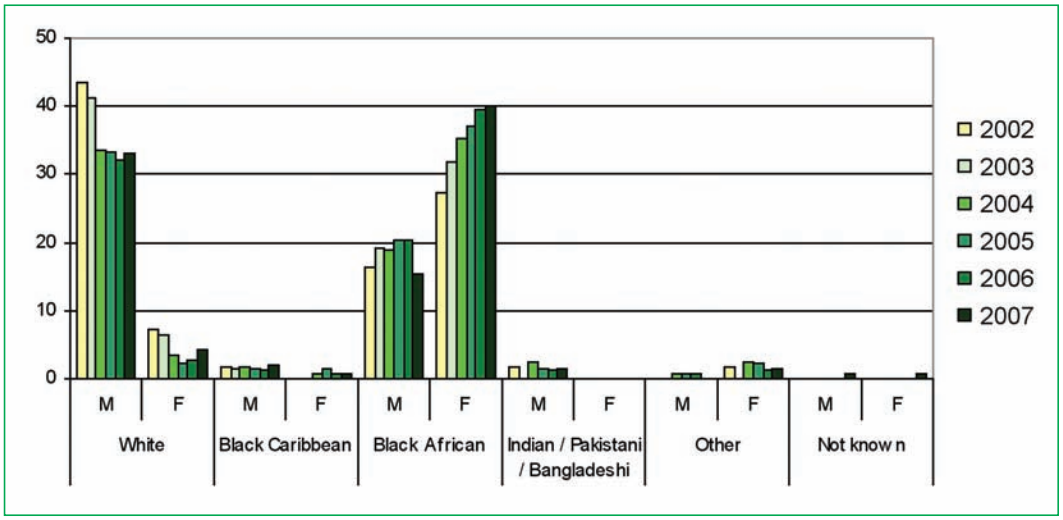
Figure 6. Probable route of transmission of HIV in Walsall patients 2002-07



Source: Health Protection Agency, SOPHID, Sept 2007

Figure 6 shows a substantial and continuous increase in the heterosexual transmission of HIV in Walsall in recent years, particularly affecting women. Heterosexual transmission accounted for 65% of all patients with diagnosed HIV infection and seen for care in 2007, including 44% who were women. In comparison, sex between men was the route of transmission for 27.5% of all HIV cases seen in 2007 (compared to 31% in 2002). However, it should be noted that MSM remains the leading route for acquiring HIV infection and that the increase in heterosexual transmission shown is mostly a reflection of infection acquired by Black African residents prior to immigration to the UK.

Figure 7. Ethnicity of Walsall patients with HIV 2002-07



Source: Health Protection Agency, SOPHID, Sept 2007

Figure 7 shows that over half (56%) of all patients in Walsall diagnosed with HIV infection and seen for care in 2007 were Black African. In this group there has been a substantial increase among women. However, as indicated above, much of the increase among Black African residents reflects infection prior to immigration to the UK. White men accounted for one third of all HIV patients and White women less than 5%. There were very few patients from other ethnic groups.

Chapter 8: Affected people (distinct socially excluded groups)

A meeting with the Men's Health Project and anecdotal evidence from several sources suggest that there are no significant issues of stigmatisation or social exclusion in Walsall as a result of being gay or bisexual. This is in keeping with national trends that see a normalisation of sexual preference. There are occasional reports of homophobic experiences reported by gay men, but none that are sustained. While there is certainly no correlation between the MSM population and relative deprivation, men with HIV infection may endure stigma and discrimination, and so experience social exclusion, irrespective of socioeconomic status. However, this does not appear to be the case in Walsall among men living with HIV infection. It is likely that confidentiality has a key role in protecting the person affected.

Chapter 9: Conclusions

Societies that are more economically equal and socially cohesive have lower overall mortality than those that are unequal (Wilkinson 1996). It follows that, in the long term, addressing the poor health of the socially excluded will require policies that lead to greater economic equality.

Government holds the key to addressing social exclusion, principally through a more equitable distribution of income. Given that a significant political shift is unlikely to occur in the foreseeable future, Government recognises the constraints under which relative deprivation and social exclusion can be effectively tackled. Although progress is gradually being made on inequality within British society, the challenge of the extremely poor and socially excluded people remains formidable. Part of the problem lies in accurately identifying social exclusion among communities, mainly because affected people with multiple problems are in touch with a number of stand alone services. Increasing multi-agency working is going to become a necessity.

Before identifying Walsall's socially excluded, a number of prominent issues in this report that are central to the state of social exclusion can be summarised:

Relative deprivation and chronic stress

Social exclusion is mainly associated with relative deprivation. Social determinants of health, such as a deprived upbringing, poor education, unemployment, inadequate housing, and a lack of social support or relationships, are strongly related to an impoverished existence. Underpinning all these factors are the fundamentals of social position and empowerment. Deficiencies in these two important areas are a source of chronic stress, and this is the basis for much ill health among the socially excluded.

A good early start in life

The early years predict a life of social exclusion. Walsall actions to address early life issues are undertaken through membership of Walsall's Children and Young Person Strategic Partnership, which includes the tPCT, the Manor Hospital, Social Services, and Education, to oversee a wide range of actions and initiatives: eg support for children in care, child protection, reducing truancy and targeting young people to prevent crime; strengthening maternity services; stepping up initiatives on smoking in pregnancy and breastfeeding; improving access for health visitor interventions to help families in need; supporting development and training for Walsall's youth service; and maintaining Walsall's well performing childhood immunisation programme.

Reinforcing the concept of family

Government has been instrumental in promoting the family concept, establishing a vision for a local system that improves the life chances of vulnerable families and helps to break the cycle of disadvantage. This includes a £16 million Pathfinder programme, of which Walsall is a part, led by the Department for Children, Schools and Families, to find solutions on the ground. In a system that Thinks Family, services would: (1) *Have no wrong door,* (2) *Look at the whole family,* (3) *Build on family strengths,* and (4) *Provide support tailored to need.*

The consequence of crime and substance misuse

Crime is heavily concentrated in socially excluded communities, where it is closely associated with drug and alcohol misuse. Walsall's Crime Reduction strategy oversees funding of a number of relevant initiatives, including: preventive services to children aged 4-12 years at risk of criminal involvement; youth inclusion programmes to reduce offending, truancy, and exclusion in deprived neighbourhoods; and drug arrest referral whereby offenders can be managed and supported by drug agencies. A range of supportive programmes include New Deal, Neighbourhood Renewal, the Street Warden programme, Youth Offending Teams, and Alcohol Harm Reduction.

Minority communities

Ethnic minority people who have mental illness or who are disabled, may endure racial abuse and discrimination which, in those who are alone, could lead to social exclusion. They may live in deprived locations but are mostly supported by very close extended family networks, and sustained by a sense of social cohesion. Yet the large extended family system is slowly drawing to an end, and with it the strong sense of support that it offers. In time, minority ethnic groups will come to experience the same risks of entering social exclusion as the rest of the population.

Determining Walsall's socially excluded

Those in poverty often overlap with those who are excluded; a complex web where a poor neighbourhood is usually a common factor. Within this complex are those in a state of deep and persistent exclusion. Government estimates suggest that this socially excluded group comprises between 2% to 3% of the population. Around 20% of the population live below the poverty line, comprising the working or coping poor, and resilient families. The 2% to 3% are found within this 20%. They can be classified as 'poverty plus' and usually contain those with multiple problems such as people with mental health issues, drug users, young offenders, and children in care. Thus, Walsall, with a population of around a quarter of a million residents, has up to 7,500 people who are in a state of deep and persistent social exclusion. It is probable that at least 10,000 Walsall people can be defined as socially excluded or at risk of being so.

Most have a view on the estimated 10,000 socially excluded people living in Walsall: who they are and where they can be found. Using a range of acknowledged markers for social exclusion, and computing them all together, the work reported here has attempted to define and map *Walsall's socially excluded: who are they?* with a fair degree of precision. Considering the various factors that influence social exclusion and available data related to these factors, an overall Social Exclusion index (SE index) has been compiled for Walsall. This enables areas of Walsall with the highest concentrations of socially excluded communities to be identified and mapped.

> As quoted by Blane *et al* (1996): *a society which nurtures people's skills and abilities throughout the population, which provides economic opportunities for all, and fosters a cohesive and integrated social environment, would do more for health than curative medical services are able to do.*

Geography

Walsall has around 100,000 properties and 250,000 population that fall into a variety of administrative, statistical and other locally defined boundaries, all with varying levels of overlap. Data used in this report were provided by health, local authority, voluntary and partner agencies at different levels of geography, from household level right up to full borough only. Some data were available for boundaries exclusively used by only one agency, *eg* West Midlands police. As such, it was impossible to collate a full and inclusive dataset of all the factors thought to demonstrate social exclusion.

It was decided to take the lowest common level of geography possible as the basis for arriving at the SE index, to assist with identification of specific areas of the borough. The geography must also be compatible with and/or able to be broadly matched with other statistical and non-statistical boundaries that exist within the Walsall borough. Lower Super Output Areas were used as the basis for the SE index, since several datasets were already available at this level, and since postcode and household level data could also be aggregated up to this level. Data were not disaggregated at higher level geographies, as this would introduce a level of estimation that would potentially skew or bias the data beyond reasonable confidence.

Data

Many data sources used within the report were considered for inclusion into the SE index. However, due to the geographical restrictions as described above, only the following 10 indicators of social exclusion were selected:

Data/Indicator of social exclusion	Metric	Source
Index of Multiple Deprivation, 2007	Integer score	Dept of Community and Local Government, ONS
Low birthweight babies	Proportion < 2500gms from total births	ONS, PHBF
Teenage pregnancy rate	Proportion of all births to girls aged 13-17 years	NHS Walsall, Community births system
Excluded children	Proportion of children excluded from school	SERCO/Education Walsall
Children in care	Rate per 1,000 population of children in care homes	NHS Walsall, Care Plus
Child protection register	Rate per 1,000 population of children on CPR	NHS Walsall, Care Plus
Not in Education, Employment or Training (NEET)	Rate per 100 population of children registered NEET	Prospects
Substance misuse	Rate per 1,000 15-59 year olds	Addaction Walsall
Children with disability	Rate per 100 population of children registered disabled	NHS Walsall, Care Plus
Adults with severe and enduring mental illness	Frequency	NHS Walsall

The rationale for inclusion of these 10 indicators of social exclusion is presented in Chapter 1. Relative deprivation is generally a universal underpinning factor in the state of social exclusion and a pivotal social determinant of health (Chapter 2). However, as presented in this report, government's Social Exclusion Task Force has highlighted other important indicators of socially excluded families that are widely acknowledged by experts in the field. They include the above listing of: teenage pregnancy, excluded children, children in care or on the child protection register, people categorised as Not in Education, Employment or Training (NEET), and substance misuse. The overriding significance of early life years to social exclusion was emphasised in Chapter 3, and for this reason we have added in the indicators of low birthweight and disability. Mental illness, referred to in Chapter 6, has similarly been added. All included indicators are acknowledged social determinants of health, highly relevant to social exclusion, and extensively referenced in this report.

There were a number of other supportive or descriptive data/indicators that were considered reasonable markers of social exclusion but were not included in the index due to small numbers, lack of data availability, or reliance on anecdotal information. These data should also be considered alongside the SE index, but only in a supportive context. These indicators were:

- Persistent young offenders (PYOs), but many detected by substance misuse.
- Prolific and other priority offenders (PPOs); same comment as for PYOs.
- Risks associated with home visits (health visitors; anecdotal evidence).
- Location of tower blocks/high-rise social housing (captured in SE areas).
- Homelessness (although affected people detected by other factors).
- Marginalised minority ethnic groups (especially migrants, but small numbers).
- Very old people (85+ years), but not discriminatory for social exclusion.

The drawbacks around availability of these data has influenced the relative weighting of the 10 indicators that were used to determine the SE index for this report.

Methodology

Our approach is new and we have no evidence to draw upon. Following rationales for inclusion, a considered weighting was applied to each selected indicator, based on the perceived degree of social exclusion. The weighting varied between 7 and 2, totalling a sum of 38 across the 10 indicators. Deprivation, as the pivotal indicator, was given the highest weighting of 7. Further information is available on the Index of Multiple Deprivation 2007 at the government website: www.communities.gov.uk. The IMD 2007 is constructed by combining seven scores, using the following weights:

- Income (22.5%).
- Employment (22.5%).
- Health, deprivation, and disability (13.5%).
- Education, skills, and training (13.5%).
- Barriers to housing and services (9.3%).
- Crime (9.3%).
- Living environment (9.3%).

This scoring includes many of the indicators of social exclusion but not all, and is clearly insufficient, particularly with respect to teenage pregnancy and children.

Accordingly, teenage pregnancy has been included for our SE index with a weighting of 5. Children in care (2) or on the child protection register (3) provide a total weighting of 5. Low birthweight (3), excluded children (2), and children with disability (2) provide a further weighting of 7, to reinforce the high significance of the early life years. Severe and enduring mental illness (not highly discriminatory) is added with a weighting of 2. As referred to in the rationale for inclusion above, there remains NEET and substance misuse. NEET was given a weighting of 5. Substance misuse was given the high weighting of 7, since we were unable to utilise the data on offenders (PYOs and PPOs, as alluded to above). However, a high proportion of offenders are inevitably captured within the data of drug and alcohol misuse.

As the indicator values were a combination of different relative measures (proportions and rates) and non-relative measures (counts or scores) on different scales, the range of values for each were divided equally into the number of weighting categories allocated to the indicator. Each Lower Super Output Area (LSOA) was allocated a weighting score for each indicator, depending on which band its value fell into. The total of the 10 indicator scores was then taken as the sum of social exclusion and the index was subsequently calculated as the proportion of the maximum SE score (38). The maximum SE index score is 1 and the minimum is 0.263 – LSOAs falling into the lowest band for any indicator still score 1 point.

Chapter 9: Conclusions

The following is a worked example of arriving at the SE index for a Lower Super Output Area of Walsall (in this case, LSOA E01010292; the results of all Walsall LSOAs are presented in Appendix 4). In this worked example, indicators with minimum/maximum values and category cut-offs are presented.

Indicator	IMD 2007	Low birthweight	Teenage Pregnancy	Excluded Children	Children in Care	Child Protection Register	NEET	Substance Misuse	Children with Disability	Severe Mental Illness
Max	73.65	18.64	47.06	11.37	30.10	17.88	22.47	24.82	1.68	19.00
Min	2.94	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Weighting	7	3	5	2	2	3	5	7	2	2
Band 1	2.94-13.04	0.00-6.21	0.00-9.41	0.00-5.68	0.00-15.05	0.00-5.96	0.00-4.49	0.00-3.55	0.00-0.84	0.00-9.50
Band 2	13.04-23.14	6.21-12.43	9.41-18.82	5.68-11.37	15.05-30.10	5.96-11.92	4.49-8.99	3.55-7.09	0.84-1.68	9.50-19.00
Band 3	23.14-33.24	12.43-18.64	18.82-28.24			11.92-17.88	8.99-13.48	7.09-10.64		
Band 4	33.24-43.35		28.24-37.65				13.48-17.98	10.64-14.18		
Band 5	43.35-53.45		37.65-47.06				17.98-22.47	14.18-17.73		
Band 6	53.45-63.55							17.73-21.27		
Band 7	63.55-73.65							21.27-24.82		

Indicator	Deprivation	Low birthweight	Teenage Pregnancy	Excluded Children	Children in Care	Child Protection Register	NEET	Substance Misuse	Children with Disability	Severe Mental Illness
Value	47.84	9.3	16.2	1.8	0.00	3.31	8.9	10.3	10.3	12
Weighted Score	5	2	2	1	1	1	2	3	1	2

Total weighted SE score = **20** for LSOA E01010292. SE index score = 20/38 = **0.526**
Ranking of social exclusion = **133rd of 169** Walsall LSOAs (1 = the least socially excluded area).

Potential uses of the SE index: opportunities for health and social care

It should be emphasised that the SE index (a new measure, as far as we are aware), as calculated in this report, is only intended for use as **a guide for identifying the locations of the socially excluded communities at a low geographic level within Walsall.** Thematic maps with contextual road networks, and/or other topographical layers or details, will aid this observational identification. If a higher level analysis is required, eg neighbourhoods, wards, or local neighbourhood partnership areas, then the LSOA scores can be aggregated to give a relative SE for each of these different geographies. Note that LSOAs fit well but not perfectly to each of these geo-layers (a look-up table can be provided upon request from the NHS Walsall Public Health Department).

The index can also be used **with social marketing data - such as that held in Mosaic, Acorn, or People and Places - to assist in methods of communication with the socially excluded.**

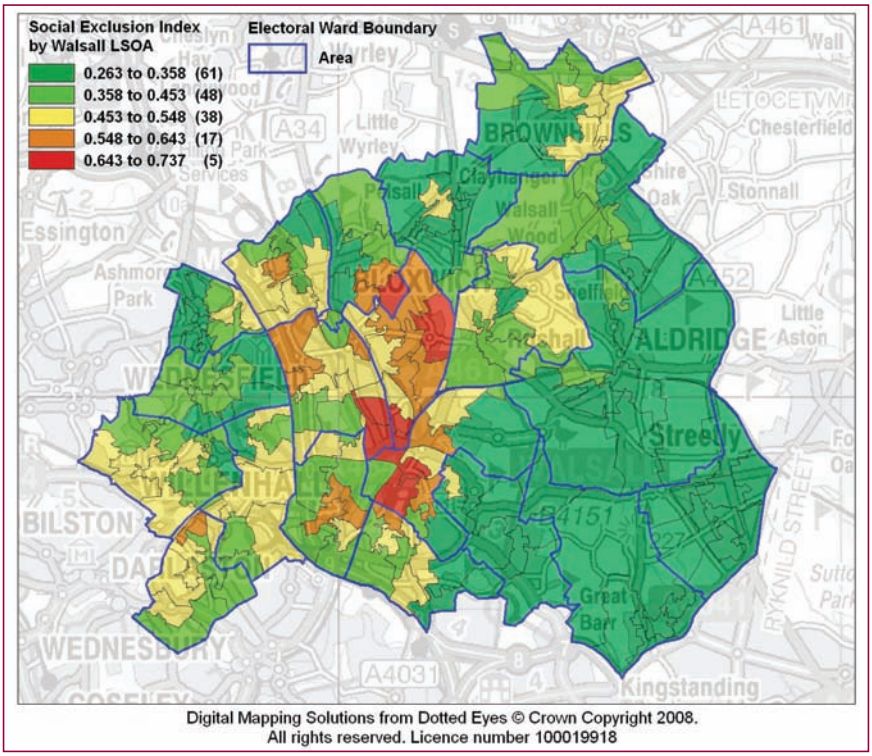
In addition, the index can be correlated with or **used alongside detailed service and activity data,** eg acute hospital admissions, usage of leisure services, social care, etc t**o highlight areas of service that may need redevelopment** to cater to a specific type of socially excluded client.

The SE index for Walsall does not claim to be a complete solution to the measurement or identification of social exclusion across the borough. It does, however, act as a guide to inform both communication strategies and commissioning development in their attempt to achieve social inclusion and reach those that are perceived as *hard to reach.* It should be used alongside other service and on-the-ground information in order to maintain its relevance and applicability.

Walsall's socially excluded areas

There are 5 LSOAs in the highest quintile (top 20%) of relative social exclusion in Walsall. These are within the town centre and the upper part of Blakenall. There are 17 further LSOA areas in the next SE quintile. These largely emanate out from the most socially excluded areas; however, there are isolated patches in Bloxwich West, Birchills Leamore, and Darlaston South wards that fall within this category. These 22 LSOAs, that make up the 40% most socially excluded, have a combined population of just over 33,000 (ONS, mid-year estimate 2005). As explored within the literature, it is estimated that at least 1 in 5 households within a socially excluded neighbourhood will actually be in a state of social exclusion, or at serious risk of being so. Therefore, there are likely to be at least 6,600 residents who are, or at risk of being, socially excluded. In all likelihood, there are pockets of social exclusion that are missed out as part of the above indexation, due to the aggregation of household and postcode level data to LSOAs. Thus, government estimates for Walsall are probably correct, in predicting up to 7,500 people who are in a state of deep and persistent social exclusion, with possibly up to 10,000 people at risk of being so. Where possible, the lowest level of data for any indicator of social exclusion should be used when planning services and interventions.

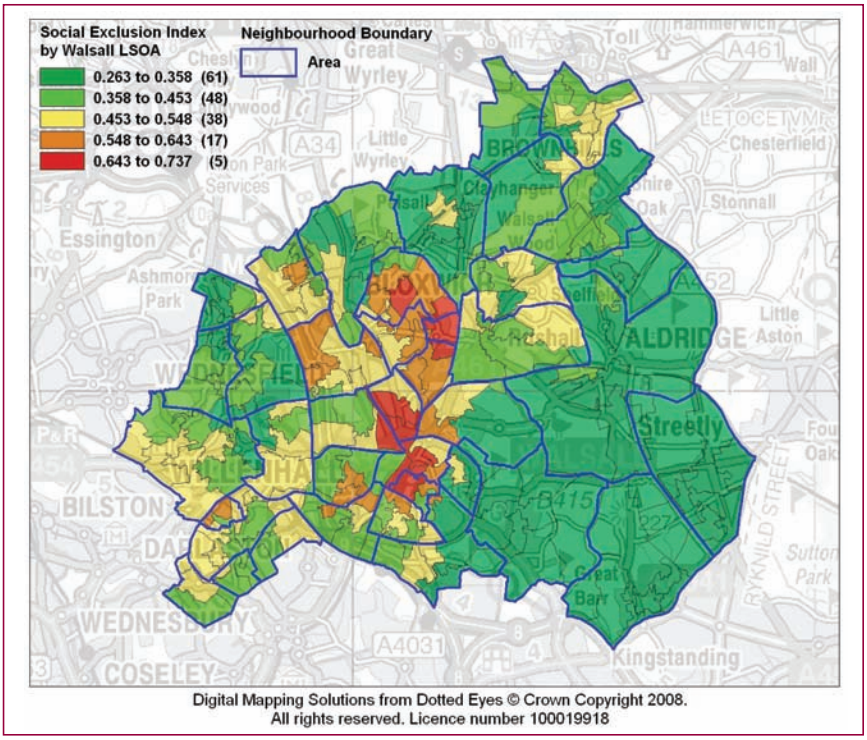
Map 23. Walsall Social Exclusion index by LSOAs and electoral wards



Source: Walsall Public Health Department

Maps 23 and 24 clearly show the most socially excluded areas of Walsall (red shading, most socially excluded; orange shading, next most socially excluded; dark green, least socially excluded) in relation to ward and neighbourhood boundaries. The keys to the named wards and boundaries are found in Appendix 1 and Appendix 2. It is evident that the socially excluded communities of Walsall, while veering in location towards the west, are very much centrally aligned - along an axis from Blakenall in the north, southward, through and including the Town Centre areas.

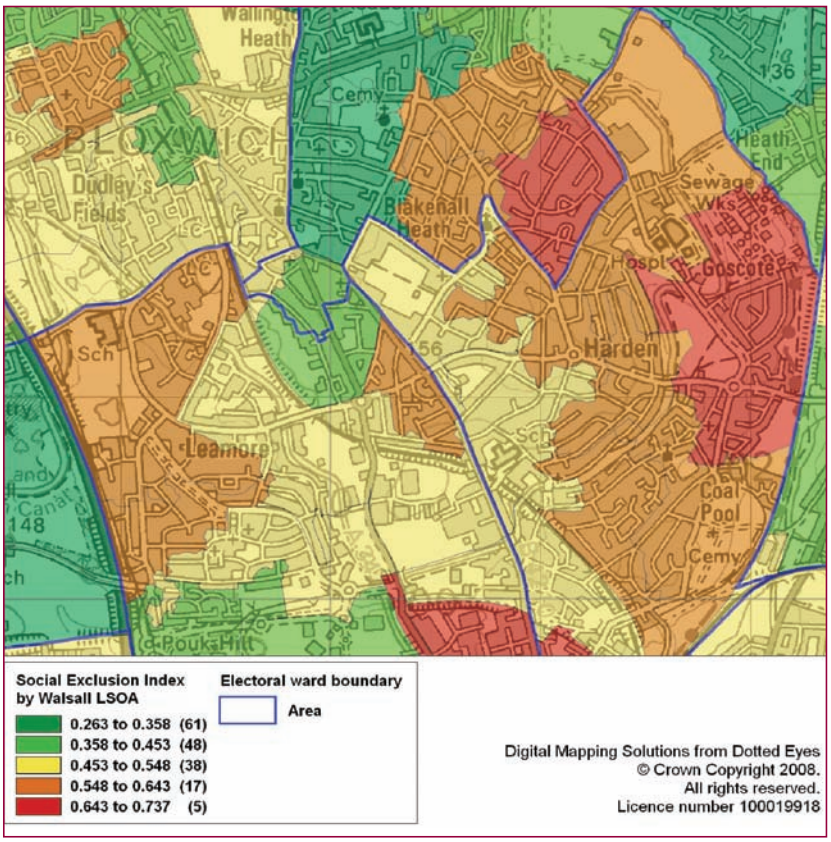
Map 24. Walsall Social Exclusion index by LSOAs and neighbourhood boundary



Source: Walsall Public Health Department

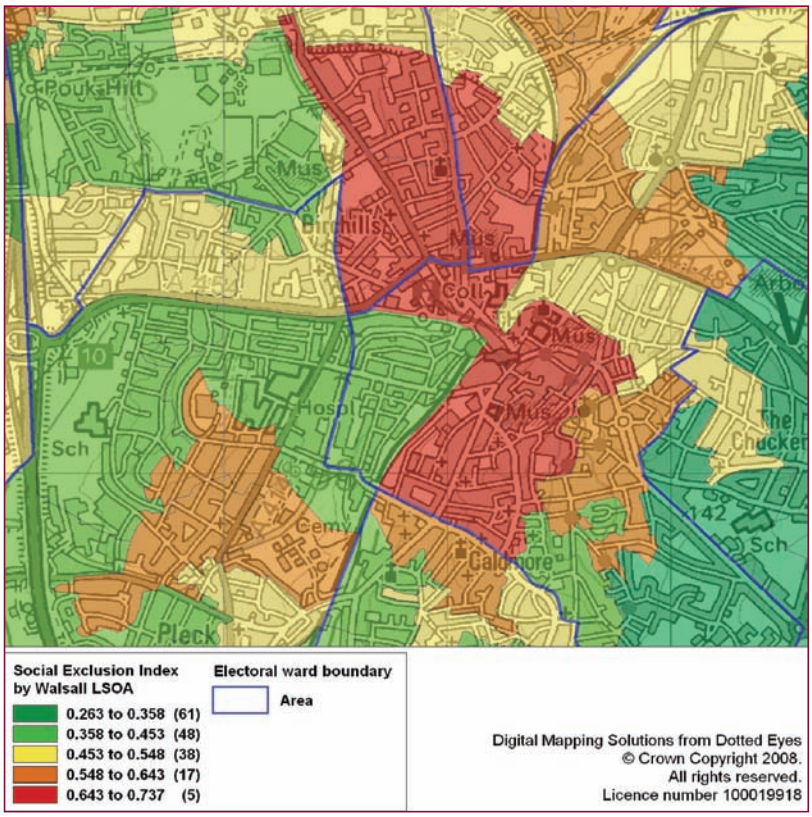
By focusing on the areas with the highest levels of social exclusion, it is possible to isolate neighbourhoods and housing estates that fall within the relevant LSOAs, and which could form the basis for targeted interventions. At street level (Maps 25a and 25b), it is clear that certain areas and estates within the North Blakenall, Goscote, Ryecroft/ Coalpool, Birchills/ Reedswood, North Walsall, Walsall Central, and Caldmore neighbourhoods are those most at risk of being socially excluded across the borough of Walsall.

Map 25a. Walsall Street Map of LSOAs with highest SE index



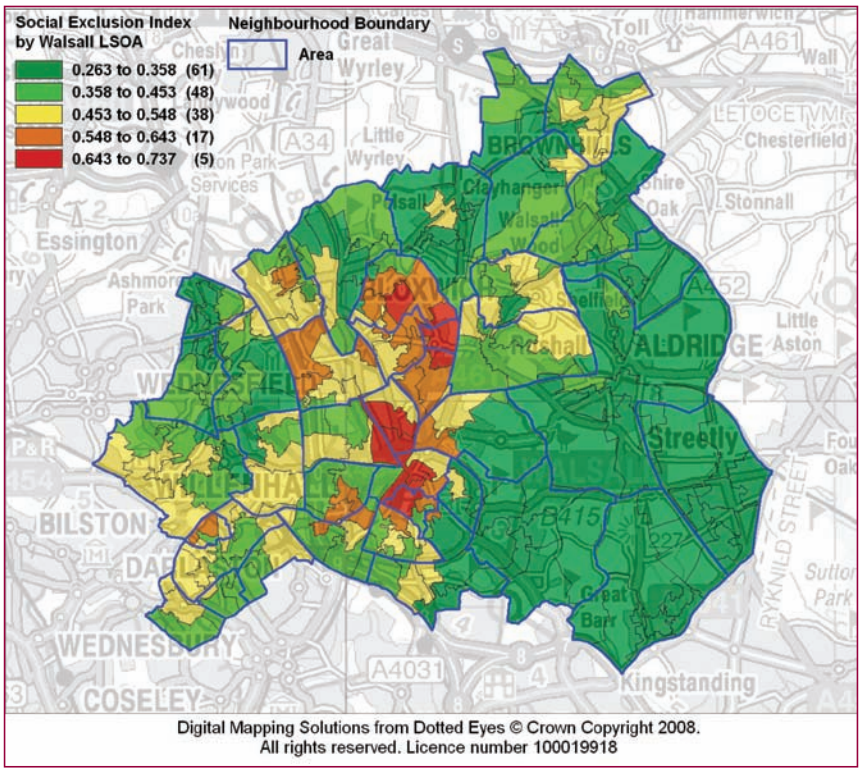
Source: Walsall Public Health Department

Map 25b. Walsall Street Map of LSOAs with highest SE index



Source: Walsall Public Health Department

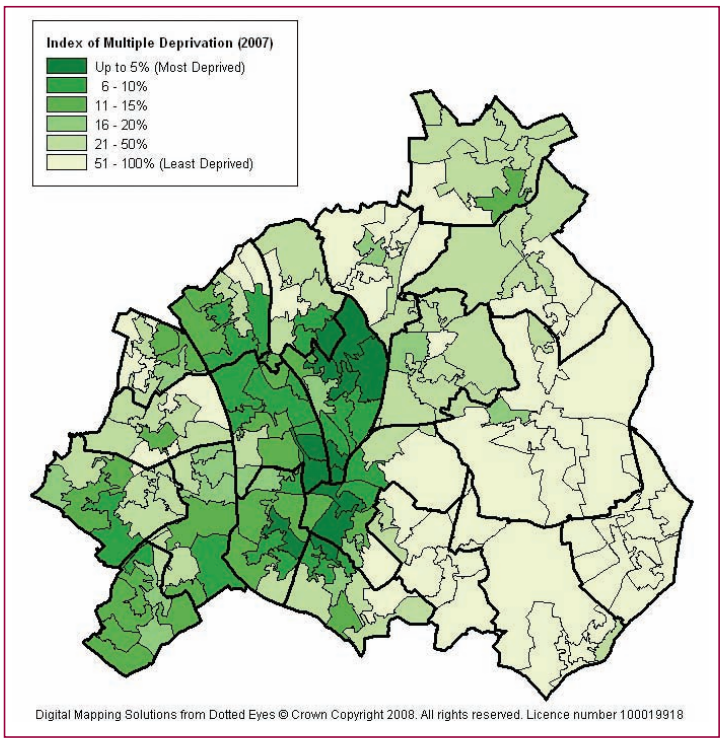
Map 24. Walsall Social Exclusion index by LSOA and neighbourhood boundary



Source: Walsall Public Health Department

By comparing the map of socially excluded neighbourhoods with that of deprivation, repeated here from Chapter 2, it could be interpreted that social exclusion may add an extra dimension to a deprived existence. The most socially excluded areas of Walsall are all captured within those that are the most deprived, but those neighbourhoods that contain the most deprived 10% of the borough population, do not necessarily include the socially excluded - particularly in the west, away from the town centre. Thus, the more discrete locations for social exclusion can make it more convenient to direct any strategies that utilise targeted interventions.

Map 1. Deprivation by LSOA in Walsall 2007



Source: Index of Multiple Deprivation 2007

Regarding the socially excluded people of Walsall, a comment should be made about the minority ethnic groups, discussed and mapped in Chapter 8. It can be seen that the Indian population mostly escapes the socially excluded areas. Many of the Pakistani people are caught in the highly socially excluded areas, especially of Birchills, the town centre and Caldmore. The Bangladeshis living in the town centre and Caldmore are similarly caught. Caribbean groups are more widely dispersed, and are generally not concentrated in the most socially excluded areas. Overall, social exclusion mainly affects the White population, followed by the Pakistani people among BME groups.

In summary, there are two principal concentrations of socially excluded areas in Walsall: (1) the Blakenall area to the north of the centre of Walsall (bounded to the west by Bloxwich Road and to the east by Lichfield Road), and (2) the Town Centre itself, concentrated in the Birchills, St Matthew's, Caldmore, and Pleck areas (the latter three within the Broadway ring road to the east and the M6 motorway to the west). There are also three other discrete locations: Mossley/Dudley Fields (in Bloxwich West) and Beechdale in the north-west, both to the east of the M6, and Rough Hay in the extreme south-west Darlaston area of the borough.

Chapter 9: Conclusions

Precise locations of socially excluded areas are listed in the box (**bold** type signifies the **highest Social Exclusion Index,** 0.643-0.737; otherwise locations with the next highest index, 0.548-0.643, are listed). It should be noted that the naming of locations *does not* indicate that all households in any particular street, for example, contain socially excluded families, but there is a high probability that one in five households may do so.

Walsall's Socially Excluded Communities

BLOXWICH EAST ward (southern part), WS3 3
NORTH BLAKENALL neighbourhood: *inc* Thames Rd, Mersey Rd, Dee Rd, Severn Rd, Wye Rd, Smithfield Rd, Green Rock La, Well La, Barracks La, Ingram Rd, Walker Rd. *Blakenall Heath, inc* Ryle St, Ingram Rd, Valley Rd, Hamilton St, Stanley St, Victoria Ave.

BLAKENALL ward, WS3 1
GOSCOTE neighbourhood: inc Hildicks Cre, Middle Cre, Goscote Lodge Cre, Goscote Cl, Goscote La (S), Goscote Pl, Harden Rd (E).
RYECROFT / COALPOOL neighbourhood: inc Coalpool La, Ross Rd, Clare Rd, Warner Rd, Deans Pl, Whateley Rd. *To the west and south, inc* Dartmouth Ave, Beddows Rd, Holden Cre, Halford Cre, Coalpool La (nr Ryecroft Cemetry).
LEAMORE neighbourhood: East part *(Harden locality)*, inc Shakespeare Cre, Chaucer Rd, Keats Rd, Goldsmith Rd, Harden Rd, Stag Hill Rd, Archer Rd, Roebuck Rd, Hawbush Rd.

BLOXWICH WEST ward (central part), WS3 2
MOSSLEY / DUDLEY FIELDS neighbourhood: *main thoroughfares (above Sneyd La) around/inc* Waverley Rd, Cresswell Cre, Tintern Cre, Heath Rd, Mossley La.

BIRCHILLS LEAMORE ward
BEECHDALE neighbourhood (2 distinct areas):
(1) *Beechdale area* (WS2 7), *inc around Frank F Harrison Sch,* Leamore La, Willenhall La, Fryers Rd, Commercial Rd, Bloxwich La, Stephenson Ave, Rutherford Rd, Telford Rd, Fleming Rd, Kelvin Rd, Priestly Rd.
(2) *East part around Leamore* (WS3 2), *inc* Beatrice St, Providence La, Bagnall St, Leamore La, Green La, Bloxwich Rd (N).

BIRCHILLS LEAMORE ward (south eastern part)
BIRCHILLS / REEDSWOOD neighbourhood (eastern part), WS2 8: *the Birchills, inc area around Walsall Locks, eg* Birchills St, Shaw St, Green La (S), Blue La West.

BLAKENALL ward (southern tip)
NORTH WALSALL neighbourhood, WS2 8: *around Stafford St & Green La, inc* Hospital St, Croft St, Lewis St, Blue Lane East, Day St, Mill St, Marlow St, Leckie Rd.

St MATTHEW'S ward (north eastern part)
HATHERTON neighbourhood (eastern part), WS4 2: *areas around* Butts Rd, *eg* Mill La, North St, Warwick St, Cecil St.

St MATTHEW'S ward (southern part)
WALSALL CENTRAL (WS1 1) and CALDMORE (WS1 3) neighbourhoods: *town centre areas, from* Hatherton Rd *southwards into* Caldmore area *as far as* Corporation St. *Two areas to the east, around:* Springhill Rd, Birmingham Rd, Lysways St, Sandwell St, Bath St.

PALFREY ward (northern part)
PALFREY neighbourhood (the Caldmore section), WS1 4: *south of* Corporation St, *inc* South St, Camden St, Rutter St, Victor St, *to* Milton St *and* Bescot St.

PLECK ward (central part)
ALUMWELL and PLECK neighbourhoods, WS2 9: *west of* Pleck Rd, *north of* Darlaston Rd, *inc* Alumwell Rd, Ida Rd, Jerome Rd, Scarborough Rd, Flaxhall St, Reservoir St, St John's Rd.

DARLASTON SOUTH ward
ROUGH HAY neighbourhood, WS10 8: *main areas above Rough Hay Sch and inc* Lowe Ave, Wolverhampton St, Willenhall St, Hall St, Rough Hay Rd.

Chapter 10: Recommendations

Government holds the key to addressing deprivation and social exclusion: Redistribute income

Wilkinson and Pickett (2007) have stated . . .

- many problems associated with relative deprivation are more prevalent in more unequal societies . . .
- these unequal societies have higher levels of morbidity and mortality, obesity, teenage birth rates, mental illness, homicide, low trust, low social capital, hostility, and racism . . .
- to which can be added lower educational performance among school children, a higher proportion of the population imprisoned, higher drug overdose mortality and lower social mobility . . .
- since ill health and a wide range of other social problems associated with social status within societies are also more common in more unequal societies, this may imply that income inequality is central to the creation of the apparently deep-seated social problems associated with poverty, relative deprivation or low social status . . .
- that the degree of material inequality in a society may not only be central to the social forces involved in national patterns of social stratification, but also that many of the problems related to low social status may be amenable to changes in income distribution.

It is in the hands of Government to redistribute wealth and income, and so have the most significant impact on social exclusion. However, a number of actions can be taken by local policy makers to improve the health of those who are socially excluded. The actions to address social exclusion in Walsall can be classified as:

- Generic, as defined by Shaw *et al* (2006) and indicated in *ITALICS.*
- Specific, as resulting from this report and indicated in **BOLD.**

Actions should be especially targeted at the socially excluded neighbourhoods identified in the Conclusions of this report. There are 20 recommended actions:

(1) Establish a Walsall Social Exclusion Task Force.

Since tackling social exclusion will be a part of addressing health inequalities, there is an opportunity for the Walsall Borough Strategic Partnership (WBSP) to establish its own Walsall Social Exclusion Taskforce (WALSET) as an integral part of a Health Inequalities Board. This would track the activities of the national Social Exclusion Taskforce. The recent development of a robust Health Inequalities Strategy will provide the necessary platform to investigate communities much closer, and with an innovation to address social exclusion.

(2) Focus on reducing the proportion of children born into and living in poverty.

(3) Remove barriers to access to health and social services, which will involve understanding where and why such barriers exist.

(4) Address the problem of stand alone services.

Most people and concerned professionals have a view on the estimated 10,000 socially excluded people living in Walsall: who they are and where they can be found. However, the reality is that agencies are geared for the majority, and although they do focus on the neediest, they often miss those with complex and multiple needs, but who require less help from any one particular service. The socially excluded may not meet the threshold of any given agency to trigger a fuller intervention, despite the scale of their problems or the harms caused to the communities in which they live. Many socially excluded people are not being picked up.

(5) Adopt multi-agency working as normal practice.

It follows on from the stand alone problem that co-ordination between services must be improved, since excluded groups face multiple problems, requiring a variety of agencies. The WBSP can play a key role in drawing partners together through existing bodies such as the Local Safe Guarding Children Board and Adult Safeguarding Arrangements, which will already include many of the key agencies. Joint strategies for families at risk can also be embedded in other local plans such as Children and Young People Plans, Local Parenting Strategies, Local Delivery Plans, and Community Safety Plans (Chapter 3). Joint commissioning can target resources more effectively at families at risk, and this should arise from the JSNA (Joint Strategic Needs Assessment); recognising that:

- There is need for better identification and early interventions. The aim must be to identify earlier those at risk of persistent exclusion and to intervene with more effective support to those most in need, before disadvantage becomes entrenched. Personalisation, rights, and responsibilities are important.
- Services must fit around needs, rather than multifaceted problems having to fit around services, and there must be more persistence and follow-up in dealing with problems, provided by dedicated administrative support.
- Excluded groups should be accorded the support of a trusted third party working on their behalf (*eg* health trainers), and they should be made aware of their rights as citizens.

The Walsall approach to domestic violence, also addressed in Chapter 3, is an excellent example of multi-agency working.

(6) Provide adequate follow-up support for those leaving institutional care.

This has not been a subject of this report but it is clear that a high proportion of socially excluded adults have been brought up in care, or have left institutions for mental health, or have been released from prison. We must have more robust systems in place to ensure better follow-up support.

(7) Introduce new social exclusion initiatives at every opportunity.

For example:

- Walsall is among 15 LAs that successfully bid for a part in a £16 million Early Intervention Pathfinder programme, led by the Department for Children, Schools and Families, for parents of 8-13 year olds at risk of negative outcomes. This programme offers disadvantaged and vulnerable families intensive help and support.
- Health and Housing Links is a strategic partnership formed between Walsall Housing Group and Walsall tPCT. This partnership has successfully bid for £500,000 of Big Lottery money to support promotion of better health in disadvantaged areas. Over three years, 10 Community Health Champions will be appointed to work with Health Trainers. It will enable both organisations to pool their resources to improve communities and boost health promotion by a total of £750,000 over the next three years.
- Walsall was successful in a Big Lottery funded 'Living Well' programme. This is a cross sector partnership initiative that is addressing common mental health issues such as anxiety and depression in young South Asian girls. A range of innovative approaches have been developed.

(8) Embrace Public Service Agreements that focus on social exclusion.

For example, there is a new Socially Excluded Adults PSA which aims to increase the proportion of socially excluded adults in settled accommodation and employment, education, or training. A particular focus is on four client groups: (a) care leavers, (b) offenders under probation supervision, (c) adults with secondary mental health problems, (d) adults with moderate to severe learning disabilities. Adults with multiple needs are typically in contact with a range of services, but tend to benefit less from the support they receive since their engagement with these services is too chaotic. Again, it is all about effective inter-agency working being crucial in ensuring a more coherent and personalised response to wider needs. The WBSP should be primed to promote the adoption of PSAs that feature elements of social exclusion.

(9) Ensure continued delivery of regeneration and housing policies in Walsall.

These areas of Walsall LA activity require continued dedication and support. The focus of neighbourhood renewal is to:

(a) raise the quality of social housing,
(b) provide new affordable housing,
(c) create new forms of tenure,
(d) tackle social exclusion, eg: rough sleepers, vulnerable tenants in sheltered and supported housing, fuel poverty, travellers' sites, and anti-social behaviour.
LAs and Registered Social Landlords are set targets for social housing to meet standards of decency by 2010. Walsall Council is well is on track in this regard.

(10) Aim to provide enough affordable housing of reasonable standard.

(11) Target Walsall employment initiatives for renewed effort.

More needs to be done in Walsall on:

(a) Commissioning vocational services for people with severe mental health problems (according to Department of Health and Department of Work and Pensions 2006 guidance). Government intends to further support this commissioning through dedicated teams within the Care Service Improvement Partnership Regions, working with Government Offices, and intends to refocus the Shift anti-stigma and discrimination programme.
(b) The Pathways to Work programme, exploring further incentives for agencies, with DH and DWP encouragement.
(c) Initiatives within the Skills for Life strategy.

(12) Assess existing income support and welfare regimes to provide an adequate standard of living for the unemployed, with adequate minimum wage to protect those on low incomes.

(13) Ensure access to educational, training, and employment opportunities, especially for those such as the long-term unemployed.

(14) Review employment policies that aim to preserve and create jobs.

(15) Talk with Walsall's disaffected youth.

Although controversial, as explained in Chapter 7 around working with gangs in Birmingham, it can be useful to seek the views of youth living in run-down, socially excluded environments.

(16) Allocate more resources to help vulnerable children.

This is particularly in the area of tackling substance misuse. People who work with vulnerable and disadvantaged children in the NHS, LAs and the education, voluntary, community, social care, and criminal justice sectors (in schools, this includes teachers, support staff, nurses, and governors) should have access to screening and assessment tools to identify a substance misuse issue. There should then be a referral mechanism to services that offer family based structured support, and intensive support for those who need it, along with parent group-based training. Group based behavioural therapy and motivational interviewing should be available and offered to children by trained practitioners. The new Walsall T3 Young People's Service is a step in the right direction, but there is need for further resources to provide more of the above elements; akin to the Addaction structured day care approach to adults with substance misuse problems at the centre in the New Deal area.

(17) Direct more sexual health resources to socially excluded youth.

Along with the challenge of teenage pregnancy among socially excluded communities in Walsall, we need more specific and targeted sexual health initiatives to address sexually transmitted infections among young people. Of course, chlamydia is rightly acquiring a high profile through its national screening programme - since the infection carries significant potential morbidity in pelvic inflammatory disease, sterility, and tubal pregnancy - but there are other important infections, such as syphilis and gonorrhoea, that also require our attention.

(18) Carry out a needs assessment of particular BME groups.

Particular BME groups, notably the African Caribbean and Bangladeshi communities settled in Walsall, are deserving of a detailed health needs assessment.

(19) Strengthen legislation to protect the rights of minority and migrant groups, particularly concerning citizenship and employment rights, anti-discrimination, and protection of those seeking asylum.

(20) Improve the health of migrants, which requires attention to the unfavourable socioeconomic position of many migrant groups and also their particular difficulty of access to health and other care services.

Local area agreements: Improving public health and social exclusion

It has been observed that LAAs have been instrumental in bringing together local organisations to focus on health outcomes. Specifically, an evaluation showed that LAAs improved joint working, promoted integration of services, and increased cooperation between partners. Some LAAs that have focussed on disadvantaged communities have already shown signs of reducing health inequalities. Experience has shown that a move towards joint directors of public health is desirable, since it is important to lobby for key public health priorities within LAAs. This is a view that has been informed through the emergence of JSNAs. Thus, LAAs provide significant opportunities in improving health and reducing health inequalities, and so can be used to tackle social exclusion.

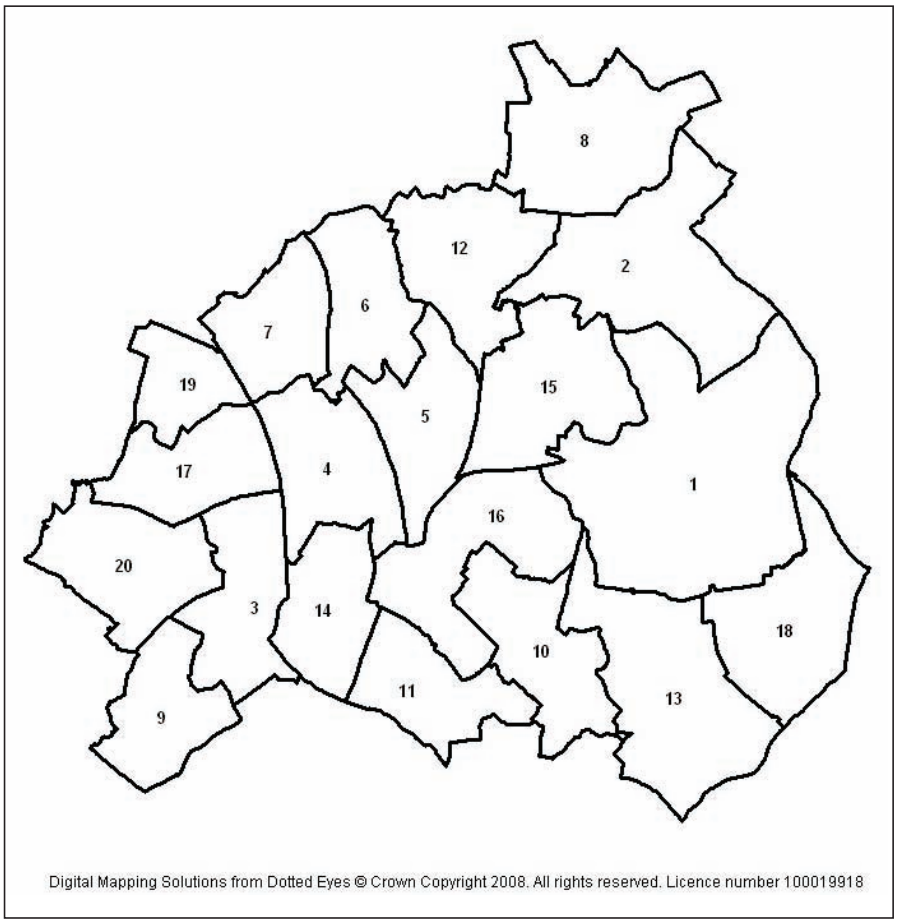
Appendix 1:

Walsall neighbourhoods

1	Aldridge
2	Aldridge North
3	Alumwell
4	Beechdale
5	Bentley
6	Birchills/Reedswood
7	Bloxwich
8	Brownhills West
9	Caldmore
10	Central Brownhills
11	Chuckery
12	Clayhanger
13	Dangerfield
14	Darlaston Central
15	Delves
16	Fallings Heath
17	Goscote
18	Hatherton
19	Leamore
20	Mossley/Dudley Fields
21	Moxley
22	New Invention
23	North Blakenall
24	North Walsall
25	North Willenhall
26	Palfrey
27	Park Hall
28	Pelsall
29	Pheasey
30	Pleck
31	Rough Hay
32	Rushall
33	Ryecroft/Coalpool
34	Shelfield
35	Short Heath
36	South Willenhall
37	Streetly
38	Walsall Central
39	Walsall Wood

Appendix 2:

Walsall wards



1	Aldridge Central and South
2	Aldridge North and Walsall Wood
3	Bentley and Darlaston North
4	Birchills Leamore
5	Blakenall
6	Bloxwich East
7	Bloxwich West
8	Brownhills
9	Darlaston South
10	Paddock
11	Palfrey
12	Pelsall
13	Pheasey Park Farm
14	Pleck
15	Rushall - Shelfield
16	St Matthew's
17	Short Heath
18	Streetly
19	Willenhall North
20	Willenhall South

Appendix 3:

Highlights of findings for the 10 worst scoring wards in Walsall, identified in Walsall Borough Strategic Partnership report undertaken by Public Management Associates in 2005.

RANKS 1 = worst; 5 = 5th worst

Birchills Leamore

High proportion of young children **4;** large South Asian population **4;** deprivation **3;** income **4;** employment **3;** health **4;** education **2;** housing **3;** access to GP services **4;** total crime **5;** educational attainment **2;** The worst housing **1** (29% no central heating); car ownership **3;** family credit claimants **2;** unemployed **3;** falls aged over 50 years **5;** teenage pregnancy **2;** breastfeeding **5.** emergency admissions of under 16s with respiratory infections **1;** obesity **1;** fruit and veg consumption **1;** smoking **2;** physical exercise **5.**

Parts of the area covered by the New Deal Initiative, with health a major theme; also Domestic Violence, Teenage Pregnancy, Community Associations, inc. Birchills, New Deal.

KEY ISSUES: Maternal and Child Health; Teenage Pregnancy; Housing; General lifestyle; Education; Income.

Pleck

Male life expectancy **3;** high proportion young children **5;** single pensioner households **4;** Asian/Indian **2;** Asian/Pakistani **3;** Black/Caribbean **2;** deprivation **4;** child poverty **5;** total crime **2;** Key Stage (KS) 3 science **4;** KS 4 5+ A-Cs **4;** housing **3;** car ownership **2;** income support **2;** unemployed **4;** limiting long term illness (LLTI) **2;** health **3;** all cause mortality **4;** road traffic accident (RTA) A&E admissions **2;** falls **2;** access to GP **1;** diabetes **4;** physical exercise (PE) **1;** fruit and veg. **5;** emergency respiratory admissions for children **5.**

KEY ISSUES: Falls Prevention; Long Term Conditions; Housing; Income; Crime.

Bentley and Darlaston North

Male life expectancy **5;** Asian/Indian **4;** Black/Caribbean **5;** total crime **4;** housing **4;** family credit **5;** access to GP **2;** smoking and obesity ≤ **5;** teenage pregnancy **5;** low birthweight **1;** emergency respiratory admissions for children **5.**

KEY ISSUES: Smoking Cessation; Maternal and Child Health; Teenage Pregnancy; Housing; Income; Crime.

Darlaston South

Deprivation **5;** single pensioner households **3;** child poverty **3;** health and education domains **5;** drug crime **4;** people with no qualifications **3;** GCSE performance **5;** car ownership **5;** income support **5;** unemployment **5;** sick/disabled **3;** LLTI **3;** teenage pregnancy **4;** breastfeeding **2;** smoking in pregnancy **2;** fruit and veg **2;** PE **3;** obesity **4;** smoking **5.**

Darlaston Community Association (four sites), but little specific on health.

KEY ISSUES: Long Term Conditions; Maternal and Child Health; Teenage Pregnancy; General lifestyle; Education; Income.

Bloxwich East

Life expectancy **2;** over 65s **3;** single pensioner households **2;** people with no qualifications **3;** fruit and veg. **2;** PE **3;** car ownership ≤ **5;** income support **4;** sick/disabled **2;** LLTI **1;** all cause mortality **1;** premature deaths **2;** deaths from CHD and stroke **1;** from respiratory disease **2;** falls **1;** teenage pregnancy **3;** breast feeding fruit and veg **5;** PE **1.**

Frank F Harrison Community Association at secondary school, but little health work.

KEY ISSUES: Falls Prevention; Long term conditions; Maternal and Child Health; Teenage Pregnancy; Income.

Bloxwich West

Drug crime **2;** people with no qualifications **5;** KS 3 reading and English **3;** housing **2;** LLTI **5;** health **5;** diabetes **2;** CHD death rate **2;** stroke death rate **4.**

KEY ISSUES: Smoking Cessation; Long Term Conditions; Maternal and Child Health; Teenage Pregnancy; Housing; Education; Income; Crime.

Appendix 3:

Blakenall

Male life expectancy **4;** high proportion young children **2;** deprivation **1;** income **1;** health and education **1;** employment **2;** housing **3;** GP access 3; child poverty **1;** people with no qualifications **1;** KS 3 English, maths, science **1;** GCSE 5+ A-Cs **2;** car ownership **4;** family credit **4;** income support **1;** unemployed **1;** sick/disabled **1;** LLTI **4;** premature deaths **1;** death rates from cancer **2** and stroke **4;** teenage pregnancy **1;** breastfeeding **1;** smoking in pregnancy **1;** smoking **1;** obesity **1.**

Blakenall Community Association is one of the most active in Walsall. Includes sports hall, and smoking cessation, falls prevention.

KEY ISSUES: Smoking cessation; Long term conditions; Maternal and Child Health; Teenage Pregnancy; Housing; Education; Income.

Willenhall South

Female life expectancy **4;** Asian/Indian **5;** Black/Caribbean **4;** total crime **3;** KS 3 scores ranging from **3-5;** sick/disabled **4;** diabetes **1;** breastfeeding **4;** smoking in pregnancy **3;** emergency respiratory admissions for children **2.**

Two active Community Associations, The Park and The Albion; Healthy Living Centre.

KEY ISSUES: Smoking cessation; Long term conditions; Maternal and Child Health; Housing; Education; Income; Crime.

Palfrey

Female life expectancy **3;** high proportion young children **1;** large ethnic populations: Asian/Indian **1;** Asian/Pakistani **2;** Black/Caribbean **3;** housing **1;** access to GP **2;** income **3;** child poverty **4;** crime rates, inc. sexual offences, ≤ **5;** people with no qualifications **5;** family credit **1;** RTA A&E admissions **3;** CHD deaths **4;** diabetes 4.

Palfrey Community Association one of the most active in Walsall; includes Healthy Living Centre (New Opportunities Fund) and Sure Start. Active Women's Groups.

KEY ISSUES: Falls prevention; Long term conditions; Income; Crime.

St Matthew's

Male and female life expectancy **1;** high proportion young children **3;** Asian/Pakistani **1;** Black/Caribbean **1;** employment **1;** access to GP **1;** income **2;** health **2;** housing **2;** child poverty **2;** total crime **1;** KS 3 English, maths, reading **2;** GCSE 5+ A-Cs **3;** car ownership **1;** family credit **3;** income support **3;** unemployed **2;** sick/disabled **5;** CHD deaths **5;** falls **3;** emergency respiratory admissions for children **4.**

Aina Women's Group, especially for Black and Minority Ethnic (BME) communities.

KEY ISSUES: Falls prevention; Long term conditions; Education; Income; Crime.

Appendix 4:

Weighted scores and Social Exclusion index scores by Walsall LSOA

Lower Super Output Area	Deprivation	Low Birthweight	Teenage Pregnancy	Excluded Children	Children in Care	Child Protection Register	NEET	Substance Misuse	Children's Disability Register	Severe and Enduring Mental Illness	Social Exclusion Score	Social Exclusion Index	Ranking (1=least socially excluded)
E01010241	1	2	2	1	1	1	1	1	1	1	12	0.316	28
E01010242	3	2	1	1	1	1	2	1	1	1	14	0.368	62
E01010243	1	2	1	1	1	1	3	1	1	1	13	0.342	49
E01010244	4	1	2	1	1	1	2	2	1	1	16	0.421	81
E01010245	1	2	1	1	1	1	1	1	1	1	11	0.289	11
E01010246	2	1	1	1	1	1	1	1	1	1	11	0.289	11
E01010247	2	1	2	1	1	1	2	1	1	1	13	0.342	49
E01010248	1	2	1	1	1	1	2	1	1	1	12	0.316	28
E01010249	3	2	2	1	1	1	1	2	1	1	15	0.395	73
E01010250	2	1	1	1	1	1	2	1	1	1	12	0.316	28
E01010251	1	2	1	1	1	1	2	1	1	1	12	0.316	28
E01010252	3	2	2	2	1	1	2	1	1	1	16	0.421	81
E01010253	3	2	1	1	1	1	2	1	1	1	14	0.368	62
E01010254	3	2	1	2	1	1	2	2	1	1	16	0.421	81
E01010255	1	2	1	1	1	1	1	1	1	1	11	0.289	11
E01010256	2	1	1	2	1	1	1	1	1	1	12	0.316	28
E01010257	1	1	1	1	1	1	1	1	1	1	10	0.263	1
E01010258	4	2	1	1	1	1	2	2	1	1	16	0.421	81
E01010259	3	1	1	1	1	1	1	1	1	1	12	0.316	28
E01010260	4	3	2	1	1	1	2	3	1	1	19	0.500	128
E01010261	4	2	4	2	1	1	2	2	1	1	20	0.526	138
E01010262	3	3	3	2	1	1	2	1	1	1	18	0.474	110
E01010263	4	2	2	1	1	2	1	2	1	1	17	0.447	98
E01010264	3	2	1	1	1	1	4	1	1	1	16	0.421	81
E01010265	5	3	1	1	1	1	3	3	1	1	20	0.526	138
E01010266	4	3	3	1	1	1	2	3	1	1	20	0.526	138
E01010267	2	2	2	1	1	1	1	1	2	1	14	0.368	62
E01010268	4	2	1	1	1	2	2	1	1	1	16	0.421	81
E01010269	5	2	1	1	1	2	2	2	1	1	18	0.474	110
E01010270	4	3	1	1	1	1	3	2	1	1	18	0.474	110
E01010271	5	2	3	1	1	1	2	1	1	1	18	0.474	110
E01010272	5	2	2	1	1	2	2	4	1	1	21	0.553	148
E01010273	5	3	1	1	1	2	4	2	1	1	21	0.553	148
E01010274	6	2	3	1	1	1	3	2	1	1	21	0.553	148
E01010275	5	2	3	1	1	1	2	2	1	1	19	0.500	128
E01010276	6	3	1	1	1	2	3	3	1	1	22	0.579	156
E01010277	4	2	3	1	1	1	2	2	1	1	18	0.474	110
E01010278	7	3	5	1	1	2	2	2	1	1	25	0.658	165
E01010279	5	2	3	1	1	1	3	2	2	1	21	0.553	148
E01010280	5	2	2	1	1	3	2	2	2	1	21	0.553	148

Appendix 4:

Lower Super Output Area	Deprivation	Low Birthweight	Teenage Pregnancy	Excluded Children	Children in Care	Child Protection Register	NEET	Substance Misuse	Children's Disability Register	Severe and Enduring Mental Illness	Social Exclusion Score	Social Exclusion Index	Ranking (1=least socially excluded)
E01010281	6	2	4	1	2	2	1	4	1	1	24	0.632	161
E01010282	4	2	3	1	1	1	2	3	1	1	19	0.500	128
E01010283	6	2	3	1	1	1	3	3	1	1	22	0.579	156
E01010284	4	1	3	1	1	1	3	1	1	1	17	0.447	98
E01010285	2	2	1	1	1	2	1	1	1	1	13	0.342	49
E01010286	5	2	3	1	1	1	2	4	1	1	21	0.553	148
E01010287	3	2	1	1	1	1	1	1	1	1	13	0.342	49
E01010288	5	2	2	1	1	1	4	3	1	1	21	0.553	148
E01010289	6	2	4	1	1	2	3	6	1	1	27	0.711	168
E01010290	3	2	3	1	1	1	2	2	1	1	17	0.447	98
E01010291	4	2	2	1	1	1	5	2	1	1	20	0.526	138
E01010292	5	2	2	1	1	1	2	3	1	2	20	0.526	138
E01010293	4	2	2	1	1	1	1	2	1	1	16	0.421	81
E01010294	5	2	1	1	1	1	3	2	1	1	18	0.474	110
E01010295	4	2	1	1	1	2	2	2	1	1	17	0.447	98
E01010296	1	2	1	1	1	1	1	1	1	1	11	0.289	11
E01010297	1	1	1	1	1	1	1	1	1	1	10	0.263	1
E01010298	3	2	2	1	1	1	2	1	1	1	15	0.395	73
E01010299	4	2	2	1	1	1	2	1	1	1	16	0.421	81
E01010300	5	1	4	1	1	1	4	4	1	1	23	0.605	160
E01010301	3	3	2	1	1	1	2	2	1	1	17	0.447	98
E01010302	4	3	1	2	1	1	3	1	1	1	18	0.474	110
E01010303	3	2	2	2	1	1	2	1	1	1	16	0.421	81
E01010304	2	3	3	1	1	1	2	2	1	1	17	0.447	98
E01010305	4	2	1	2	1	3	1	1	2	1	18	0.474	110
E01010306	2	2	1	1	1	1	1	1	1	1	12	0.316	28
E01010307	1	2	1	1	1	1	1	1	1	1	11	0.289	11
E01010308	4	1	4	2	1	1	2	3	1	1	20	0.526	138
E01010309	4	2	1	2	1	1	1	1	1	1	15	0.395	73
E01010310	5	2	3	1	1	1	3	2	1	1	20	0.526	138
E01010311	4	2	1	1	1	1	1	1	1	1	14	0.368	62
E01010312	4	2	2	2	1	1	3	1	1	1	18	0.474	110
E01010313	4	2	2	2	1	1	1	1	1	1	16	0.421	81
E01010314	4	2	4	1	1	1	1	1	2	1	18	0.474	110
E01010315	4	2	2	1	1	1	1	1	1	1	15	0.395	73
E01010316	5	2	2	2	1	1	2	4	1	1	21	0.553	148
E01010317	1	1	1	1	1	1	1	1	1	1	10	0.263	1
E01010318	5	3	1	1	1	1	3	5	1	1	22	0.579	156
E01010319	1	2	1	1	1	1	1	2	1	1	12	0.316	28
E01010320	3	1	4	1	1	1	3	2	1	1	18	0.474	110
E01010321	4	2	1	1	1	1	4	2	1	1	18	0.474	110
E01010322	3	2	2	2	1	1	1	1	2	1	16	0.421	81

Appendix 4:

Lower Super Output Area	Deprivation	Low Birthweight	Teenage Pregnancy	Excluded Children	Children in Care	Child Protection Register	NEET	Substance Misuse	Children's Disability Register	Severe and Enduring Mental Illness	Social Exclusion Score	Social Exclusion Index	Ranking (1=least socially excluded)
E01010323	3	2	1	1	1	1	2	1	1	1	14	0.368	62
E01010324	3	1	3	1	1	1	2	1	1	1	15	0.395	73
E01010325	2	2	3	2	2	1	2	1	2	2	19	0.500	128
E01010326	2	2	1	1	1	1	1	1	1	1	12	0.316	28
E01010327	4	3	1	1	1	1	3	2	1	1	18	0.474	110
E01010328	1	3	2	1	1	1	1	1	1	1	13	0.342	49
E01010329	1	2	1	1	1	1	1	1	1	1	11	0.289	11
E01010330	2	2	2	1	1	1	1	1	1	1	13	0.342	49
E01010331	1	2	1	1	1	1	1	1	2	1	12	0.316	28
E01010332	1	2	1	1	1	1	1	1	1	1	11	0.289	11
E01010333	1	1	1	1	1	1	1	1	2	1	11	0.289	11
E01010334	1	2	1	1	1	1	2	1	1	1	12	0.316	28
E01010335	5	2	3	1	1	1	2	2	1	1	19	0.500	128
E01010336	3	2	1	1	1	1	2	1	1	1	14	0.368	62
E01010337	2	2	1	1	1	1	1	2	1	1	13	0.342	49
E01010338	4	2	1	2	1	2	1	2	2	1	18	0.474	110
E01010339	2	2	1	1	1	1	1	2	1	1	13	0.342	49
E01010340	6	3	1	1	1	2	2	6	1	1	24	0.632	161
E01010341	5	3	1	1	1	1	2	1	1	1	17	0.447	98
E01010342	5	3	1	1	1	1	2	2	1	1	18	0.474	110
E01010343	5	2	1	1	1	2	2	1	2	2	19	0.500	128
E01010344	4	2	1	1	1	1	2	2	2	1	17	0.447	98
E01010345	1	1	1	1	1	1	1	1	1	1	10	0.263	1
E01010346	1	2	1	1	1	1	1	1	1	1	11	0.289	11
E01010347	4	1	2	1	1	1	3	3	1	1	18	0.474	110
E01010348	2	1	2	1	1	1	2	1	1	1	13	0.342	49
E01010349	2	1	1	1	1	1	1	1	1	1	11	0.289	11
E01010350	2	1	1	1	1	1	1	2	1	1	12	0.316	28
E01010351	2	1	1	1	1	3	2	2	2	1	16	0.421	81
E01010352	1	2	1	1	1	1	1	1	1	1	11	0.289	11
E01010353	3	2	1	1	1	1	4	2	2	1	18	0.474	110
E01010354	3	2	1	1	1	1	2	1	1	1	14	0.368	62
E01010355	1	1	1	1	1	1	1	1	1	1	10	0.263	1
E01010356	2	2	2	1	1	1	1	1	1	1	13	0.342	49
E01010357	1	2	2	1	1	1	1	1	1	1	12	0.316	28
E01010358	2	2	1	1	1	1	1	1	1	1	12	0.316	28
E01010359	2	1	2	1	1	1	1	1	1	1	12	0.316	28
E01010360	1	1	1	1	1	1	1	1	1	1	10	0.263	1
E01010361	3	2	1	1	1	1	2	1	1	1	14	0.368	62
E01010362	4	2	1	1	1	1	3	1	1	1	16	0.421	81
E01010363	4	2	2	1	1	1	3	1	1	1	17	0.447	98
E01010364	6	1	2	1	1	2	2	6	1	2	24	0.632	161

Appendix 4:

Lower Super Output Area	Deprivation	Low Birthweight	Teenage Pregnancy	Excluded Children	Children in Care	Child Protection Register	NEET	Substance Misuse	Children's Disability Register	Severe and Enduring Mental Illness	Social Exclusion Score	Social Exclusion Index	Ranking (1=least socially excluded)
E01010365	5	2	1	1	1	3	2	2	1	1	19	0.500	128
E01010366	5	2	2	1	1	1	3	5	1	1	22	0.579	156
E01010367	4	2	1	1	1	1	2	1	1	1	15	0.395	73
E01010368	7	3	1	1	1	3	3	7	1	1	28	0.737	169
E01010369	5	2	1	1	1	1	2	4	1	1	19	0.500	128
E01010370	4	3	1	1	1	3	5	3	2	1	24	0.632	161
E01010371	7	2	3	1	1	1	4	3	1	2	25	0.658	165
E01010372	4	3	1	1	1	1	2	2	1	1	17	0.447	98
E01010373	2	2	1	1	1	1	1	1	1	1	12	0.316	28
E01010374	5	3	1	1	1	1	3	3	1	1	20	0.526	138
E01010375	7	2	1	1	1	1	2	7	2	1	25	0.658	165
E01010376	2	1	2	1	1	1	1	1	1	1	12	0.316	28
E01010377	3	1	1	2	1	1	2	1	1	1	14	0.368	62
E01010378	2	1	1	1	1	1	1	1	1	1	11	0.289	11
E01010379	2	2	1	1	1	1	1	2	1	1	13	0.342	49
E01010380	2	2	1	1	1	1	2	1	2	1	14	0.368	62
E01010381	3	2	2	1	1	1	2	2	1	1	16	0.421	81
E01010382	3	2	1	1	1	1	2	2	1	1	15	0.395	73
E01010383	4	2	1	1	1	1	2	2	1	1	16	0.421	81
E01010384	1	1	1	1	1	1	1	1	1	1	10	0.263	1
E01010385	1	1	1	1	1	1	1	1	1	1	10	0.263	1
E01010386	1	1	3	1	1	1	1	1	1	1	12	0.316	28
E01010387	1	1	1	1	1	1	1	1	1	1	10	0.263	1
E01010388	1	1	2	1	1	1	1	1	1	1	11	0.289	11
E01010389	1	3	2	1	1	1	1	1	1	1	13	0.342	49
E01010390	1	1	1	1	1	1	1	2	1	1	11	0.289	11
E01010391	1	1	1	1	1	1	1	1	2	1	11	0.289	11
E01010392	1	1	1	1	1	1	1	1	1	1	10	0.263	1
E01010393	2	1	1	1	1	1	1	1	1	1	11	0.289	11
E01010394	2	2	1	1	1	1	1	1	1	1	12	0.316	28
E01010395	1	2	1	1	1	1	1	1	1	1	11	0.289	11
E01010396	4	2	1	2	1	1	2	2	1	1	17	0.447	98
E01010397	4	2	1	2	1	1	2	1	1	1	16	0.421	81
E01010398	1	2	2	1	1	1	1	1	1	1	12	0.316	28
E01010399	2	1	1	1	1	1	1	2	1	1	12	0.316	28
E01010400	4	2	2	1	1	1	2	3	1	1	18	0.474	110
E01010401	4	2	4	1	1	1	2	2	1	1	19	0.500	128
E01010402	2	3	1	1	1	1	1	1	1	1	13	0.342	49
E01010403	4	3	1	2	1	2	3	2	1	1	20	0.526	138
E01010404	4	2	2	2	1	1	2	2	2	1	19	0.500	128
E01010405	3	2	2	1	1	1	3	1	1	1	16	0.421	81
E01010406	5	2	2	2	1	1	2	3	1	1	20	0.526	138
E01010407	3	1	2	2	1	1	1	2	1	1	15	0.395	73
E01010408	4	2	1	2	1	1	1	3	1	1	17	0.447	98
E01010409	3	2	1	1	1	1	1	2	1	1	14	0.368	62

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Abbreviations

AIDS	Acquired immune deficiency syndrome
ASB	Anti Social Behaviour
BME	Black and Minority Ethnic
C4H	Communities for Health
CAT	Contact and Assessment Team
CDRP	Crime and Disorder Reduction Partnership
CHD	Coronary heart disease
CLG	Communities and Local Government
CPA	Comprehensive Performance Assessment
DAAT	Drug and Alcohol Action Team
DCLG	Department of Communities and Local Government
DCSF	Department for Children, Schools and Families
DfES	Department for Education and Skills
DH	Department of Health
DHSS	Department of Health and Social Security
DIP	Drug Intervention Programme
DIUS	Department for Innovation, Universities and Skills
DPH	Director of Public Health
DTLR	Dept. for Transport, Local Government and the Regions
DWP	Department for Work and Pensions
EHC	Emergency hormonal contraception
ESOL	English for Speakers of Other Languages
HA	Health Authority
HIPB	Health Inequalities Partnership Board
HIV	Human immunodeficiency virus
HMSO	Her Majesty's Stationery Office
IMD	Index of Multiple Deprivation
JSNA	Joint Strategic Needs Assessment
KS	Key Stage (education level)
LA	Local Authority
LAA	Local Area Agreement
LDP	Local Delivery Plan
LEA	Local Education Authority
LINk	Local Involvement Network
LLTI	Limiting Long Term Illness
LNP	Local Neighbourhood Partnership
LSP	Local Strategic Partnership
MAPPAs	Multi Agency Public Protection Arrangements
MBC	Metropolitan Borough Council
MMR	Measles, Mumps, Rubella
MoJ	Ministry of Justice
MSM	Men who have sex with men
MST	Multi-systemic Therapy
NEET	Not in Employment, Education, or Training
NESPS	Neighbourhood Employment and Skill Plans
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NSF	National Service Framework
NTA	National Treatment Agency
ONS	Office of National Statistics
PBC	Practice Based Commissioning
PCT	Primary Care Trust
PE	Physical Exercise
PPO	Prolific and other Priority Offender
PSA	Public Service Agreement
PSHE	Personal, Social and Health Education
PYO	Persistent Young Offender
RTA	Road Traffic Accident
SEAL	Social and Emotional Aspects of Learning
SMR	Standardized Mortality Ratio
SHA	Strategic Health Authority
SPIR	Shared Partnership Information Resource
SRE	Sex and Relationships Education
STI	Sexually transmitted infection
tPCT	Teaching Primary Care Trust
UNICEF	United Nations International Children's Emergency Fund
WALCAT	Walsall College of Arts and Technology
WBSP	Walsall Borough Strategic Partnership
WHO	World Health Organization
YOT	Youth Offending Team

Inequalities, deprivation and social exclusion