


PEOPLE PLACE AND + OPPORTUNITY

Reducing health inequalities in Lambeth



CONTENTS

1	Foreword
2	Introduction: what are health inequalities and how do they come about?
8	Place: understanding inequality in Lambeth
16	Lambeth's people
22	Impact of inequality on health: illustrated for five conditions
23	Childhood obesity and inequalities
26	Sexual health
30	Smoking and inequalities
31	Mental health
35	Multiple long term conditions
36	Conclusions and recommendations: Actions to tackle inequalities across the system
39	References

 This symbol indicates that a mouse click will take you to an online video or website for further information

Acknowledgements

Thanks to all the authors and contributors to this year's annual public health report: Stef Abrar; James Crompton; Vida Cunningham; Hiten Dodhia; Carla Hobart; Catherine Huntley; Bimpe Oki; Rachel Scantlebury; Madhumita Shrotri; and, Jean Taylor.

Our particular thanks go to the partners and residents who took the time to participate in the filmed case studies; and, to Dr Stephanie Hatch and the SELCoH Team for allowing us to highlight their research.

Photo credits

Front cover © David Orekoya
Page 3 © tubecreature.com
Pages 6, 11, 20, 25, 35; © Lambeth Council
Pages 9, 13, 14, 15, 29, 31, 32, 33; © Shutterstock
Page 21 © Lambeth Portuguese Wellbeing Partnership

FOREWORD

Our health is our most valuable asset, as individuals, families and communities. The burden of ill health on our relationships, ability to study, work and play affects our lives directly and indirectly.

But this burden is not equal across society. In Lambeth, we know that some groups of people are impacted at a younger age by chronic disease, that outcomes are worse depending where you live, and that a baby boy born in Clapham Common ward can expect to live up to 4 years less than a baby boy born just down the road in Clapham Town. A Black Caribbean man living in Lambeth is likely to experience his first long term condition 10 years earlier than his White British counterpart. A man in Lambeth can on average expect to live 3 years less in good health than a woman.

We describe these differences as health inequalities. However they are in fact outcomes of social inequalities, linked to factors such as income, education, housing, access to opportunity and being able to participate in society. Healthcare can support people once they become ill, but to prevent the intergenerational cycles of health inequalities we see in Lambeth and across the country, we need to work in a different way.

In Lambeth we have recognised the impact of inequalities for a long time, and both the Council and NHS have tried to make a difference to those with the worst outcomes. The Equality Commission published a series of recommendations for how the Council and partners could continue to tackle some of the issues which affect particular groups in Lambeth.

The Black Thrive partnership is working with local people, as well as statutory and voluntary sector partners, to address some of the inequality in mental health outcomes in Lambeth's Black community. The Lambeth Early Action Partnership is seeking to improve the start in life for children in the four most deprived wards in the borough.

So what does this report add? Whilst it very much builds on what we already know, it comes at a time when public finances are at breaking point. And it provides a stark warning. Things are already getting worse for many of our residents. However, this can be masked by the growth we see in some parts of borough. It is important that we pay attention to this detail because we know that wider inequality is bad for us all – our health, our economy, our communities and our collective resilience.

We need to work in a very different way to address the underlying causes of health inequalities. We need to have strong partnerships to ensure that economic growth includes everyone and that the life chances of a baby born in the Lambeth today will not just be determined by those of their parents. By building infrastructure which supports community cohesion rather than division, by creating opportunities and ambition for those who feel they have none, and by critically examining our decisions as a Council and health system as policy makers, providers of services, employers and partners, we can lead by example.

And the really good news is that many of the things we need to do to invest in better health and resilience in our communities are the same things we need to do to make the borough as a whole flourish.

Ruth Hutt
Director of Public Health



INTRODUCTION: WHAT ARE HEALTH INEQUALITIES AND HOW DO THEY COME ABOUT?

Key messages

1

There are significant inequalities (inequities) in both life expectancy and healthy life expectancy in Lambeth.

3

For this reason, a reduction in avoidable health inequalities (inequity) cannot be achieved by through healthcare alone.

2

These are primarily socially determined, that is to say, that they are influenced by factors outside of health services, and beyond personal behaviours.

4

Health action to tackle inequalities needs to use 'proportionate universalism', delivering universal services but at a scale and intensity that is proportionate to the level of disadvantage experienced by those groups experiencing the greatest health inequality.

What do we mean by health inequality and inequity?

This report talks about health inequalities in Lambeth, but really it is about health inequities; in other words, the differences in health outcomes for different resident groups in Lambeth that are unfair or avoidable.

Talking about health inequities is important, because it emphasises how a range of external factors such as social and economic conditions, rather than just those relating to an individual's genetics or biological processes, can contribute to people experiencing better or worse health outcomes. So whilst the remainder of this report will refer to health inequalities, what we mean is those inequalities that, put simply, it is in our power to put right.

To address these health inequalities, we need to address the full range of factors that contribute to them, as well as developing health actions that recognise the inequalities. We need to do this not by targeting services (which has potential to stigmatise already marginalised groups) but to deliver universal services at a scale and intensity that is proportionate to the level of disadvantage or need (this is 'proportionate universalism'). We need to do this in a way that recognises the specific needs of particular groups, and those factors which may influence access to and use of services.

Life expectancy and inequity

A critical indicator of health inequality is life expectancy (LE); a measure that offers a stark picture of unfair and avoidable health inequalities.

The gap in life expectancy between the most and least deprived areas in England is 9.3 years for males and 7.3 years for females. In London, life expectancy is also strongly correlated to the specific area where you live. People who live in more prosperous areas of central London can expect to live an average of 11 years longer than those living in areas like Lambeth's Stockwell.

Life expectancy in Lambeth is broadly in line with the average for England as a whole: for men it is one year lower than in England as a whole, for women it is the same. The gap between Lambeth and England life expectancy has closed over the last 2 decades.

Figure 1
The difference between equality and equity

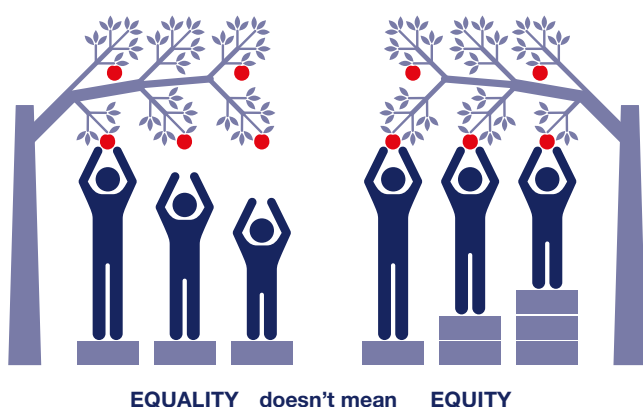
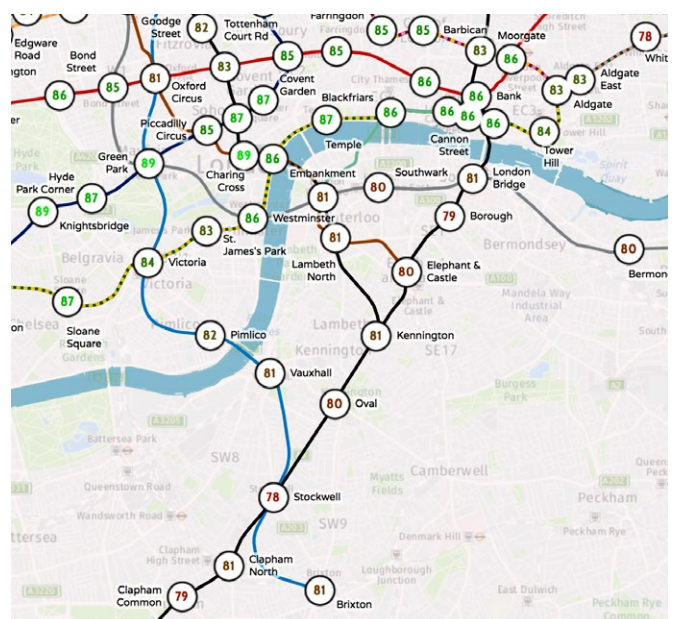


Figure 2
London's life expectancy gap



http://tubecreature.com/#/livesontheonline/current/same/U*/TFTFTF/13/-0.1311/51.4852/. Metric data from ONS (2009-2013), M/F average, full populations for MSOAs touching buffer around tube station centroids

Healthy life expectancy & inequity

Healthy life expectancy (HLE) is the number of years we live in good health. Women in Lambeth have a healthy life expectancy of 63.4 years. This has not changed in the past decade. For men there has been a 6.8 year decline in healthy life expectancy since 2011-13, and it is now 58.4 years¹. An average Lambeth resident will spend around 20 years in poor health.

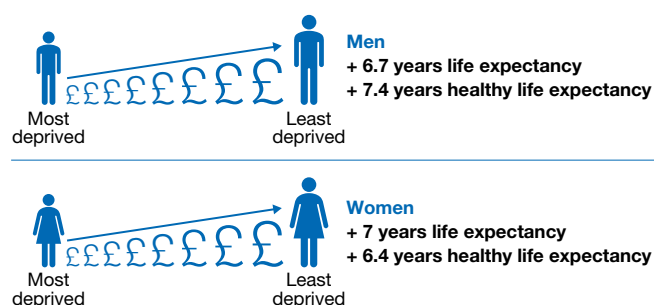
As with life expectancy, there are significant inequalities in healthy life expectancy, and these are primarily related to deprivation. Deprivation reduces life expectancy considerably. It also reduces the proportion of people's life spent in good health.

A man living in the most deprived ward of Lambeth can expect to be in good health for 7 years less than one living in the least deprived wards in Lambeth.

For example, the gap in life expectancy for men in Lambeth is 6.7 years depending on whether they live in the most or least deprived areas of the borough (life expectancy ranges from 74.6 to 81.3 in Lambeth). The gap in healthy life expectancy is even higher at 7.4 years (56.9 to 64.3).

Figure 3

Life expectancy and healthy life expectancy



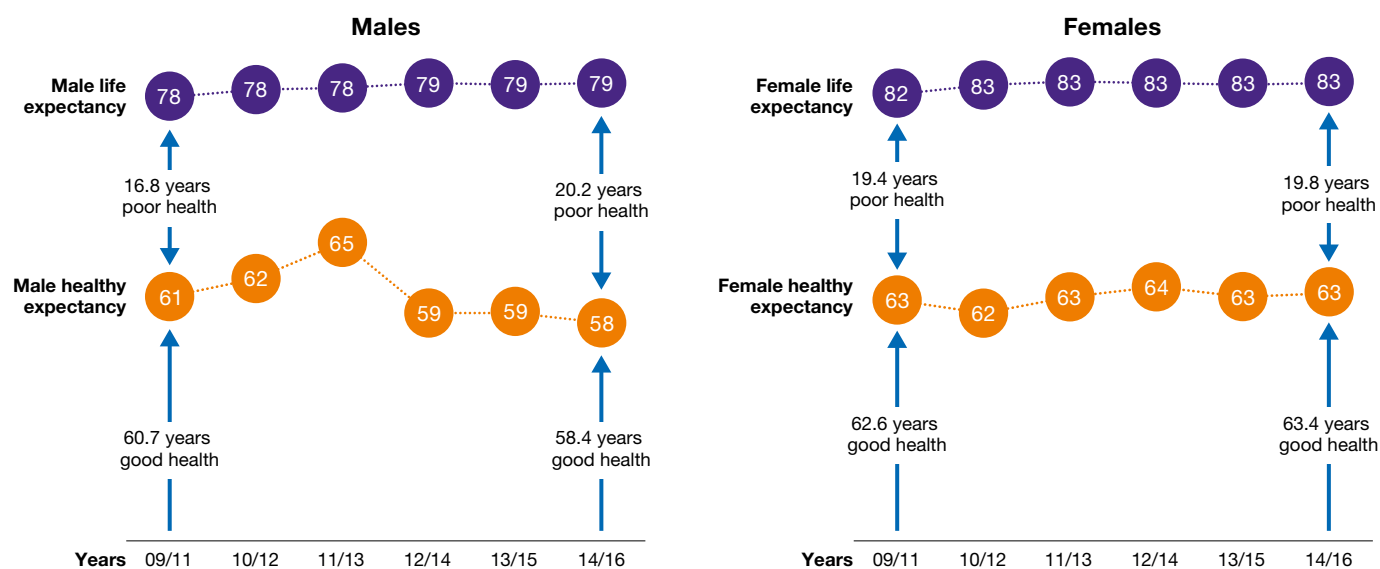
Source: Fingertips <https://fingertips.phe.org.uk/>

For women living in Lambeth, the picture is slightly different: the life expectancy gap is 7 years (80.5 to 87.5), but the healthy life expectancy gap is 6.4 (59.1 to 65.5). The difference between healthy life expectancy and life expectancy varies across the borough, from between 14 to 20.2 years for men and 17.5 to 27.4 years for women.

For more details about Health and Health inequality outcomes please see the [Lambeth JSNA](#), the APHR Stats bulletin, [Life Expectancy](#) and [Avoidable deaths](#) factsheets.

Figure 4

Trend in life expectancy, healthy life expectancy and years spent in poor health from birth, males and females, Lambeth, 2009 to 2011 up to 2014 to 2016



Source: PHE Fingertips

¹ Since 2009-2011. Data for healthy life expectancy (HLE) are published by ONS as three-year averages. This measure of years spent in poor health is self-reported and does not adjust for the severity of ill health or the types of conditions that may be present.

What produces health inequalities?

Inequalities result from variations in the distribution of socioeconomic determinants of health, such as education, employment, income and housing, or what the World Health Organisation (WHO) describes as *'the conditions in which people are born, grow, live, work and age'*.

Thinking about socioeconomic determinants of health is important because it recognises that the choices available to people, and the risks they are exposed to, are affected by their circumstances – the 'causes of the causes' of ill health. These determinants interact with each other in complex ways.

Of all the characteristics outlined in the framework above, health inequalities are most strongly correlated with income or socioeconomic deprivation.

Research shows that health follows a clear social gradient. This means that higher social status, whether measured by education, income or occupation, is associated with better health and longer life expectancy. More detail can be found in Marmot et al's *'Fair Society, Healthy Lives'* [link](#).

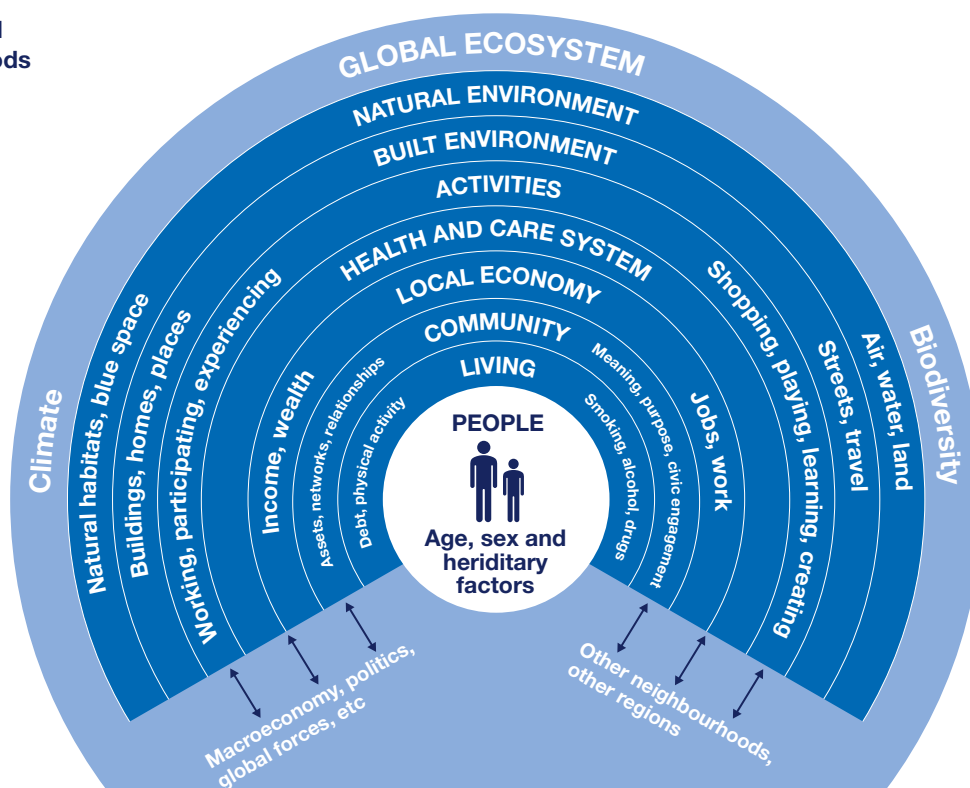
This also means that more economically unequal societies have worse health and social problems. Health inequalities therefore affect each one of us, and require action across a range of population groups.

'Societies with greater economic inequality appear to experience worse health and wellbeing than those that are more equal, not only for those at the bottom of the socio-economic ladder, but all the way up to the top.'

Wilkinson, R. G., & Pickett, K. E. (2009), *The spirit level: why more equal societies almost always do better*

Figure 5 shows that a range of factors contribute to health outcomes. However, it does not demonstrate the complex ways in which different dimensions of the model interact to create health inequalities. These fall into three broad categories: 'place'; 'people'; and, 'time'.

Figure 5
The determinants of health and well-being in our neighbourhoods



Dimensions of health inequality



Place



- Socio-economic disadvantages 'cluster' in specific places and communities.
- The environments within which people make choices ('choice architecture') can influence health behaviours. For example, road layouts may influence people's willingness to cycle; or, the prevalence of fast food outlets compared to other sources of food may influence healthy eating behaviours.
- There are population-level health effects of living in an unequal society: including stress and other mental health issues.



People



- There is a complex interplay between the environment people live in and their genes (epigenetics). So, for example, air pollution may "trigger" a genetic susceptibility to health issues.
- 'Psychosocial' factors like stress, social relationships (social cohesion), and personal resilience may cause individuals experiencing social inequality to experience worse health.
- The inter-relationship between some diseases and their social impact can widen inequalities, e.g. the ability to work can have an impact on mental health as well as vice versa.



Time

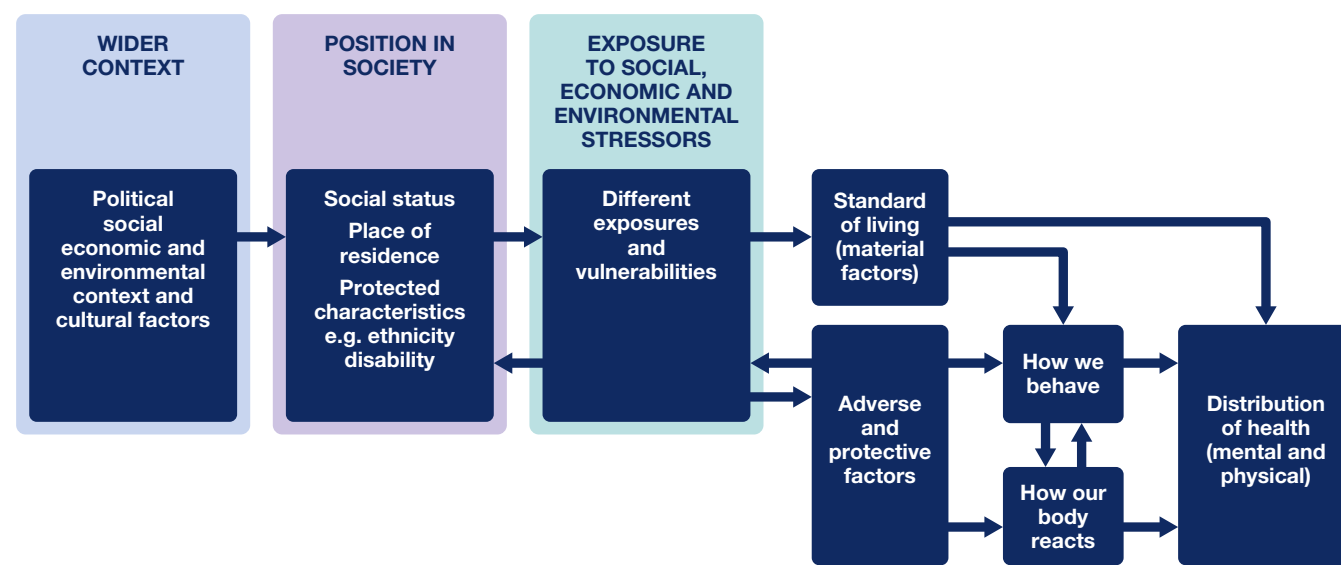


- Socio-economic disadvantages and poor health outcomes can be 'passed down' between generations.
- Harmful events (e.g. adverse childhood experiences²) or exposures (for example, living in poverty) in critical or sensitive periods over the life-course contribute to poorer health outcomes.
- Disadvantage can accumulate over time: social determinants influence health, but health, in turn, influences key social determinants (for example, education and employment outcomes). This means that there is potential for specific communities to accumulate multiple disadvantages over time.

² These are traumatic events such as suffering child maltreatment or living in a household affected by domestic violence, substance misuse or mental illness, experienced in childhood.

Psychosocial pathways and health outcomes

Figure 6
PHE Psychosocial pathways and health outcomes:
 Informing action on health inequalities 2017



There are a range of studies that weigh up the relative contribution of different factors to health outcomes (figure 6).

Though their approaches vary, they all show that the contribution of social determinants to ill-health considerably outweighs that of individual hereditary factors and of healthcare services. Thus, if wider social inequalities are reduced, reductions in health inequalities will likely follow.

The next section examines the role of specific social determinants and looks at how these are shared in the local Lambeth context.

For more information visit
www.kingsfund.org.uk/publications/inequalities-life-expectancy

PLACE: UNDERSTANDING INEQUALITY IN LAMBETH

Key messages

1

Social determinants of health are the most important factor influencing health outcomes and inequalities, but are unevenly distributed across Lambeth's population.

3

Mapping inequalities at an area level also helps specify where particular types of intervention need to happen.

2

Understanding these inequalities and who is affected by them can help to identify groups who may be vulnerable to poor health outcomes and understand what can be done to reduce or avoid these. It can also help anticipate future trends in health inequalities.


Social deprivation and wider determinants

The components of ‘place,’ or the social environment in which we live, has the biggest impact on health inequalities. This includes the distribution of income, employment and working conditions, crime, housing, sense of community etc.

Another social determinant and aspect of place is, of course, the physical environment that we live in. This is about the quality of the built environment, but also the existence of local services and amenities; and, the strength and resilience of our local communities.

Understanding who is affected by inequalities relating to different social determinants factors can help to identify groups who may be vulnerable to poor health outcomes and understand what can be done to reduce or avoid these. It can also help anticipate future trends in health inequalities.

Mapping distribution of social determinants at an area level also helps specify where particular types of intervention need to happen – for example, in supporting communities by developing community resilience or social infrastructure, as we are trying to do through Lambeth’s local care networks (see conclusions section).

Here, we provide an overview of social determinants in Lambeth and how they are distributed across the population. [For more information, see the PHE Fingertips for Lambeth](#) .

Deprivation and inequality

There is strong evidence that both deprivation (a lack of money, resources and access to life opportunities) and being in a position of relative disadvantage (having significantly less resource than others) is associated with poorer health.

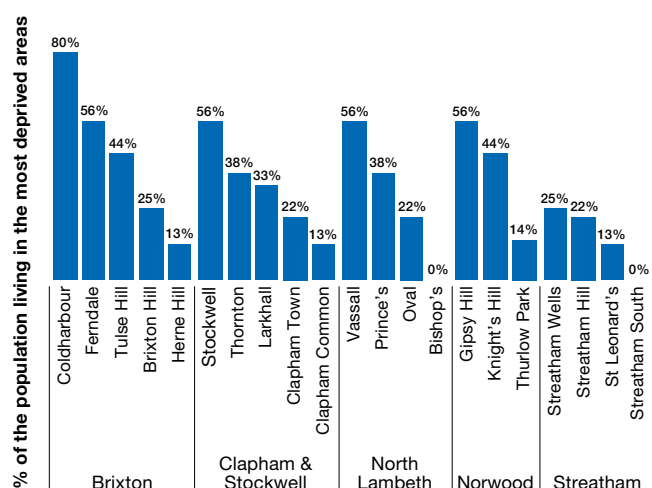
As in other areas of London, Lambeth has relatively affluent areas situated alongside more deprived areas. This deprivation is concentrated in small areas, at sub-ward level.

Large numbers of residents are affected by significant deprivation: nearly one third of the borough’s population live in areas which are among the most deprived fifth of areas in the country.

Poverty and income insecurity

Poverty and income insecurity is one of the strongest determinants of health inequalities. As well as affecting material deprivation, poverty limits access to opportunities, and the stress associated with poverty can contribute to

Figure 7
Distribution (%) of Lambeth population by ward level in top quintile of deprivation (i.e. most deprived)



Source: IMD 2015, Department for Communities and Local Government



unhealthy behaviours. **Childhood poverty has particular implications: we know that growing up in poverty has lifelong effects on health** [↗](#).

Whilst Lambeth is becoming more affluent overall, this masks high levels of poverty: **Just under 30% of Lambeth residents live in poverty after housing costs; worse than the London average of 27%** [↗](#), and the child poverty rate is even higher: 36% of children live in poverty.

Whilst Lambeth's poverty rate has not increased over the last decade, we know that this is likely to mask **the degree and persistence of poverty affecting Lambeth's residents** [↗](#). There is increasing evidence that the 'safety net' that would once have been available for those unable to work, or stuck in low-paid/ precarious work, has been weakened, and that as a result these residents will be living on incomes well below the poverty line. **Some groups of residents are particularly likely to be living in 'destitution'** [↗](#), in other words not able to afford the bare essentials needed to live eat, stay warm and dry, and keep clean, with significant impacts on their health. In Lambeth, more poverty or destitution is reflected in increases in fuel and food poverty; and, indebtedness.

We also know that patterns of poverty have changed. Whilst it is still the case that unemployment and poverty are strongly linked, households with at least one working member are now much more likely to live in poverty. In London, **58% of people living in poverty are living in a working family, compared to 44% a decade ago and 28% two decades ago** [↗](#).

Employment, pay and working conditions

Being employed, being adequately paid and working in decent conditions are also important social determinants of health. The long-term unemployed have a lower life expectancy and worse health than those in work; and children growing up in workless households are almost twice as likely to perform worse at all stages of education compared with children growing up in working families.

"Every Pound Counts" is a local authority-led initiative which provides welfare and benefit advice to people with disabilities or long-term conditions, including people with mental health support needs and children with complex support needs and all carers.

Eligible residents are referred to the service by GPs, discharge teams and other agencies. The service includes benefit checks to identify those who are entitled to benefit and are not claiming, as well as advice to people with specific benefits.

The demand for this specialised service has increased since the implementation of the welfare reforms.

The overall employment picture for Lambeth residents is positive: almost 80% of Lambeth's working age population are employed (the third highest rate in London) and the numbers of unemployed residents are considerably below its pre-recession average and in-line with the London average. Lambeth also has relatively low numbers of working age residents who are either not looking for work or not available for work (classed as 'economically inactive').

However; in **Lambeth, 19% of residents in work are paid below the recommended London Living Wage**. This indicates that around 30,000 residents are likely to be in work on 'low-pay' [↗](#).

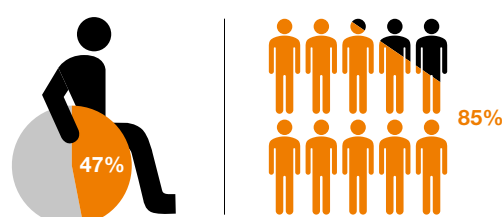
Poor working conditions, including the use of zero-hours contracts or unpredictable work patterns, are also an issue, and produce income insecurity and stress for our residents. Addressing these is a key priority for the Equality Commission in the coming year.

Figure 8
Black residents are 4 x more likely to be unemployed than white residents



Source: Lambeth Equality Commission


Figure 9
47% of disabled residents are employed compared to 85% of non-disabled residents




Source: Lambeth Equality Commission



Education and lifelong learning

As well as influencing other social determinants of health, such as income and employment, education outcomes (including but not limited to qualifications achieved) have been shown to have a wider impact on health, particularly healthy behaviours. This is true of school education, but there is also evidence that participation in [lifelong learning also has a range of health impacts](#) , including: mental health and wellbeing; sense of control over people's lives; prevention of cognitive decline; and, improved health literacy.


The majority of children in Lambeth have access to good quality education, and Lambeth's schools have made significant progress in performance, including in narrowing the gap for different groups of pupils. However, there are some groups of children and young people who are less likely to achieve good educational outcomes. This is not just about attainment; it relates to a wider set of issues including engagement, progression and risk of exclusion from school. Tackling all of these inequalities is an ongoing strategic commitment, and is a key priority of the [Lambeth Equality Commission](#) .

Inadequate housing

Whilst the relationship between housing and health is complex, there is evidence that poor housing is strongly associated with poor physical health and psychological distress; whereas, secure and good quality homes will lead to improved health.

The effects of London-wide housing issues are pronounced in Lambeth. There is a lack of affordable housing supply across both the social and rented sectors, and private rents are expensive. The number of people needing temporary housing is increasing, with the majority of households needing it now being placed outside the borough. There are also issues with the quality and adequacy of housing. Lambeth has high levels of overcrowding, and whilst the implementation of the Lambeth Housing Standard should have positive impacts for the quality of social housing in the borough; housing quality remains an issue for other residents, particularly those housed in some parts of the private rented sector.

Crime

Experience and fear of, [crime can have a wide ranging effect on people's health](#) , including their mental health and wellbeing; social capital and resilience; and participation in public life. Being a victim or a perpetrator of a crime – and particularly a violent crime – is also associated with a variety of health issues, including a range of mental health issues.

Lambeth suffers high levels of violent crime compared to the rest of London and the country more widely. In the last year, there has been a considerable increase in the numbers of knife crime related fatalities, with a disproportionate impact on young black men.

Social contact, social capital, participation and community

We know that increasing numbers of people do not have the social contact they want, and admit to being lonely [📺](#). This can contribute to a range of poor health and wellbeing outcomes. We also know that lack not just of social contact, but of social bonds based on trust ('social capital') has a negative effect on health outcomes (including the ability to [recover from illness](#) [📺](#)), as well on wider social determinants of health (for example, access to employment opportunities). Conversely, strong social and community relationships play an important role in promoting individual health. Participation in local organisations, including decision making forums, has also been shown to be a social determinant of health.

Lambeth has a long-standing tradition of active and engaged local communities, with high overall levels of community cohesion and trust between residents. However, we know that not everyone has relationships of trust or is likely to participate in local activities, clubs or decision making. For example, local evidence shows that [disabled people and older people, as well as some other groups, are less likely to participate in and feel connected to their local communities](#) [📺](#). We are also aware that there are a wider set of factors which may influence community ties, and which are relevant to Lambeth. For example, [high rates of people moving home within and between areas can disrupt social ties and community networks, and is related to higher levels of stress and mental health problems](#) [📺](#).

Watch the video



Lindsay, a Lambeth resident, talks about the impact of her chronic illness and how she has got involved in local creative activities.

[Click the screen above to hear more](#) [📺](#)

Built and natural environment

Factors associated with the built and natural environment such as noise, physical layout, air quality and the quality of green spaces also affect individual health and wellbeing [📺](#). We know from national evidence that access to good environments is uneven: residents

living in deprived areas are much more likely to be exposed to excessive noise pollution and poor air quality, both of which have wide ranging mental and physical health impacts. They are also less likely to have access to nearby green spaces. There is also emerging evidence that the existence of welcoming local communal physical spaces such as parks, libraries, or playgrounds, are important for encouraging people to assemble, get to know each other, and build communities- and can have a dramatic impact on health and wellbeing.

In Lambeth, the picture is mixed when it comes to the local environment. We have a number of award-winning parks but there is evidence that some groups of residents use these more than others. As an inner-city London borough, we suffer from issues relating to pollution and poor air quality – issues which we are taking a range of issues to address as a borough and with partners like TfL.

Relationships and family life

Stable and supportive family relationships are an important protective factor in people's health. In contrast, relationship problems and difficulties within a family are linked to poorer health outcomes, particularly relating to mental health and unhealthy behaviours such as drug and alcohol misuse. For example, we know that survivors of domestic abuse have a higher risk of mental health problems.

As one indicator of relationship quality, Lambeth has high reported rates of domestic violence. Recent trends show an increased need associated with this issue, including higher numbers of 'repeat victims' and an increase in the number of adult safeguarding concerns.

Caring responsibilities

Whilst having stable and supportive relationships is treated as an important determinant of health, there is typically less emphasis in formal models on the impact of having caring responsibilities for others (whether adults and children) on an individual's health. This is particularly important where the carer has main or sole caring responsibly, and it is long term.

We know that having more significant caring responsibilities has a knock on impact on other social determinants, including employment, income and social contact, which in turn will have a knock on impact on health [📺](#). In addition, the physical and emotional toll of caring responsibilities influence health outcomes. There is a relationship between intensity of caring responsibilities and health outcomes: [those providing 50 hours or more of care a week are twice as likely to be in bad health as the general population](#) [📺](#).

Watch the video



Raquel, a Lambeth resident, talks about the impact of being a carer for her learning disabled daughter.


[Click the screen above to hear more](#) 

Distribution of social determinants of health

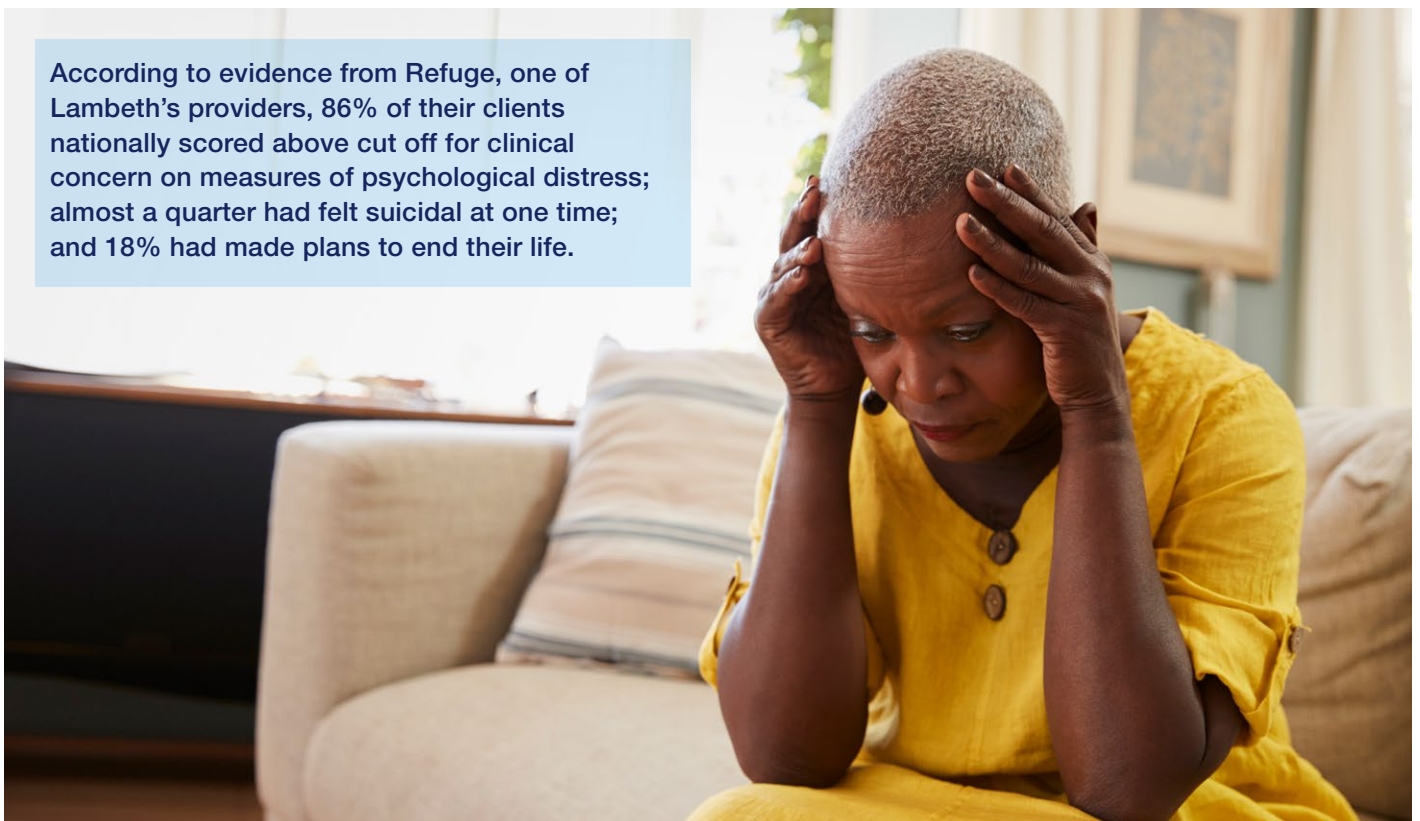
We know that in Lambeth, as elsewhere, the social determinants of health are unevenly distributed. This was shown in the work of the [Lambeth Equality Commission](#) , which charted a range of inequalities and made recommendations about what need to be done to address them. These are currently being implemented, alongside a range of other council, partner and voluntary and community sector led activities and initiatives to address these inequalities.

Looking across the social determinants covered here, we can see that some groups experience disadvantage across a range of areas. For example:

- Black Caribbean and Portuguese pupils are at greater risk of education underachievement, as are pupils with Special Educational Needs and Disabilities (SEND).
- BAME residents (particularly black residents), migrant groups (particularly Portuguese residents), disabled residents, and residents with a mental health issues are both more likely to be unemployed and to be in low-paid work.
- BAME people are disproportionately more likely to be victims of crime and are also disproportionately more likely to be represented in the criminal justice system.

Of course, whilst these statistics capture the disadvantage affecting groups with a single [protected characteristic](#) , we know that our residents will have multiple protected characteristics and that these will sometimes ‘intersect’ so that they are exposed to multiple disadvantages. For example, both BAME and disabled residents are more likely to be affected by education and employment disadvantage, and more likely to live in poverty. Multiple disadvantages may combine to contribute to worse outcomes and may also mean that the context in which health interventions need to be delivered is especially complex.

According to evidence from Refuge, one of Lambeth’s providers, 86% of their clients nationally scored above cut off for clinical concern on measures of psychological distress; almost a quarter had felt suicidal at one time; and 18% had made plans to end their life.



Chronic conditions

“We see a lot of patients with chronic conditions such as COPD without heating and hot water in their homes”

Nurse, @home team

The multi-disciplinary @home team deliver short term intensive clinical support in patients' own homes in order to avoid hospital admissions and facilitate reductions in length of inpatient stay.

However, a range of risk factors and inequalities underlie the acute episodes of illness that the team manage. For example poor quality housing, a lack of heating, alcohol misuse, smoking, obesity and poor diet contribute to the causation and exacerbation of injuries and conditions such as falls and COPD (chronic obstructive pulmonary disease). These factors are more common in deprived households. The wider socio-economic circumstances individuals find themselves in, and the impact of life-limiting long term conditions and social isolation on their wellbeing, can make it challenging to mitigate these risks and enable healthy behaviours.



Social injustices

“It’s a choice between ‘heat’ or ‘eat’ for some people”

Disabled resident

There are over 11 million people with a limiting long term illness, impairment or disability in the UK. They are likely to experience greater vulnerability to developing additional health conditions and have higher rates of premature death. Health inequalities result from the complex interaction of the social and economic inequalities experienced by disabled people.

Social injustices including unemployment and poverty are important drivers of health inequalities in this population. The financial impact disability, and resulting care needs, can have on individuals can be a significant stressor impacting on mental and physical health. In addition, everyday physical and attitudinal barriers to access are still experienced by disabled residents, including in health and social care settings.



Isolation

“I used to talk to the neighbour, but nowadays the only person I talk to is my community nurse”

Resident, 79

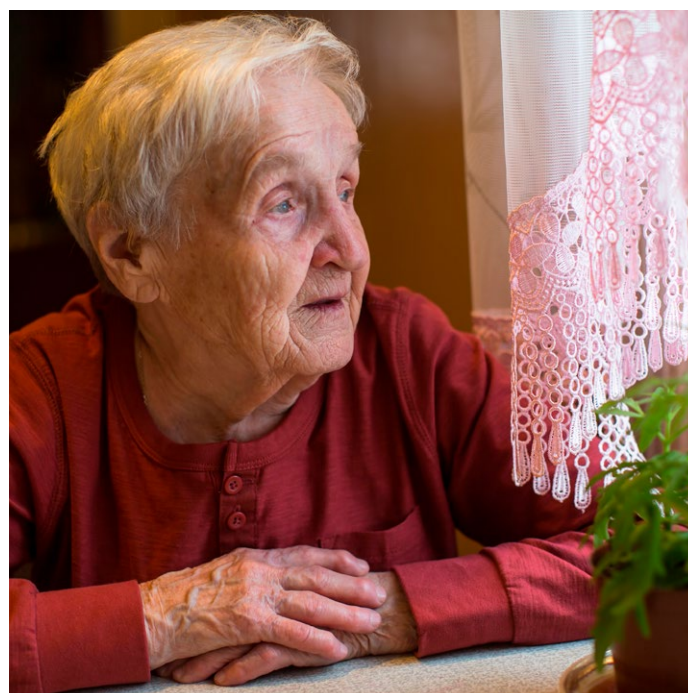
“Some people are so lonely its heart-breaking”

Nurse, @home team

Many residents with long term conditions have a limited, and declining, social network, which can bring about loneliness and reduced wellbeing.

Poor mobility, issues with inappropriate housing and bereavement can all contribute to reduced social networks and people spending increasing amounts of time at home.

Some residents are eager to take part in activities, but are not sure where to look to find these, and unable to travel far to get to them. Better signposting to local activities would boost the quality of life of many, and could also provide an opportunity to increase physical activity and improve diet for vulnerable residents.



LAMBETH'S PEOPLE

Key messages

1

Our population is growing, and we are the fifth most densely populated local authority in England and Wales.

3

Lambeth is very diverse borough, both in terms of ethnicity, but also in terms of a wider range of characteristics.

2

We are a highly mobile borough: large numbers both arrive and leave every year.

4

Understanding who our residents are and what matters to them is critical if we are going to deliver the health services and interventions they need, and reduce health inequalities affecting them.

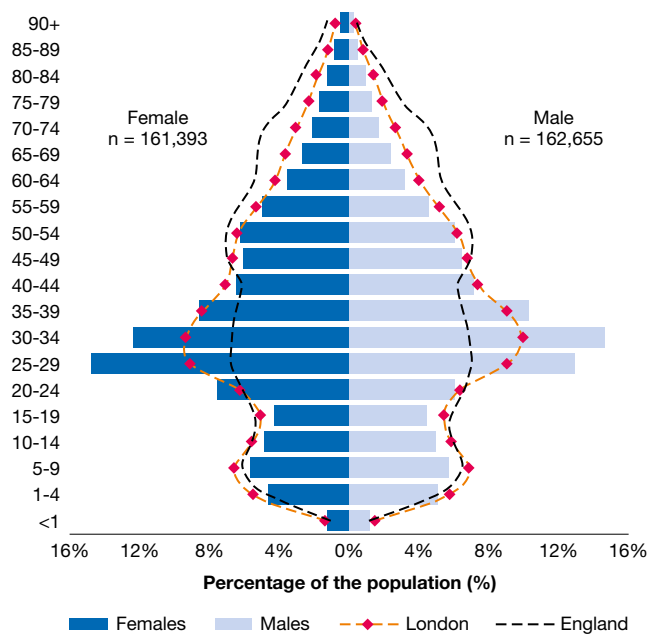
Demographic information

Lambeth has a resident population size of 324,800 and this is growing. The GLA demographic projections estimate Lambeth's population to grow from 334,724 to 346,279 (increase of 11,555) over the next ten years, representing a 3.5% increase between 2018-2028.

This growth is the result of migration and natural change. Lambeth's population is highly mobile: it has the fourth highest turnover of residents in England. Every year, 40,000 people leave the borough, and over 40,000 others move to it.

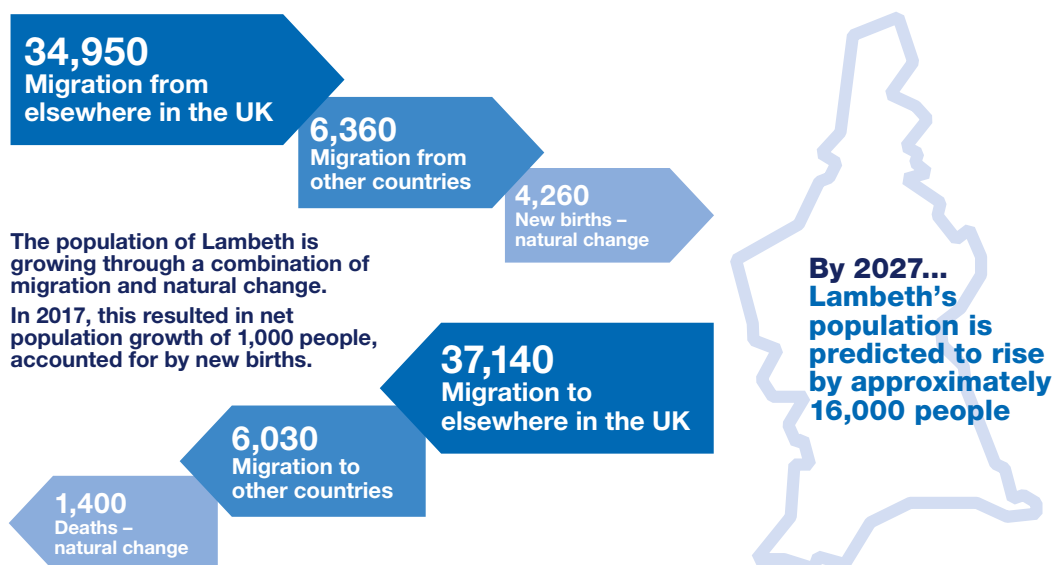
Lambeth has a relatively young age profile compared to the country as a whole. In Lambeth, around 51 percent of the population are aged 20-44, whereas in England this is only 34 percent. Consequently, Lambeth has a smaller proportion of older people when compared to England. This is projected to remain similar until 2025, but at the same time the population is ageing. Figure 3 shows a projected increase in the 55-74 age group and the 75+ age group by 35% and 20% respectively between 2015 and 2025.

Figure 10
Population pyramid, Lambeth vs London and England



Source: ONS mid-2017 population estimates (MYE)

Figure 11
Population growth in Lambeth



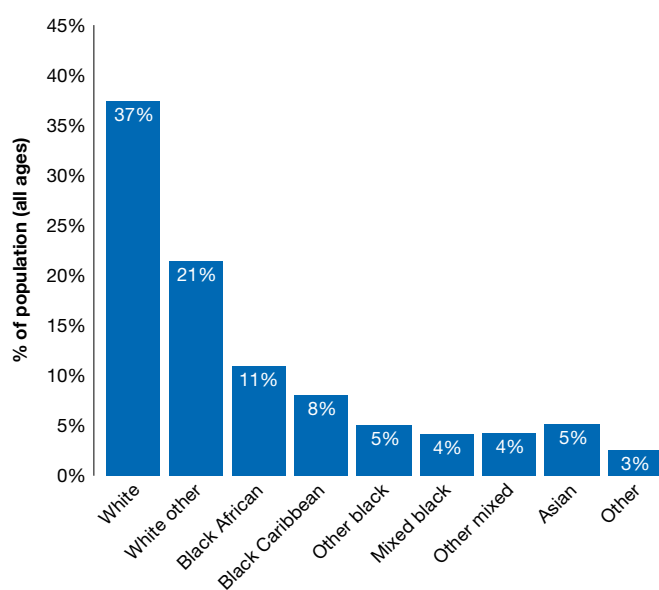
Source: ONS, Sub-national population projections 2016 (2017 to 2027)

Demographic information (continued)

Lambeth is an ethnically diverse population who identify with a range of different cultures and backgrounds. The Black, Asian and Minority Ethnic (BAME) community accounts for around 42 percent (60 percent including white other) of the total population. This compared to England, where over 80 per cent of the population is classified as White British. [For more detail, please consult the JSNA demography factsheet](#).

Overall, Lambeth has a relatively low rate of residents with limiting long-term health problems or disabilities across the population: 13% population or 38,670 residents say that day-to-day activities are limited by a long-term illness or disability, lower than the rate for London (14%). However, the rate is much higher for older residents: 60% of those with a long-term illness or disability are aged 50 and over. Similarly, the number of carers is lower than London overall, with 1.41% of the population (4,270 people) having caring responsibilities compared to the whole of London (1.83%).

Figure 12
Percentage of Lambeth's population by ethnic group



Source: GLA 2016 Round Ethnic Projections

Why does demography matter?

Demography encompasses range of factors including – sex, age, ethnicity – that affect population health. For example:

- There is a relationship between ethnicity and ill health, with BAME groups as a whole being more likely to report ill-health. Ill-health among BAME people also starts at a younger age than in the White British population.
- The age profile of a population will affect prevalence of different conditions. Understanding the current and future age structure of population is important for identifying health risks and protective factors at different life stages and learning how these can accumulate over people's lifetime. This helps us to consider critical periods in shaping long term health outcomes such as infancy and childhood.

Watch the video



The family nurse partnership offers targeted support to young mothers to help them and their children achieve the best start.

[Click the screen above to hear more](#)

High risk groups

Some groups of our residents are more likely to have unequal access to key opportunities, and to be more exposed/vulnerable to unfavourable social, economic and environmental circumstances which may lead to poor mental and physical health. They may also experience barriers to accessing health and other services.

Figure 13



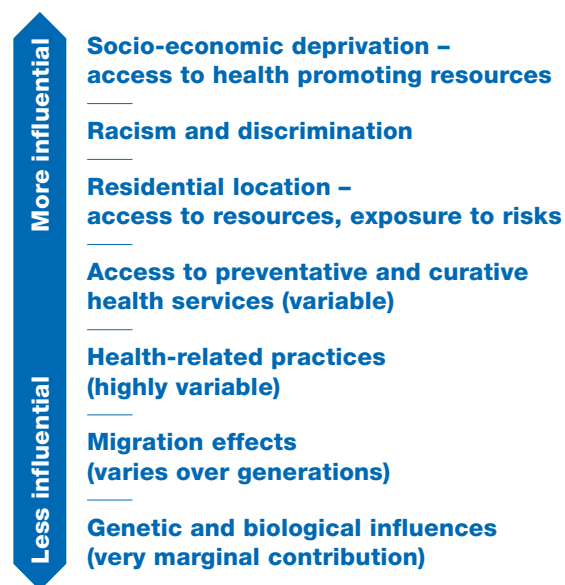
High risk groups (continued)

Factors contributing to health inequalities

A range of different factors contribute to health inequalities in high risk groups. For example, the following key determinants are known to be the main contributors to the health inequalities for Black Asian and Minority Ethnic (BAME) communities:

Figure 14

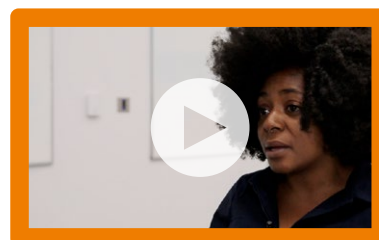
Key determinants to health inequalities Black Asian and Minority Ethnic (BAME) communities




Source: The PHE Health Equity Report, *Focus on Ethnicity*, August 2018



Watch the video



Click the screen above to hear more  about the causes of health inequalities from those working in the local community.

The following section draws out how we are seeking to meet the specific needs of our different population groups as part of our wider approach to addressing health inequalities and tackling specific conditions.

High risk groups (continued)

Case study Lambeth Portuguese Wellbeing Partnership

“Many, particularly the older, Portuguese residents are vulnerable and at risk of health inequalities because they don’t know the language, don’t know the services available and they don’t access the services”

Maria, Respeito

One in six Lambeth residents is a Portuguese speaker. Our Portuguese national communities are concentrated in the North of the borough, where they settled in the 1970 and 80s, arriving from Portugal and Madeira. Due to low levels of literacy, many ended up in low skilled jobs.

Deprivation and associated poor housing is an issue driving inequalities in this population, but isolation, alcohol misuse and domestic violence also feature, impacting family life and wellbeing. Control for blood pressure and diabetes markers is often very poor amongst Portuguese people, and they have the highest risk of cardiovascular disease compared to any other ‘white’ ethnic group locally.

The Lambeth Portuguese Wellbeing Partnership (LPWP) consists of over 40 individuals and organisations working together to address the health and wellbeing inequalities that the Portuguese community experience. The LPWP is taking a holistic view of the needs of the community, working with the grassroots organisations that provide front line support.

For more information visit

www.lpwp.org



IMPACT OF INEQUALITY ON HEALTH: ILLUSTRATED FOR FIVE CONDITIONS

Key messages

1

Whilst social determinants are the most important driver of health, health behaviours and lifestyles are a second driver of health.

2

All health behaviours take place within a social, cultural, economic, and environmental context. Some contexts may promote the adoption of healthy behaviours, while others make it more difficult.

3

Our approach to addressing key health issues is informed by:

- our understanding about the context in which specific health inequalities are produced;
- who is affected by these inequalities and, their specific needs;
- the behaviours that will lead to better health outcomes.

There is now a wealth of evidence that the wider (social) determinants of health are the most important driver of health. Our health behaviours and lifestyles are the second most important driver of health. They include smoking, alcohol consumption, diet and exercise.

While health behaviours have traditionally been viewed as a product of individual decisions; this interpretation is unhelpful, as it fails to take into account the influence of an individual's environment and history on their behaviour.

All health behaviours take place within a social, cultural, economic, and environmental context. Some contexts may promote the adoption of healthy behaviours, while others make it more difficult. People who are exposed to health inequalities have fewer opportunities to adopt healthy behaviours, which in turn reinforces the pre-existing inequality. In this way, health behaviours and health inequalities are inextricably connected.

Here, we illustrate the combination of these drivers of inequality in some of the most important health issues affecting Lambeth and share the work we are doing to address these. The health issues covered include:

- **Childhood obesity**
- **Sexual health**
- **Smoking**
- **Mental health**
- **Multiple long-term conditions**

Childhood obesity and inequalities

[Link to childhood obesity factsheet](#) 

Lambeth has high levels of childhood obesity. Childhood obesity is a consequence of complex factors related to individual biology, eating behaviours, and physical activity; set within a social, cultural and environmental landscape.

Childhood obesity is linked not only to poor physical health, but to wider social and mental health issues. For example, obese children are more likely to be absent from school and experience bullying, which in turn may impact their self-esteem and educational performance.

These impacts may be prolonged due to the 'conveyor belt' effect, in which excess weight in children continues into adulthood. Approximately 70% of obese children will become obese adults, leading to a greater risk of health problems and premature death.

What the main inequalities issues are

Local data shows that all ethnic subgroups in Lambeth are more likely to be obese compared to the White British group, with Black Caribbean and Asian residents nearly twice as likely to be obese. Children from lower socio-economic backgrounds are twice as likely to be obese compared to their peers from higher socio-economic backgrounds.

These inequalities are likely driven by inequalities in the social, economic, psychological, cultural, and physical environments of Lambeth residents. For example:

- Low-income households may be less likely to have disposable income for non-essential costs such as leisure-time physical activity, and are disproportionately affected by any increases in food prices.
- Areas of greater deprivation tend to have reduced access to environments that support physical activity such as parks, gardens, or safe play areas. Deprived areas also have increased exposure to cheap, unhealthy food, and poor access to healthy foods.

Figure 15

By age 11, 39% of children are overweight or obese



Source: NCMP

Childhood obesity and inequalities (continued)

Figure 16

It is three times more expensive to get the energy we need from healthy food than unhealthy food.



Source: Jones et al.

What we are already doing

Over several years, the Lambeth Public Health Team has carried an extensive programme of engagement and consultation activities with our communities, involving children, parents and other stakeholders on healthy weight, wellbeing and food issues. Lambeth is taking a system wide approach to address childhood obesity which includes a range of prevention and treatment interventions at individual, community and at borough policy level, using universal and more targeted approaches.

Universal initiatives include:

- Supporting breastfeeding through [UNICEF Baby Friendly Initiative](#) .
- Working with schools through the London Healthy Schools Programme and supporting them to maximise the local impact of national initiatives e.g. Healthy Pupil Capital Funds, Change4Life.
- Making healthy weight “everybody’s business” by developing the capacity of all those who work with children and young families to effectively raise the issue, provide evidence based advice and signpost to relevant local healthy eating and physical activity initiatives.
- Working with local community organisations to promote food growing and access to other local food related activities.
- Supporting Healthy High Street projects and working with local food businesses and to increase the availability and affordability of healthier food options.
- Implementation of a borough wide policy to restrict more fast food premises opening near schools.

Targeted initiatives include:

- Provision of targeted nutrition support and advice to families from disadvantaged backgrounds and at risk of poor nutrition and its consequences; right from supporting breastfeeding, the introduction of solids for infants to a balanced healthy diet for children and young people. Additional support is offered on how to practically eat healthily on a budget.
- Promoting the uptake of the Healthy Start vouchers with a local supplement for additional fruit and vegetables for low income families.
- For those children who are already at risk, weight management support is offered to them and their families through bespoke programmes and assistance from a specialist school nurse.

What we are going to do in the future

The success of place-based approaches demonstrates the value of a systems-wide approach to childhood obesity, embracing local communities, businesses, and statutory and voluntary sectors.

We will continue to address the issue of rising food poverty by tackling its root causes, and the issue of “holiday hunger” affecting those children who access free school meals.

Lambeth has many beautiful, award-winning parks. We will create opportunities to use these assets to improve the health and wellbeing of our residents, including increasing accessibility and making better links with the NHS.

Case study 1

Gipsy Hill Village Food Project

Lambeth was nominated Food Flagship Borough in recognition of the work being carried out to address the food environment. The Gipsy Hill Food project was implemented as part of the Food Flagship Programme, and worked with residents to identify local food issues and solutions. This approach helped residents to connect, network and support each other as well as making links with local organisations and other borough services.

Childhood obesity and inequalities (continued)

Case study 2 Understanding the impact of food poverty and addressing the causes

Understanding the impact:

Food poverty is an increasing problem around the UK, and holiday hunger, where families struggle to feed children over the school holidays, is one manifestation of this. Research with local residents was undertaken in August 2018 to discuss the issues of feeding children during the summer holidays. There was generally a consensus that holiday hunger is an issue in Lambeth, which manifested in eating cheaper but less healthy foods, or a reliance on food banks. Holiday hunger was considered a direct result of low level of income, but some participants mentioned time as a factor for parents who were working and for whom takeaways are a convenient alternative to cooking.

Addressing the causes:

Public Health supports the implementation of a range of measures to address food poverty and its consequences. The team carries out a yearly assessment on the progress being made in the borough to improve the provision of good food and address food poverty. A range of indicators are used to measure the progress being made across all London boroughs. These are published by Sustain as annual reports with league tables. This year, 2018 (and in 2016); Lambeth was assessed as the borough doing the most to address food poverty.

Case study 3 Rachel

Rachel, a young mum with two children (a seven and three year old), had recently moved to Lambeth from another London borough. At the time she came into contact with her local children's centre she was expecting her third child. She had attended the centre because a neighbour knew she was struggling and thought she would get help there the same way the neighbour had.

The first session Rachel attended was 'Cook & Eat', a practical and hands-on support session delivered by community food workers. This included cooking and healthy eating tips and advice, help with shopping on a budget and other practical help, including signposting to other services. This led to Rachel meeting several of the team members at the children's centre. She was told about the Healthy Start Voucher and given help to apply. The centre staff were also able to sign-post her to another support session being delivered by the Rose Voucher programme. This provided her with financial help to purchase fresh fruit and vegetables and milk.

Rachel's oldest child is eligible for free school meals, but during the school holidays, she felt the financial strain of having to provide an additional meal. She was also signposted to a holiday club. This meant that during school holidays her seven year old had somewhere to go, friends to play with and she was also re-assured that her child would get a healthy meal during the school holidays. Rachel felt that the support she got was so invaluable to her overall wellbeing and her children's, that when an opportunity arose to become a parent champion she was very enthusiastic to attend the training that was being provided. She is now a local champion and has recently recruited two more of her neighbours with small children to be involved as well.

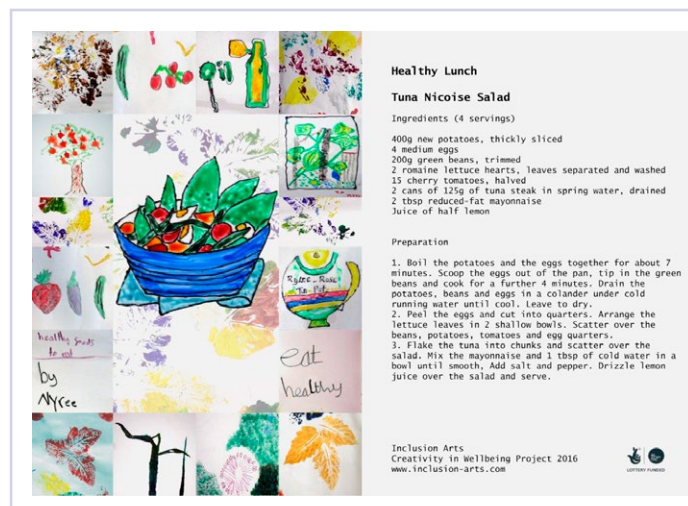


Figure 17
An image from Inclusion Arts 'Creativity in Wellbeing' project, which aimed to promote food growing and healthy eating to members of the community, particularly those at risk of obesity and ill health. This project was funded by Big Lottery.

Sexual health

Inequalities in sexual health in Lambeth can be characterised in three main areas; teenage pregnancy, abortion, and HIV and sexually transmitted infections. This is an overview of these issues. The recently refreshed Lambeth, Southwark and Lewisham Sexual Health Strategy provides further detail on these differences and how we plan to address them.

Teenage pregnancy

What the main inequalities are

At the community level, child poverty and unemployment rates are particularly strongly linked with under-18s conception. As different areas of Lambeth experience different degrees of deprivation, the risk of teenage pregnancy is distributed unequally across the borough.

Through a whole-system approach, including good local sexual health services, teenage pregnancy rates have fallen significantly in Lambeth since 2002, and at a higher rate than nationally. Consequently, the rate of teenage pregnancy in Lambeth in 2016 was very similar to the

national average. In real terms this meant that 200 fewer teenagers per year became pregnant between 2006 and 2016. The number of babies born to teenage mothers is at an all-time low. This is important as we know being the child of a teenage parent has an intergenerational impact on inequality.

PHE has identified 10 key factors of effective strategies to reduce teenage conceptions [1](#). Many of these are already in place in Lambeth and have contributed to Lambeth's success with reducing teenage pregnancy rates over the recent years.

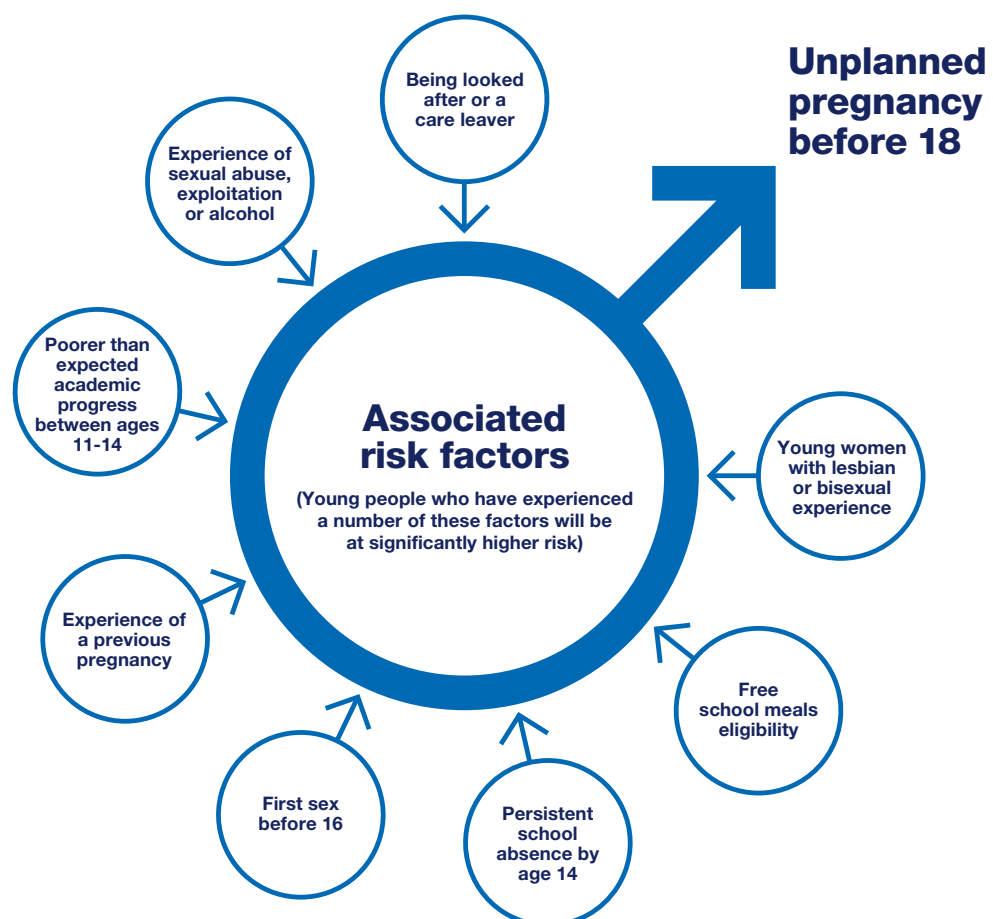
Universal initiatives include:

- Come Correct scheme (delivered by Brook) – free condoms and information for all people under 25. Condom distribution schemes have been found to be successful at a national level and this is reflected in the high number of repeat users we see locally.

Targeted initiatives include:

- The integrated substance misuse and sexual health service for young people has specific sessions for Children Looked After as well as those involved with the Youth Offending Service.

Figure 18
Risk factors for unplanned pregnancy before 18



Sexual health (continued)

What we are going to do in the future

The joint Lambeth, Southwark and Lewisham sexual health strategy for 2018-2023 highlights the need to reduce inequalities in sexual and reproductive health.

Abortion

High rates of abortion and particularly high rates of subsequent abortions (more than one within a year) are thought to reflect an unmet need for contraception. The time immediately following abortion is important for contraceptive intervention, particularly long-acting reversible contraceptive (LARC) methods. However, LARC uptake in abortion services in LSL has remained below 45% since 2014/15, and has now declined to around 20%. This may be due to the increase in women choosing early medical abortions (EMAs) which do not require clinical follow-up and therefore these women may miss out on the opportunity to discuss LARC methods post-abortion.

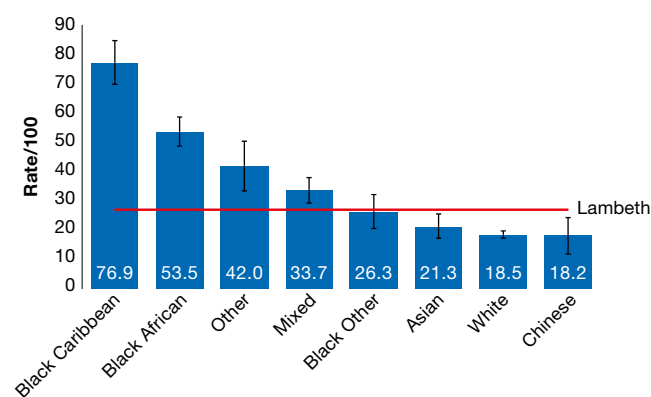
What the main inequalities are

Not only are there inequalities in rates of abortion and subsequent abortion between Lambeth and both London and England as whole, there are also significant inequalities within Lambeth between different groups of women.

Local data shows that in 2017, there was a significant disparity in abortion rates between women of different ethnicities, with women who identify as Black Caribbean (over three times more likely) and Black African (twice as likely) being most likely to have an abortion.

In 2017, 40% of abortions in Lambeth were among women who had a previous abortion (compared to 42% for London and 39% for England). 11% of women aged under 19 who had an abortion had had a previous abortion compared to 32% for under 25s and 45% for over 25s. Again, Black African and Caribbean women were most likely to have repeat abortions.

Figure 19
Termination of pregnancies by ethnicity



Source: BPAS-MSI (local analysis)

What we are already doing

Examples of universal services

- Free universal contraception services, including LARC, through primary care (GPs) or through sexual health clinics.
- Free emergency hormonal contraceptives through a number of pharmacies as well as GPs and sexual health clinics.

Examples of targeted services

Tailored sexual health services for young people, and targeted outreach services for Black African & Caribbean communities as well as Men who have Sex with Men across Lambeth, Southwark & Lewisham (see case study).

What we are going to do in the future


A key indicator of unmet contraceptive need, and therefore the risk of abortion, is the repeat use of emergency hormonal contraception or “morning after pill”. Repeat use of emergency contraception follows similar patterns to abortion. The current pharmacy-based emergency contraceptive service will soon be expanded to enable dispensing of regular oral contraceptive and booking of fast-track clinic appointments for LARC fitting. This aims to improve access to all contraceptive options in the community thereby reducing the risk of unplanned pregnancy and abortion for the most at-risk women.

The sexual health strategy outlines plans to reduce the rate of subsequent abortions by 20% by ensuring that every woman can have a LARC method fitted in either primary care or sexual health services within 4 weeks of booking an appointment³.

³ Data for Lambeth, Southwark and Lewisham.

Sexual health (continued)

HIV

Lambeth has consistently had the highest prevalence of HIV amongst England boroughs, [with 2017 figures showing the rate of new diagnoses at 42.2 per 100,000 compared to 8.7 for England and 21.7 for London as a whole](#) . However incidence (new cases) of HIV has reduced significantly in Lambeth over recent years, much more rapidly than the national rate of decline, within the context of better testing coverage – 2017 figures show that HIV testing coverage in Lambeth was 68.9%, significantly better than the England average of 65.7%.

Early diagnosis is crucial to minimising the health impacts of HIV. Currently in Lambeth, more than a quarter of people living with HIV received a late diagnosis, however Lambeth (along with most of London) has consistently performed better on this outcome than the rest of England.

These successes are largely due to evidence-based universal and targeted prevention initiatives.

Since its inception in 2014, the London HIV Prevention Programme has been hosted in Lambeth on behalf of all London boroughs. Key components of the programme include:

1. 'Do It London', the award-winning campaign that promotes testing and safe sex to all Londoners.
2. Targeted condom provision, outreach and testing services for the most at-risk groups.

Other key factors contributing to the recent decline in new HIV infections include the availability of pre-exposure prophylaxis (PrEP) to at-risk groups as part of the national PrEP impact trial and high-quality locally commissioned services delivered by community-led organisations (see video and case study).

Watch the video



Hear more about HIV peer counselling.

[Click the screen above](#) 

London, with Lambeth playing a key role, has become the third city internationally to exceed the UNAIDS 90-90-90 target. In 2017:

- **92% of Londoners living with HIV infection were diagnosed**
- **98% of HIV+ Londoners are on treatment**
- **97% of Londoners on treatment have an undetectable viral load and therefore cannot transmit the virus**



What are the main inequalities?

The burden of HIV, both nationally and locally, is highest in men who have sex with men (MSM) and in Black African communities. In 2016, the majority (76%) of new HIV diagnoses were in men, and specifically in men who have sex with men (MSM). In terms of ethnicity, men and women show different patterns of inequality. Of all men diagnosed with HIV in 2016, 64% were White, and of all women diagnosed with HIV, 64% were Black African⁴.

Considerable inequalities also exist for timely diagnosis, with people aged 50-64, people identifying as Black African or Other ethnicity, and people exposed through heterosexual contact being at highest risk of a late diagnosis.

What are we already doing

Universal

- Free self-sampling tests via the recently established sexual health online service ([Sexual Health London](#) ) as well as all sexual health and primary care services
- [London-wide media campaign for prevention and testing](#) 

Targeted

- Outreach services in key venues used by MSM
- Outreach services tailored to BAME communities
- Community-led HIV peer counselling

What are we going to do in the future

Whilst good progress has been made in reducing the impact of HIV on the population in Lambeth, more needs to be done to reduce inequalities. Tackling stigma in BAME communities and improving testing uptake amongst women, heterosexual people and people over 50 will be key to doing this.

Along with the rest of London, which is now an HIV Fast-Track city, we are now working towards achievement of the Fast-Track cities target of 0-0-0: zero HIV-related stigma, zero HIV transmissions, and zero HIV-related deaths.

⁴ Data for Lambeth, Southwark and Lewisham.

Sexual health (continued)

Case study **RISE**

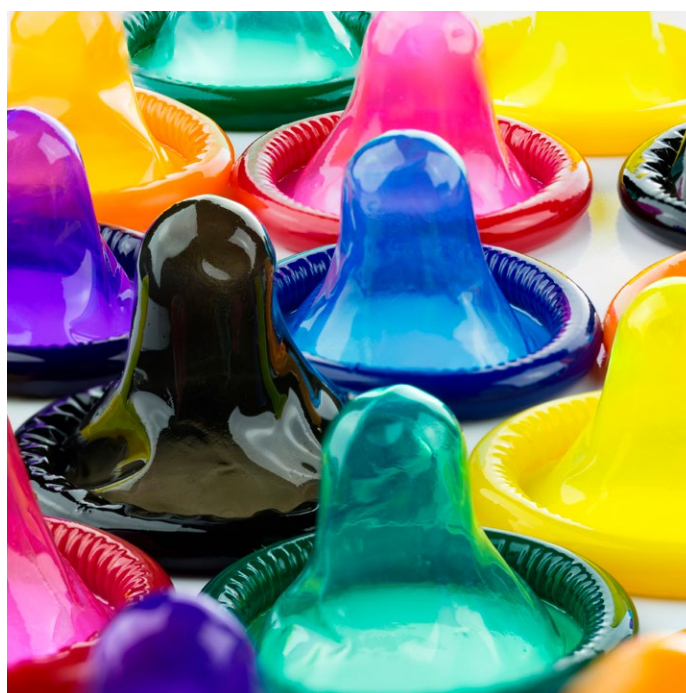
Lambeth commissions the RISE Partnership to provide sexual health services to Black African & Caribbean communities as well as MSM across Lambeth, Southwark & Lewisham. NAZ, a sexual health charity within the partnership, is dedicated to delivering culturally-sensitive sexual health services to Black, Asian and Minority Ethnic communities. Below is an example of how their work has had an impact.

During an outreach session in Lambeth last February, a Black African female resident engaged with the service for an HIV test. Through discussion it emerged that her partner was in West Africa and she was concerned that when she next visited him they would have condomless sex as this was his preference. She was concerned about contracting HIV but didn't know that she was eligible for pre-exposure prophylaxis (PrEP) as she was at high risk of HIV.

After a conversation about the efficacy and ease of use of PrEP, she felt confident about accessing the treatment and using it when visiting her partner. She felt that this was a good solution as it provided her with the protection she needed whilst avoiding awkward conversations with her partner about condomless sex.

She was given an HIV test with direct referral made to PrEP trail at the Caldecott Centre. NAZ is able to directly refer to this service, and this relationship gives their clients the confidence that they will be seen quickly and won't have to wait in long queues.

For more information visit
www.risepartnership.co.uk 
www.naz.org.uk 



Smoking and inequalities

Smoking is the single biggest preventable cause of death and illness in Lambeth, and the most important driver of health inequalities.

The highest rates of smoking are consistently found among those who are most disadvantaged. People whose control over their daily lives is highly constrained, and who do not have the resources and opportunities to thrive, are most likely to be smokers and least likely to quit.

The more disadvantaged a person is, the more likely they are to smoke, and to suffer from smoking-related disease and premature death. Smoking is transferred across the generations in a cycle underpinned by social norms, familiarisation, and addiction. In poorer communities, young people are more exposed to smoking behaviour, more likely to try smoking and, once addicted, they find it harder to quit.

What the main inequalities issues are

Like the rest of England, overall smoking rates in Lambeth have fallen (14.6% in Lambeth). However, stark inequalities remain across different population groups. Smoking is more than twice as common in the 'routine and manual' occupational group than in the 'managerial and professional' occupational group.

Smoking rates amongst people with a mental health condition (approx. 40%) are significantly higher than in the general population. This association becomes stronger as the severity of the mental health condition increases. As a result of high smoking rates, people with a mental health condition also have high mortality rates compared to the general population, and smoking is the single largest contributor to their 10-20 year reduced life expectancy.

There is also higher smoking prevalence among LGBTQ+ adults, which may likely to be linked to higher stress levels and poorer mental health in this population.

Smoking rates tend to be higher in the following groups compared to the general population:

- People who are unemployed
- People who are homeless
- People who receive welfare benefits
- People with no qualifications
- Lone parents

Smoking could push certain groups below the poverty line. Almost half of all the children living in poverty in the UK live with at least one parent who smokes. In these households, low incomes are driven down further by spending on tobacco, squeezing resources for basic needs. ASH estimates that when net income and smoking expenditure is taken into account, 17% of Lambeth households with a smoker fall below the poverty line. If these smokers were to quit, 2,006 households in Lambeth would be elevated out of poverty.

What we are already doing

A comprehensive tobacco control approach is being implemented to reduce health inequalities. This focuses on preventing the most vulnerable from taking up smoking, and targets support to disadvantaged smokers to help them quit. Specific initiatives include:

- Highlighting the risks of tobacco use through health and wellbeing school programmes to prevent children taking up smoking.
- Tackling illegal tobacco sales. This involves enforcing laws against underage tobacco sales, and working with communities to stop illicit tobacco. Cheap tobacco makes smoking affordable, which reduces people's motivation to quit; encourages smokers to smoke more; and makes it easier for children to take up the habit.
- Specialist stop smoking support for smokers from disadvantaged groups and those with long term conditions, including mental health and pregnant women.
- Promotion of smoke free environments, particularly to protect children by making playgrounds in local parks smoke free.
- Increasing access to stop smoking support through the London Stop Smoking Portal.

What we are going to do in the future



As the more addicted smokers tend to be the most disadvantaged, taking a holistic approach to support quitting will be important and may require the use of harm reduction measures.

The NHS plays a significant role in identifying smokers but are also in an ideal position to offer effective brief advice, including prescribing relevant medication and signposting to appropriate stop smoking support. In addition, hospital trusts should consider providing stop smoking support, using evidence based approaches such as the Ottawa model. This has been further endorsed by the NHS long term plan.

Mental health

Lambeth experiences a comparatively high burden of severe mental ill-health compared to the London average. In Lambeth, 1.4% of people aged over 18 years registered with GPs have a severe mental illness (defined as patients with schizophrenia, bipolar affective disorder and other psychoses⁵). This compares with a national rate in 2016/17 of 0.92% in England as a whole, and 1.1% in London.

Common mental illnesses, including depression, are also prevalent in the borough with 8.5% of the local population aged over 18 being on the depression register⁶.

However, we know from the recent [SELCoH research](#)  that rates of common mental illness (anxiety, depression or both) in South East London are higher than our GP registers suggest, with nearly 1 in 4 people having symptoms. There is also [a higher prevalence of Common Mental Disorders \(CMD\), including a nearly four-fold greater proportion of depressive episodes, in a South East London study population than in England as a whole](#) .

There are inter-linking physical, social, environmental and psychological causes for mental illness, and a person's mental health and many common mental disorders are shaped by the various social, economic, and physical


environments operating at different stages of life. Risk factors for many common mental disorders are heavily associated with social inequalities, whereby the greater the inequality the higher the inequality in risk.

There is a link between psychosis and living in urban, densely populated neighbourhoods such as ours; with chronic stress, discrimination and stigma being important contributory factors.

The early years are critical. With 50% of severe mental disorders emerging prior to 14 years of age and 75% emerging by 24 years of age. Pre and postnatal maternal health, family relationships and adverse childhood experiences influence this picture.

What are the main inequalities?



Socio-economic factors

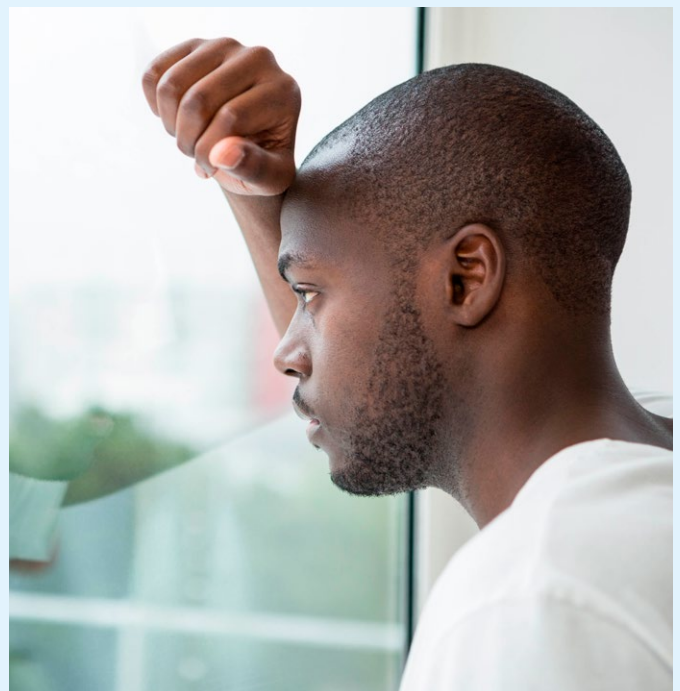
The relationship between deprivation and mental health is complex and it is hard to disentangle cause and effect. Experiencing disadvantage can increase the risk of mental health problems. People with mental health problems can be affected by a 'spiral of adversity'⁷ where factors such as employment, income and relationships are impacted by their condition. [People who live in deprived areas are more likely to need mental healthcare but less likely to access support and to recover following treatment](#) .

This compounds and worsens mental health problems.

Young people with mental health issues can experience an accumulation of challenges over their life course. For example, one mother revealed that her son, who was experiencing mental illness, was involved multiple times with the police and justice system but that his mental health issues were rarely recognised within the way his case was managed. In addition, experiencing mental illness as a young adult impacted his ability to gain qualifications.

Now he is older, she expects his history of mental illness, involvement in the justice system and lack of qualifications is likely to impact his ability to find employment.

Vulnerable and disadvantaged children and young people are also [less likely to access mental health services](#)  and [attend arranged appointments](#)  so therefore may not receive the care they need. Pro-active case-finding is therefore essential in reducing such inequalities for young people.



^{5, 6} GP register data as at April 2018.

⁷ Faculty of Public Health, Mental Health Foundation. Better Mental Health for All: A Public Health Approach to Mental Health Improvement (2016).

Mental health (continued)

Deprivation is an important risk factor for mental ill health in our population. A study of the Lambeth and Southwark population (South East London Community Health (SELCoH) study) has highlighted that participants from lower socioeconomic groups (those with lower income and/or education) were more likely to meet the criteria for CMD, to rate themselves as having fair or poor health and to report long standing illness than those in higher socioeconomic groups.

Unmanageable financial debt is also associated with poorer mental health. This finding has been highlighted locally in the SELCoH research, with a clear association found between those reporting debt and those with mental health symptoms. **Further, reporting debt was strongly associated with mental health service use in the past year** [\[1\]](#).

Drugs & alcohol

Harmful use of alcohol or drugs often contributes to or co-exists with mental health problems and leads to poorer outcomes. People with co-occurring mental illness and alcohol/drug use often have multiple needs, with poor physical health alongside social issues such as debt, unemployment or housing problems. They are also more likely to be admitted to hospital, to self-harm and to die by suicide.

Lambeth has a higher rate of concurrent contact with mental health services and substance misuse services for drug misuse than in London and England. Illicit drug use in the past year has been found to be higher in the SELCoH

study population as compared to England, with cannabis and cocaine the illicit drugs reported most frequently.

However, the prevalence of hazardous alcohol use was higher in the national sample than in SELCoH [\[1\]](#).

Physical health

Mental and physical health are inextricably linked and are both determinants and consequences of each other.

On average, men with severe mental health conditions die 20 years earlier, and women die 15 years earlier, than the general population. Compared with the general population people in contact with specialist mental health services have:

- Nearly 4 times the rate of deaths from diseases of the respiratory system.
- Just over 4 times the rate of deaths from diseases of the digestive system.
- Nearly 3 times the rate of deaths from diseases of the circulatory system.

Much of the extra burden of poor physical health among those with mental health problems can be explained by health behaviours such smoking and alcohol. Other factors also play a part such as barriers to receiving adequate physical healthcare; less than a third of people with schizophrenia in hospital received the recommended assessment of cardiovascular risk in the previous 12 months.

Figure 20
Up to 47% of study participants with debt problems reporting mental health symptoms



Mental health (continued)

Ethnicity

Black residents are disproportionately likely to present with severe mental illness. In Lambeth, if you are of black heritage, you are twice as likely to have a severe mental illness compared with your white British counterpart and more likely to be sectioned under the Mental Health Act. From GP records we know that:

- 1.4% (1,370) of those from a white British background were registered with severe mental illness.
- 2.8% (1,900) of those from black backgrounds were registered with severe mental illness.

However, the picture is not uniform within the black community. Numerically the largest group of black people affected in Lambeth continues to be those from a black Caribbean background:

National data on contact with mental health services shows that black people are more likely to arrive in services with more severe mental ill-health, have greater contact with the police, and are more likely to be compulsorily detained under the Mental Health Act and restrained whilst in hospital.

Intersectional inequalities, stigma and discrimination

Identifying high risk groups for common mental disorder (CMD) is not always straightforward. For example, local research has found no difference in CMD by ethnicity or migration status when considered separately but rather

when risk factors and inequalities are considered together it emerges that there are **two distinct high risk groups for common mental illnesses locally** [↗](#):

1. Migrant, mixed ethnicity and low socioeconomic status.
2. UK-born, white ethnicity and low socioeconomic status.

Stigma, prejudice and discrimination appear to be on the rise, with examples of racism and assault against migrants and religious and ethnic minorities. In south east London **discrimination is associated with higher rates of common mental health conditions, and this effect was strongest for individuals who had recently migrated to the UK, an ethnically heterogeneous group, and black ethnic groups** [↗](#).

Sexuality

LGBTQ people can be at a higher risk of experiencing a mental health problem than the wider population.

The reasons for this are complex and not yet fully understood. However, mental health problems experienced by LGBTQ people have been linked to:

- Discrimination
- Bullying
- Homophobia, biphobia or transphobia

Adverse mental health outcomes among non-heterosexual individuals compared to heterosexual individuals have been identified in the South East London population, with more pronounced disparities in the local area in comparison to national data [↗](#).

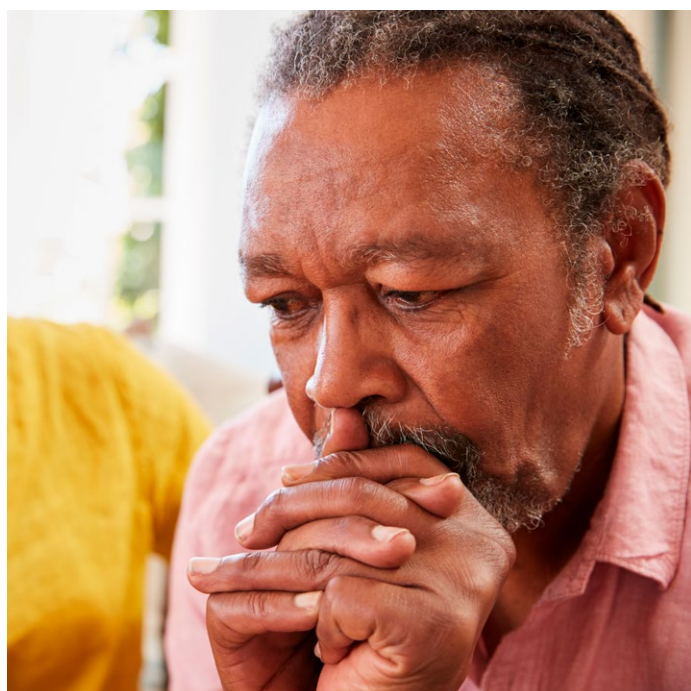
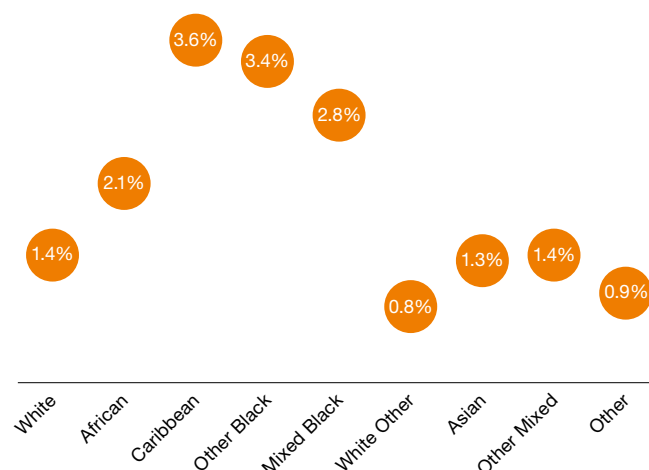


Figure 21
Detected SMI prevalence by ethnicity in Lambeth





Source: Lambeth DataNet, Registered GP patients

Mental health (continued)

Neighbourhood violence and mental health

Crime, safety and violence in Lambeth are a key area of risk in relation to mental health. Lambeth has the highest rate of first time entrants to the youth justice system in London, and high rates of both first-time offenders and re-offending. Lambeth also has the 8th highest rate of violent crime in London. Overall, Lambeth has the greatest level of 'crime deprivation' (representing the risk of personal and material victimisation) in London.

With regards to neighbourhood experiences, evidence from local research showed that [concern about neighbourhood disorder, experiencing and witnessing violence are all independently associated with greater odds of CMD](#) . Levels of concern about neighbourhood disorder, particularly crime, are high in Lambeth, especially in the youngest age group (16-24-year olds) and those who are unemployed. Concern about disorder was found to be greater in income deprived areas, with this acting as more important predictor of concerns than an area's reported crime rates. There is significant overlap between violence perpetration, being a victim of violence and witnessing violence in the SELCoH study population and a complex relationship between exposure to violence and mental disorders.


An [association between exposure to one or more types of violence in the past year and current mental disorders has been found in the local population](#)  as summarised below:


Exposure to violence (in the past year)	Associated mental disorders
Witnessing violence	Current Common Mental Disorder Post-traumatic stress disorder (PTSD) symptoms
Violence perpetration	Current CMD PTSD symptoms Illicit drug use
Victimisation	Lifetime and recent drug use

Lifetime exposure to two or more types of violence is associated with increased risk for all mental health outcomes, suggesting a cumulative effect in the South East London population. A persistent relationship between exposure to violence and abuse, particularly in childhood, with experiences of psychotic symptoms in adulthood also exists locally.

What we are already doing – and what we will do more of in the future


There are significant challenges to commissioning mental health services in Lambeth such as high demand for services, lack of co-ordination between services, financial pressures as well as healthcare inequalities. In order to address these and improve the experience and outcomes for users of mental health services in Lambeth, the system needs to continue to change and develop.

The [Living Well Network Alliance](#)  (LWNA), a unique collaboration of commissioners and providers, is starting to apply an outcomes-based contracting approach to mental health services. This shift is considered to be potentially transformative for the mental health system in Lambeth. Outcomes-based contracts shift the focus, challenging providers to design and deliver services in a way which meets these ambitions.

As part of this commitment, we are implementing the recommendations of the Black Health and Wellbeing commission (2014) through the [Black Thrive partnership](#) .

Watch the video



Hear about Black Thrive.
Click the screen above 

Multiple long term conditions

'Multiple long term conditions' (mLTCs) refers to the co-existence of two or more chronic/long term conditions, each one of which is either:

- A physical non-communicable disease of long duration, such as a cardiovascular disease or cancer.
- A mental health condition of long duration, such as a mood disorder or dementia.
- An infectious disease of long duration, such as HIV or hepatitis C.

mLTCs are very common: in Lambeth, more than 20% of the population will be affected.

mLTCs are an important public health issue because they are linked to a range of adverse consequences including: increased risk of emergency admission to hospitals, reduced quality of life, increased risk of premature death, impact on care givers and wider economy more generally (sickness absence, unemployment). They also account for the majority of NHS expenditure: treatment and care for people with long-term conditions is estimated to take up around £7 in every £10 of total health and social care expenditure.

People are more likely to develop mLTCs if they smoke, have a poor diet or high blood pressure, so that controlling these key risk factors has a protective effect. Certain "primary" long term conditions may also be risk for developing further mLTCs, including: diabetes, heart disease, poor mental health. Managing these well is therefore important in helping to prevent the development of other mLTCs.



There is also emerging evidence that exposure to adverse childhood events also increases likelihood of known risk factors for LTCs as well the risk of LTCs in adulthood.

What the main inequalities issues are

As might be expected, age increases the chance of being affected by mLTCs, although it is not uncommon in younger people: they affect 58 per cent of people over 60 compared to 14 per cent under 40. People who live in deprived areas, lower socio-economic groups and BAME groups are more likely to be affected earlier in their lives.

What we are already doing

- Local implementation of a number of evidence-based guidelines for managing individual LTCs.
- A programme to improve detection of people with undiagnosed high blood pressure.
- A programme to improve care processes for people with diabetes (an important primary condition that leads to other secondary conditions).

What we are going to do in the future

- Seeking improvements in the reduction of known risk factors both at individual and population levels (e.g. strategies to tackle unhealthy weight, tobacco control, control blood pressure). This will include better management in primary care.
- Improving care coordination of people with mLTCs by implementing recommendations from recently published NICE guidelines on mLTCs. This will involve tailoring our approach to supporting people affected; improving their quality of life by reducing treatment burden, adverse events and unplanned care; and, focusing on individual needs, preferences and priorities.

Watch the video



Hear more about community connectors and how they link people in to holistic support.

[Click the screen above](#) 

CONCLUSIONS AND RECOMMENDATIONS: ACTIONS TO TACKLE INEQUALITIES ACROSS THE SYSTEM

Lambeth has made great progress in the last 10 years to reduce many of the health inequalities described in this report.

This progress was made against the backdrop of a rapidly changing borough, which is experiencing economic growth and improved life chances for many. But we cannot take this for granted.

In Lambeth, as elsewhere, the impact of external factors including austerity puts the progress we have made at risk.

Whilst many of these differences in health outcomes have been known for over 30 years we rarely discuss them with the communities most impacted. Black Thrive is a great example of how our approach is changing.

We need to show a commitment to overcoming some of the barriers to good health from the perspective of our residents, including making Lambeth a healthier place to live. This is more, not less, important in the current financial context. We need to treat our residents' health as an asset, invest in it and protect it.

The development of our local integrated health and social care system "Lambeth Together" provides us with an opportunity to embed new ways of working with local people. Improving health and social care in Lambeth is underpinned by three approaches, linked to the themes of this report of place, people and opportunity:

- Health in All Policies
- Active and empowered communities
- Integrated health and social care delivery

A place for health

As Lambeth changes as a place we need try to "design in" health and wellbeing. The quality of local environments is

important for attracting investment and growth. It is also important to consider how residents feel about their local area. Good quality local environments can also improve public health and wellbeing, by creating opportunities for social interaction, fostering good social relationships, and discouraging crime.

By identifying areas of the borough that are either in danger of being left behind, or where there is more potential to harness the benefits of change, we can support better health outcomes for all. This is about understanding the distribution of poverty, education and employment; and, also about understanding the strength and resilience of our local communities, and assessing how far the physical environments in which they live support good health.

Through Lambeth Together our community based health and social care services will increasingly focus around smaller level geographies through the development of networks of neighbourhood care. This means that services, as well as a wider "wellbeing" offer can be more responsive to local need. Practically, this includes a range of NHS, council services and voluntary sector organisations working together with residents to ensure they can access and engage in a range of activities and services which support them to stay well whilst also providing advocacy into the wider system around other determinants of health.

Recommendation

- Development of neighbourhood based care should be informed by area profiles which include the social determinants of health, community assets and social infrastructure, social capital and other aspects of community resilience. These can feed into our programme of work more widely, as well as specific priorities like preventing youth violence.

People power – active and empowered communities

As the public purse has been squeezed there has been an increasing focus on “targeted services”. By targeting we create two groups – those who get a service and those who don’t. The reality is that all inequality exists along a gradient and outcomes follow this gradient – there is no “cut off” point; as income, education and opportunities improve so do health outcomes. The more we sort people into “target groups” the more we miss the opportunity for wider population health gain, both to intervene earlier, but also to give some people the relatively small level of support they may need to close the gap in outcomes. A little effort for a large number of people may pay a greater health dividend than a large effort for a small number.

Using policy drivers can help with this – for example, the smoking ban had far more impact on reducing the health impact of smoking than individual level stop smoking services. However, the approaches are not mutually exclusive, they complement each other.

Whilst we have a good baseline understanding of who our residents are, where they live, and their needs, there is more we can learn. One way to tackle inequalities is by working with those most affected to develop policies and solutions which enable social and economic mobility to improve life chances.

We do not have good mechanisms for discussing these issues with those most affected, which impacts on our ability to empower and motivate communities to take action for themselves. Lambeth has a long legacy of movement for social change, and we have seen that the best results often come from grassroots groups coming together to address the issues that affect them. We need to capitalise on these approaches as we grow as a borough.

By sharing what we know and checking against the lived experience of our residents using all our networks we can improve our understanding of what might work and tailor our approaches for different groups.

We need to embrace the digital world as part of our health and social care system and as a means of engaging with

our residents in relation to their health. People need to have better access and control over their personal health information as well as health messages to support them to support their own health needs.

We also need to consider changing the language we use to focus on a wider narrative about supporting our residents to live good lives and being able to take up the opportunities available to them, rather than focusing on health which for many people is synonymous with “poor health”.

As integration of health and social care happens at a local level it becomes easier to identify the other assets available in an area to support people to improve and maintain their health.

Recommendations:

- Ensure that our response to inequality is proportionate to need rather than focusing purely on “target groups” which may miss opportunities for earlier intervention and preclude people at the margins of the target groups reaching their full potential.
- Find new ways of engaging with residents around the issues which influence their health, particularly for groups with the worst outcomes. Develop new ways to support our residents manage their own health and enable them to contribute to the design of their environments and local services.

Opportunities – rising to the challenges by strengthening our health in all policies approach

Most of the inequalities highlighted in this report are a result of a complex interplay of social, environmental and individual factors. This level of complexity requires action at many different levels to have an impact.

Lambeth is undergoing significant growth. As well as being an increasingly important source of income for the council, this creates opportunities for us to use both the process and proceeds of growth to address some of the biggest challenges facing us as a health and social care system. For the Council, tackling inequality is one of these and this report makes the case for strengthening our organisational focus on understanding the health related impact of the decisions that we take (Health in All Policies).

There are a number of specific areas where we think that there would be particular benefit in thinking about health:

- In the design of places and spaces which can improve health and wellbeing including our parks, town centres and estates.

- In thinking about how we gain and squeeze social value from new developments which can support community infrastructure over a longer period, foster resilience and create social mobility (e.g., be it through training, jobs, public spaces or other initiatives) legacies.
- To ensure that new growth and development isn't at the expense of health and wellbeing by adversely affecting the wider determinants of health.

Most aspects of our lives have been changed beyond recognition by technological advances and new ways for sending and receiving information. Health and social care services are still far behind most other sectors in this regard. The health and care system has been slow to harness opportunities proffered by "big data" to support service design and decision making at scale. There programmes of work across London and SE London which may accelerate the pace of this work.

The Lambeth population is a huge asset to the borough. In general, the population is young, well-educated and in employment. As a council we need to leverage these assets to support the minority who are unable to access the opportunities available. Lambeth Council has been lobbying hard to encourage employers to pay London Living Wage (LLW), as increasing numbers of people in work find themselves struggling to make ends meet, but we think there is more we can do here, and as part of the Equality Commission implementation activity, will be looking for opportunities to drive not just take up of LLW by local employers, but more focus on good working conditions.

Recommendations:

- Explore how benefits of growth can be levered to help us address health inequalities, for example by assessing opportunities to strengthen focus on health outcomes in implementation of Community Infrastructure Levy (CIL)/Cooperative Local Investment Plans (CLIPs) processes and through using some of our consultation processes to better understand how we can remove barriers to health.
- A key recommendation of this report is to share the information we have more widely, using different media, including film, digital content and social media to get messages out, to the public, professionals and those who can work within communities to create change.

'What can I do to make a difference?'⁸

This report seeks to show that many different things contribute to people's health and that these reach far beyond an individual's genetic makeup or even their access to health services. Looking across all partner organisations, there are a range of things we can all do, and even small things will make a difference.

Our ask of our colleagues in the council and our key partners, is that when you are planning services, designing policies or strategies, you consider whether there is potential to:

















- Have an impact on one or more of the social determinants of health.
- Have an impact on health and wellbeing.
- Increase or decrease health inequalities.


If answer is yes to any of these questions, please consider:

- How, in your work, could you more explicitly address health and wellbeing.
- Talking to us (your public health team) to find out more about what you can do.
- Consult our JSNA page for more data.
- Engage others (including your partners or key stakeholders) about the part they play in improving people's health.


⁸ Adapted from The Health Foundation.

REFERENCES

- Ambrose, A. (2018) [Better Housing, Better Health in Lambeth: The Lambeth Housing Standard Health Impact Assessment and Cost Benefit Analysis](#) . Sheffield: Sheffield Hallam University
- Aschan, L., Goodwin, L., Cross, S., Moran, P., Hotopf, M., Hatch, S.L. (2013) [Suicidal behaviours in South East London: Prevalence, risk factors and the role of socio-economic status](#) . *Journal of Affective Disorder*, 150: 441-449.
- Bibby, J. and Lovell, N. (2018) [What makes us healthy? An introduction to the social determinants of health](#) . London: The Health Foundation
- Bhavsar, V.G., Boydell, J.E., McGuire, P., Harris V., Hotopf M. H., Hatch S.L., MacCabe J.H., Morgan C. (2017) [Childhood abuse and psychotic experiences – evidence for mediation by adulthood adverse life events: Adulthood adversity and psychotic experiences](#) . *Epidemiology and Psychiatric Services*, 2017 DOI: 10.1017/S2045796017000518.
- Buck, D. and Gregory, S. (2013) [Improving the public's health: A resource for local authorities](#) . London: King's Fund
- Brown J.S.L., Evans-Lacko, S., Aschan, L., Henderson, M.J., Hatch, S.L. and Hotopf, M. (2014) [Seeking informal and formal help for mental health problems in the community: a secondary analysis from a psychiatric morbidity survey in South London](#) . *BMC Psychiatry*, 14(1):275.
- Brown, J.S.L., Ferner, H., Wingrove, J., Aschan, L., Hatch, S.L. and Hotopf, M. (2014) [How equitable are psychological therapy services in South East London now? A comparison of referrals to a new psychological therapy service with participants in a psychiatric morbidity survey in the same London borough](#) . *Social Psychiatry and Psychiatric Epidemiology*, 49:1893-902.
- [Crime Survey of England and Wales](#) 
- [Demography factsheet: Lambeth 'a diverse and changing population'](#) , May 2017.
- Department of Health (2012). [Long-term conditions compendium of Information: 3rd edition](#) 
- Fitzpatrick, S. Bramley, G. et al. (2018) [Destitution in the UK 2018](#) 
- Frissa, S., Hatch, S., Gizard, B., Fear, N., & Hotopf, M. (2013). [Trauma and current symptoms of PTSD in a South East London community](#)  *Social Psychiatry and Psychiatric Epidemiology*, 48(8), 1199-1209.
- Goodwin, L., Gizard, B., Aschan, L., MacCrimmon, S., Hotopf, M., Hatch, S.L. (2017) [Taking an intersectional approach to define latent classes of socioeconomic status, ethnicity and migration status for psychiatric epidemiological research](#) . *Epidemiology and Psychiatric Sciences*, DOI: 10.1017/S2045796017000142.
- Gunasinghe, C., Gizard, B., Aschan, L., MacCrimmon, S., Hotopf, M., Hatch, S.L. (2018) [Debt, Common Mental Disorders and Mental Health Help-seeking](#) . *Journal of Mental Health*, DOI: 10.1080/09638237.2018.1487541.
- Hatch, S.L., Frissa, S., Verdecchia, M., Stewart, R., Fear, N.T., Reichenberg, A., Morgan, C., Kankulu, B., Clark, J., Gizard, B., Medcalf, R., the SELCoH study team, Hotopf, M. (2011) [Identifying socio-demographic and socio-economic determinants of health inequalities in a diverse London community: the South East London Community Health \(SELCoH\) study](#) . *BMC Public Health*, doi: 10.1186/1471-2458-11-861.
- Hatch, S.L., Gizard, B., Williams, D.R., Frissa, S., Goodwin, L., Hotopf, M. (2016) [Discrimination and common mental disorder among migrant and ethnic groups: findings from a south east London community sample](#) . *Social Psychiatry and Psychiatric Epidemiology*, 2016, 51:689–701.
- Hatch, S.L., Woodhead, C., Frissa, S., Fear, N.T., Verdecchia, M., Stewart, R., Fear, N.T., Reichenberg, A., Morgan, C., Bebbington, P., McManus, S., Brugha, T., Kankulu, B., Clark, J., Gizard, B., Medcalf, R., the SELCoH study team, Hotopf M. (2012) [Importance of thinking locally for public mental health: Comparisons of the South East London Community Health Study and the 2007 English Adult Psychiatric Morbidity Survey](#) . *PLoS One*, 7:e48012.
- [Health Profile for England](#)  2017.
- Hughes, K., Bellis, K.A., Hardcastle, K. et al (2017) [The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis](#) ; *Lancet Public Health* 2: e356–66

Lambeth Council (2016) [Inequality in Lambeth: Understanding the impact of national and local changes on Lambeth residents: A Cumulative Equalities Impact Assessment](#) .

Jones NRV, Conklin AI, Suhrcke M, et al. (2014) The Growing Price Gap between More and Less Healthy Foods: Analysis of a Novel Longitudinal UK Dataset PLOS One

Kadra, G., Dean, K., Hotopf, M., Hatch, S.L. (2014) [Investigating Exposure to Violence and Mental Health in a Diverse Urban Community Sample: Data from the South East London Community Health \(SELCoH\) Survey](#) . PLoS ONE 9(4):


Klinenberg, E. (2018) *Palaces for the People*. London: Bodley Head


[Lambeth Equality Commission final report and briefing papers](#) .

[Lambeth Financial Resilience Strategy](#) .


Lambeth, Southwark and Lewisham sexual health strategy 2018-23


Marmot, M. (2011) [Fair society, healthy lives: the Marmot Review](#) .


McGovern, L., Miller, G., Hughes-Cromwick, P. (2014). [Health Policy Brief: The relative contribution of multiple determinants to health outcomes](#) . Health Affairs. August 2014

McManus, S., Bebbington, P., Jenkins, R., et al. (2016) [Mental health and wellbeing in England](#) . Adult Psychiatric Morbidity Survey 2014.

[Mental health JSNA](#) .


Morgan, C., Reininghaus, U., Reichenberg, A., Frissa, S., SELCoH study team, Hotopf, M., Hatch, S.L. (2014) [Adversity, Cannabis Use and Psychotic Experiences: Evidence of Cumulative and Synergistic Effects](#) , *British Journal of Psychiatry*, 2014, 204:346-353.


Polling, C., Bakolis, I., Hotopf, M., Hatch, S.L. (2018) [Spatial patterning of self-harm rates within urban areas](#) . *Social Psychiatry and Psychiatric Epidemiology*, DOI: 10.1007/s00127-018-1601-3

Polling, C., Khondoker, M., Hatch, S., et al. [Influence of perceived and actual neighbourhood disorder on common mental illness](#) . (2014) *Social psychiatry and psychiatric epidemiology* 2014;49(6):889-901.


Public Health England 'Fingertips' .

Refuge (2018) [Domestic Abuse and Suicide](#) .

Social Metrics Commission (2018) [A new measure of poverty for the UK](#) .


Team' PHDS. [Emergency Hospital Admissions for Intentional Self-Harm: Directly age-sex standardised rate per 100,000](#)  Crown Copyright source: Public Health England; 2017.

[Teenage Pregnancy Prevention Framework](#) .

The King's Fund (2018) [Putting Health into Place: Introducing NHS England's Healthy New Towns programme](#) .

[Trust for London: London Poverty Profile](#) .

Wilkinson, R. G., and Pickett, K. E. (2009), *The spirit level: why more equal societies almost always do better*. London: Penguin

Woodhead, C., Gazard, B., Hotopf, M., Rahman, Q., Rimes, K.A., & Hatch, S.L. (2016). [Mental health among UK inner city non-heterosexuals: the role of risk factors, protective factors and place](#) . *Epidemiology and Psychiatric Sciences*, 25, 450-461.

UK Census 2011

