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Health Inequalities Research Network Conference

Session Abstracts

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Contents

Keynote Session

Confronting Social Inequalities in Health: Challenges and Opportunities

David R. Williams
Harvard University, Cambridge, US

Wednesday 14 May
1600-1730 - Max Nasatyr Room

David R. Williams is the Florence and Laura Norman Professor of Public Health at the Harvard School of Public Health and Professor of African and African American Studies and of Sociology at Harvard University. His prior academic appointments were at Yale University and the University of Michigan. He holds an MPH from Loma Linda University and a PhD in Sociology from the University of Michigan.

Dr. Williams is an internationally recognized authority on social influences on health. His research has enhanced our understanding of the complex ways in which socioeconomic status, race, stress, racial discrimination and religious involvement can affect health. He is the author of more than 325 scholarly papers and he has served on the editorial board of 12 scientific journals and as a reviewer for over 60 journals. He was ranked as one of the Top 10 Most Cited Researchers in the Social Sciences in the world during the decade 1995 to 2005 and as the Most Cited Black Scholar in the Social Sciences, worldwide, in 2008.

He has received numerous honors and awards. He is an elected to member of the Institute of Medicine and the American Academy of Arts and Sciences. He has also received an inaugural Decade of Behavior Research Award, the Leo G. Reeder Award from the American Sociological Association, and the Stephen Smith Award for Distinguished Contributions in Public Health from the New York Academy of Medicine.

Dr. Williams has been involved in the development of health policy at the national level in the U.S. He has served on the National Committee on Vital and Health Statistics and on seven committees for the Institute of Medicine including the Committee that prepared the Unequal Treatment report. Dr Williams has also played a visible, national leadership role in raising awareness levels of the problem of health disparities and identifying interventions to address them. He has also served as the staff director of the Robert Wood Johnson Foundation's Commission to Build a Healthier America. This national, independent and nonpartisan health commission focused on identifying evidence-based non-medical strategies that can improve the health of all Americans and reduce racial and socioeconomic gaps in health.

Dr. Williams has appeared on national television, including ABC's Evening News, CNN, PBS, C-SPAN and the Discovery Channel. His research has been featured or he has been quoted in the national print media including the New York Times, Time, Newsweek, the Wall Street Journal, the Washington Post, Jet, Essence and USA Today. He was also a key scientific advisor to the award-winning PBS film series, Unnatural Causes: Is inequality Making Us Sick? ●

Policy and health inequalities

ABSTRACT TITLES

Representing the problem of health inequality in UK social policy
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FULL ABSTRACTS

Representing the problem of health inequality in UK social policy

Natasha Kriznik - *Durham University*

Health inequality is a contested policy concept and has been on the political agenda in the UK in some form since the publication of the Black Report in 1980. However, it was not really accepted as a social problem until the publication of 'The Health of the Nation' in 1992, and the subsequent election of New Labour in 1997 when strategies were developed and implemented in order to reduce levels of health inequality. While there are a number of policy documents suggesting courses of action that should be taken to address health inequality, there is little discussion about the evolution of such policy except in terms of evaluating the advantages and disadvantages of different solutions.

Bambra, Fox and Scott-Samuel (2005) suggest there is a lack of knowledge and understanding about the politics of health. Their article proposes a number of reasons as to why health is often viewed as apolitical, citing chief among them the approaches used to examine and evaluate health policy. They argue that discussions of health policy analysis are often focused on the 'content' of policies, i.e. centring on a comparison between the pros and cons of courses of action in relation to political standpoints, and these analyses rarely examine the political nature of the policy process. Little attention is paid to how the problem is framed by wider political ideology, and the potential impact this has on what is considered as a social problem in the first place and what solutions are put forward to alleviate or solve the aforementioned issue.

Analytical approaches developed under Interpretive Policy Analysis (IPA) can be used in order to fill in this knowledge gap. By adopting the view that social policy actively creates understandings of problems through representation, Bacchi (2009: 262) argues that "policy analysis requires problem-questioning rather than problem-solving". As such, this position argues that policy problems should only be understood as representations and not as the definitive view on an issue. Policy analysis should be concerned with examining the conditions which allow particular representations of problems to exist while preventing other definitions from being used. This approach therefore not only answers Bambra, Fox and Scott-Samuel's (2005) concerns about the politics of health but also provides a new perspective on analysing health inequality policy.

This paper will demonstrate how adopting Bacchi's (2009) "What's the problem represented to be?" approach can be beneficial to the study of health inequality policy in two ways. Firstly, the view of policy as creating representations of problems allows us to examine why certain conceptions of health inequality manifest at particular points in time by taking into account underlying assumptions and normative considerations and concerns. Secondly, it enables us to provide a history of perspectives and understandings of health inequality as a policy problem through investigating broader public health discourses surrounding the issue of health inequality.

The paper will present findings from an analysis of English social policy documents concerned with health policy from 1980-2010 in order to demonstrate continuities and changes in these discourses and the way in which the issue of "differences in health outcomes" is defined and discussed in these documents. While it is possible to see a difference in understanding and explanation of the problem just in the changing labels given to the problem over time ("variations in health", "systematic variations in health", "health inequality" or "inequalities in health") there are some discourses which remain central to discussions around the problem of "differences in health" – for example, economic concerns, responsibility, prevention, health promotion – and clearly frame policy discussion. In this way it is possible to see the evolution of the problem of health inequality within social policy.

Impact of universal health insurance coverage on hypertension management: a cross-national study in the United States and England

Andrew Dalton - *University of Oxford*

Background: The Patient Protection and Affordable Care Act (ACA) galvanised debate in the United States (US) over the merits of universal health coverage. Comparison with countries providing universal coverage may illustrate whether the ACA can improve health outcomes and reduce disparities. We aimed to compare quality and disparities in hypertension management by socio-economic position in the US and England, the latter of which has universal health care, free at the point of access.

Methods: We used cross-sectional data from the Health and Retirement Survey in the US, and the English Longitudinal Study for Aging from England We included non-Hispanic White respondents aged 50-64 years (US market-based v NHS) and >65 years (US-Medicare v NHS) with diagnosed hypertension. We compared blood pressure control to clinical guideline (140/90 mmHg) and audit (150/90 mmHg) targets; mean systolic and diastolic blood pressure and antihypertensive prescribing, and disparities in each by educational attainment, income and wealth. We standardised outcomes using regression models.

Results: There were no significant differences in aggregate achievement of clinical targets aged 50 to 65 years (US market-based vs. NHS - 62.3% vs. 61.3% [p=0.835]). There was, however, greater control in the US in patients aged 65 years and over (US Medicare vs. NHS - 53.5% vs. 58.2% [p=0.043]). England had no significant socioeconomic disparity in blood pressure control (60.9% vs. 63.5% [p=0.588], high and low wealth aged ≥65 years). The US had socioeconomic differences in the 50-64 years group (71.7% vs. 55.2% [p=0.003], high and low wealth); these were attenuated but not abolished in Medicare beneficiaries. The US has significantly more prescribing of anti-hypertensive medication across all levels of SEP. We found no evidence of disparities in English patients, while significant wealth and income disparities in blood pressure control and prescribing among younger US patients. Disparities in both were generally attenuated but not abolished in insured patients aged under-65 and older patients eligible for Medicare.

Conclusion: Moves towards universal health coverage in the US may reduce disparities in hypertension management. The current situation, providing universal coverage for residents aged 65 years and over, may not be sufficient for equality in care.

Violence and abuse as priorities for public health

Sally McManus - *NatCen Social Research*

Background: This work is part of an independent study commissioned and funded by DH's Policy Research Programme to examine effective responses to the long-term consequences of violence and abuse (http://www.natcen.ac.uk/our-research/research/responding-effectively-to-long-term-consequences-of-violence-and-abuse-(reva)/). We conducted secondary analysis of the Adult Psychiatric Morbidity Survey, the primary national data source on rates of treated and untreated mental illness in the population, and its risk factors. The general population survey has a probability sample of 7,500 people aged 16 and over. Latent class analysis was used to segment the population and multiple regression analysis to examine the role of violence as abuse as risk factors for poor mental health and other outcomes.

Key Findings: A quarter of the English population has experience of violence and abuse in their lives. This has enormous relevance for mental health policy:

National Suicide Prevention Strategy -
Our analysis shows that suicide attempts are 15 times more likely among people who have experienced extensive physical and sexual abuse. More than half of people with the most extensive experience of physical and sexual violence and abuse in their lives have self-harmed.

Wider public health agenda - As local authorities take on responsibility for public health, they should note that this evidence links the experience of extensive physical and sexual abuse with being disabled, alcohol dependent, drug dependent, a smoker, and obese.

Health care commissioning - Despite being 15 times more likely to have multiple (3+) mental disorders, people with extensive experience of physical and sexual violence were just 4 times more likely to have discussed mental health with a GP and 3 times more likely to have accessed community services. But 12 times more likely to be a mental health unit in-patient. Routine enquiry by services into experience of abuse is needed to address cause and continuation of poor mental health.

Preliminary results report:
www.natcen.ac.uk/media/205520/reva-strand-1-13th-may-briefing-report-2-.pdf

An integrated response to child poverty: learning from the Healthier, Wealthier Children project

Lynn Naven - *Glasgow Centre for Population Health*

Background: The links between child poverty and poor health, educational and social development are widely recognised and cause persistent inequalities throughout life1. There is growing recognition throughout the UK of the need for service integration at local level to tackle such inequalities.

Project focus: The Healthier, Wealthier Children (HWC) project was established in October 2010 with Scottish Government funding for 15 months, to address high child poverty levels in NHS Greater Glasgow and Clyde

(NHSGGC). It was an integrated partnership approach between NHSGGC, local authorities and the voluntary sector to develop sustainable referral pathways between health and locally-commissioned money/welfare advice services. The project aimed to maximise the income of pregnant women and families with young children at risk of, or experiencing, poverty. It involved staff working together to raise awareness and develop the project in the 10 Community Health and Care Partnership (CH(C)P) areas across NHSGGC. In April 2012, a second phase of reduced funding was provided for a further year to help mainstream HWC among partner agencies.

Evaluation: A mixed-methods evaluation was carried out by the Glasgow Centre for Population Health, covering both project phases during the period October 2010 to March 20132,3.

Results: This NHS, local authority and third sector partnership work led to two system-wide operational changes in response to child poverty. Firstly, within a large NHSGGC workforce of health visitors and midwives (approximately 1,200), there was increased awareness of child poverty with both staff groups initiating the majority of the 5,003 referrals to advice services during the evaluation period. Both groups reported the importance of the referral pathway in enabling them to raise the subject of money worries with women and families. Secondly, advice services reported increased understanding of the needs of this new client group, not previously known to access mainstream advice services. This prompted changes in delivery that included offering outreach advice sessions in baby clinics, home visits and telephone appointments. Some advice services have now extended telephone appointments to all their clients. Services also indicated an on-going willingness and commitment to work with NHS colleagues on this agenda. At a strategic level, HWC project referrals were incorporated into a newly-commissioned Glasgow City Council contract for mainstream advice services aimed at all residents in the city.The key client outcomes from the 5,003 referrals included total financial gain of over £4.5 million for approximately 50% of families referred for advice, and other important non-financial gains, such as reduced stress and worry, improved quality of life, and help and advice with childcare, employment and housing issues. Work also included re-negotiating payments to creditors and switching to lower-cost options for domestic energy and banking services.

Conclusion: The HWC project demonstrated that implementing a system-wide integrated approach to child poverty is achievable without major service re-design and can result in tangible outcomes for women and families. Current UK policy changes, such as health and social care integration, the transfer of public health functions to local authorities and NHS commissioning changes, provide opportunities to share lessons from this NHS partnership approach to addressing child poverty. ●

Disparities in access to healthcare

ABSTRACT TITLES

Access to healthcare: inequalities and barriers: a cross-country comparison
Erica Howard - *Middlesex University*

Mapping of psychological therapies post-self-harm presentation from the Emergency Department
Cindy Wong - *King's College London*

'Well I'm sort of in two minds about it': Qualitative investigation of the social influences and barriers to seeking healthcare for mental health problems among the UK military
Marie-Louise Sharp - *King's College London*

Comparing Blood Pressure and Body Mass Index Recording for Major Mental Illness, Diabetes and Chronic Kidney Disease. Analysis of National QOF Data for the UK
Julie Langan-Martin - *University of Glasgow*

FULL ABSTRACTS

Access to healthcare: inequalities and barriers: a cross-country comparison

Erica Howard - *Middlesex University*

This presentation is based on some of the findings of the research project 'inequalities and multiple discrimination in access to and quality of healthcare', funded by the European Union Fundamental Rights Agency and led by a team of researchers at Middlesex University. Five countries took part in the research: Austria, Czech Republic, Italy, Sweden and the UK and the research was done in 2010-2011. The research specifically focused on the vulnerability to inequalities of people at the intersection of gender, ethnicity, age and disability. The research included interviews with health care users and health care professionals, as well as with legal experts on equality and advocacy groups and policy makers in this area.

The focus of the presentation will be on barriers to access to healthcare faced by people with multiple and intersectional vulnerabilities. In this context, barriers involve mechanisms or structures that impede or delay access to health services or reduce their quality or effectiveness. Many barriers involve (indirect) discrimination, where an apparently neutral practice places persons of a particular racial or ethnic origin, gender, age or disability (or other discrimination ground covered by the national legislation) at a particular disadvantage. This is covered by EU and national anti-discrimination legislation.

The health care professionals in the countries researched often stated that they provide equal care for all without making any distinctions on grounds like racial or ethnic origin, gender, disability and age. But such universal, standardised or 'one-size-fits-all' healthcare can give rise to barriers for minority groups and for people with intersecting vulnerabilities and have the potential to create inequalities. Such approaches might well need to be adapted to meet the needs of vulnerable groups and to provide equal access to healthcare for all.

The research identified 6 specific barriers to access to healthcare: communication and language barriers; lack of information about healthcare entitlements and services; financial barriers; organisational barriers and accessibility; working conditions, living conditions and care responsibilities; and cultural and psychological barriers. These barriers overlap and often reinforce each other to create even bigger barriers. Many health care users also emphasised, above all, the lack of dignity and respect they had experienced when meeting, interacting and communicating with health care staff. The paper will focus on these barriers and the way the interplay of ethnicity, gender, disability and age increases the impact of each specific barrier.

Mapping of psychological therapies post-self-harm presentation from the Emergency Department

Cindy Wong - *King's College London*

Self-harm behaviours, according to the National Institute for Health and Clinical Excellence (NICE) Guideline, refer to any act of self-poisoning with medication or self-injury by cutting. Self-harm arising from excessive consumption of alcohol or recreational drugs, starvation in anorexia nervosa or accidental harm to oneself is excluded.

In the UK, a study showed that 6.9% participants aged between 15 and 16 years reported an episode of self-harm behaviours in the previous year. Only 12.6% of episodes were presented to the hospital. When comparing the rate of self-harm in Europe, UK has the highest rate and at 400 cases in 100,000 population per year.

Around 140,000 to 150,000 cases of self-harm are presented to hospital each year in the UK, while 93% of cases are presented to the Accident and Emergency Department. The commonest type of self-harm behaviours is self-poisoning, which accounts for 70% of self-harm presentations. Other Common methods of self-mutilation include cutting or craving on skin, picking at a wound, hitting self, biting self, burning skin and pulling out one's own hair.

When it comes to the function of self-harm behaviours, Nock and Prinstein proposed four primary functions of the behaviour, including automatic negative reinforcement, automatic positive reinforcement, social negative reinforcement and social positive reinforcement. Non-suicidal self-injury behaviours are thought to be associated with a purpose, for example, relief from a negative feeling, cognitive state or interpersonal difficulty or induction of a positive feeling state.

After the short-term management of self-harm behaviours in the Emergency Department, service users may be discharged and referred for further psychological therapy as an aspiration from NICE Guidelines. These psychological therapies may be provided in a range of different settings such as the secondary care mental health trust or by the Improving Assess to Psychological Therapies (IAPT) programme. The engagement rate in psychological therapies in SLaM and IAPT would be collected and analysed to understand the factors leading to the engagement as well as non-engagement in psychotherapies. Demographic data would be collected to show the prevalence of psychological therapies among different groups of individuals with self-harm behaviours.

As suggested by the American Psychiatric Association (2010) in the coming diagnostic and Statistical Manual of Mental Disorders (DSM-5), deliberate self-injurious behaviours would cause clinically significant distress or impairment in interpersonal, academic, or other important areas of functioning. For the sake of providing effective and further improved health care plans to individuals with self-harm behaviours, the reasons for the participation of psychological therapies and the causes and functions of, could be provided to individuals at national and community level. Meanwhile, preventive healthcare measures could be further designed as well.

'Well I'm sort of in two minds about it': Qualitative investigation of the social influences and barriers to seeking healthcare for mental health problems among the UK military

Marie-Louise Sharp - *King's College London*

Background: Approximately 60% of military personnel who experience mental health problems, do not seek help, yet many of them could benefit from professional treatment. The typical demographic of the military provides one explanation for why help is not sought, with help-seeking lowest in young males in the general population; however there are further issues relating to the military. These include;

concerns related to stigma, career progression, negative attitudes/expectations about treatment, poor recognition of the need for treatment, military culture and the separate healthcare systems provided by the Defence Medical Services (in-Service) and the NHS (Ex-Service). Currently there is little research in this area that utilises qualitative methods. It is crucial that the pathways to help-seeking and healthcare are improved through better understanding of both the enabling and disabling factors that facilitate or hinder military personnel when seeking help for mental health problems.

Methods: 16 UK military personnel (Service and Ex-Service) were followed up from a sub-sample of the Kings Centre for Military Health Research cohort study data collection phase 2007-2009. Two groups of individuals were recruited through a screening tool of current non-help-seekers (10 individuals) and help-seekers (6 individuals).Eligibility criteria included: males, aged 18-35 years who reported having experienced a stress, emotional or alcohol problem within the last year and report currently experiencing symptoms of depression, anxiety, Post Traumatic Stress Disorder or alcohol misuse.Thematic Analysis was used to analyse in-depth semi-structured telephone interviews, which discussed barriers and facilitators of seeking healthcare for mental health problems.

Results: Barriers to care were widely evident across the non-help-seeking and help-seeking groups. Barriers were highly influenced by military culture and background and primarily included; a lack of recognition of the need to seek medical care, stigma, masculine norms that viewed help-seeking as 'weak', discipline enacted in-Service before help or support offered, barriers arising from bullying, poor social networks andnegative attitudes/expectations towards mental health treatment.Facilitators of help-seeking were far less reported but primarily included; a desire to get better, masculine norms that viewed help-seeking as 'brave', supportive social networks and positive attitudes/expectations of mental health treatment. The quality and success of help-seekers overall was poor in terms of engagement with treatment and health outcomes.

Conclusions: Despite recent increased mental health services for UK military and programs to reduce stigma, barriers to care are still prominent across non-help-seeking and help-seeking groups.All participants reported multiple, interacting barriers to care. The lack of judgment of need to seek medical care and stigma were most commonly described and may be crucial barriers to overcome in the help-seeking pathway.Supportive social networks and a desire to get better were often deciding factors in help-seeking.Help-seeking was most likely when combined with a high severity of problem and the presence of facilitating factors.The issues distinguishing between help-seeking and non-help-seeking groups, and the quality of help-seeking will be explored in future work.

Comparing Blood Pressure and Body Mass Index Recording for Major Mental Illness, Diabetes and Chronic Kidney Disease. Analysis of National QOF Data for the UK

Julie Langan-Martin - *University of Glasgow*

Background: The General Medical Services Quality and Outcomes Framework (QOF), was introduced into the UK in 2004, and was aimed to improve the quality of primary care. Although most practices have performed well under the QOF scheme, improved patient outcomes have not been consistently observed. There had been concerned raised by the Royal College of General Practioners (UK) that by financially rewarding practices for meeting a range of indicator targets, patient care may suffer and in particular there were concerns that those with multiple chronic physical health problems, those living in more deprived areas and those with mental illness may suffer the most. Within the QOF certain chronic diseases are incentivised and specific targets such as Body Mass Index and Blood Pressure recording are set. Although Major Mental Illness (schizophrenia, bipolar disorder and related psychoses) is incentivised, these individuals continue to die 15-20 years prematurely, largely due to physical health problem. While non-engagement with healthcare services is an issue, systemic barriers to care may contribute to the health inequalities seen as there is evidence that individuals with MMI receive less screening and fewer preventative interventions than individuals without MMI. However it is currently unknown if these inequalities occur within the QOF.

Aims: To describe and compare population achievement and exception rates for Blood Pressure (BP) and Body Mass Index (BMI) recording for individuals with MMI relative to Diabetes and Chronic Kidney Disease (CKD) across the UK during 2012/2013. We also aimed to compare population achievement rates of these indicators between England, Scotland, Wales and Northern Ireland.

Method: Achievement and exception rate data for the MMI and Chronic Kidney Disease Blood Pressure (BP) indicators, along with the MMI and Diabetes Body Mass Index (BMI) indicators were obtained for 9,731 GP practices across Scotland, England, Northern Ireland and Wales for 2012/2013. Population achievement rates were calculated and compared across indicators by chronic disease, year and country.

Results: Population achievement rates for Blood Pressure (BP) and Body Mass Index (BMI) recording for patients with MMI were significantly lower, while exception rates were significantly higher, than for those with CKD or diabetes. For the whole of the UK, population achievement rate for body mass index (BMI) in those with MMI was 84.0% [IQR 76.3-90.0%] compared to 92.5% [IQR 89.7-94.9%], ($p<0.001$) in those with diabetes. Exception rate was significantly higher in those with MMI compared to those with diabetes (8.1% [IQR 2.7-16.1%] vs. 2.0% [IQR 0.8-4.2%], p<0.001). Similarly for blood pressure recording in those with MMI population achievement rate was lower than in those with CKD (87.0% [IQR 81.3-91.7%] vs. 97.1% [IQR 95.5-98.4%], p<0.001) while exception rate was higher (6.5% [IQR 2.2-13.2%] vs. 0.0% [IQR 0.0-0.6%], p<0.001). This pattern of population achievement and exception rates was seen in each of the four countries. Compared to England, Northern Ireland had significantly higher median population achievement rates for both the BP and BMI MMI Indicators, whereas Scotland had significantly lower median population achievement rates. Differences in median population achievement rate for the CKD and Diabetes indicator were less marked across the four countries.

Conclusion: We found lower population achievement and higher exception rates for the recording of blood pressure and Body Mass Index in MMI compared to Chronic Kidney Disease and Diabetes across the whole of the UK. A significantly higher population achievement rate for the MMI indicators was present in Northern Ireland compared to England. These findings may be evidence of inequalities in the monitoring of physical health for individuals with MMI within the UK's primary care system. Further investigation of this complex issue is merited. ●

Inequalities in child health

ABSTRACT TITLES

FULL ABSTRACTS

European Comparative Cohort Study of Social Inequalities in Child Health and Development: Findings from the DRIVERS Birth Cohorts

Milagros Ruiz - *University College London*

Introduction: Healthy growth in early childhood has become a major priority to reduce health inequalities across Europe. It is now increasingly recognised that the first years of life may provide children with lasting benefits throughout the life course. Investigation of social inequalities in early childhood health has important implications for the health of future generations, but it is not readily known how inequalities in early childhood health and development vary across the region of Europe.

Methods: Longitudinal data from twelve birth cohorts across the European region participating in the DRIVERS for Health Equity – Early Childhood Development research programme were used. Mother's level of education was collected at the time of birth and health and confounding data were measured prospectively at subsequent follow-ups to the age of 8. Regression models were estimated within each cohort and meta-analyses were conducted to assess the extent of heterogeneity between regions of Europe.

Results: The association between low maternal education and increased risk of adverse child health and health behaviours were not entirely consistent across Europe. Social inequalities in preterm births were generally unobserved in Southern and Central/Eastern Europe, but were sizeable in Northern and Western Europe. Estimated by the Relative Index of Inequality (RII), inequalities in the Netherlands, Sweden and the UK were 1.72 (1.15 – 2.60), 1.57 (1.14 – 2.15), and 1.49 (1.07 – 2.06). A similar pattern arose for children born small for gestational age. Social inequalities in asthma were identified in the Western countries alone, namely France, 2.07 (1.10 – 3.89), the Netherlands, 1.65 (1.01 – 2.72) and the UK, 1.71 (1.42 – 2.06). The likelihood of being overweight at preschool age was associated with low maternal education in Northern and Western Europe, but gradients were negligible in Southern and Central/Eastern Europe. In comparison to the child health outcomes studied, inequalities in breastfeeding and sedentary behaviour were greater in magnitude and exhibited fewer regional variations across Europe.

Discussion: This work highlights the value of comparative cohort analysis in early childhood to better understand how social inequalities in health emerge in different settings across Europe.

Understanding social inequalities in child obesity in the UK

Alice Goisis - *University College London*

The prevalence of obesity in young children has increased over the past decades in many developed countries including the U.K. Existing research documents that in the U.K. over the past 10 years the risk of overweight/obesity has increased from 17% to 22% in boys aged 2-5 years old and from 20% to 25% in girls. The increasing prevalence of child obesity has attracted the attention of U.K. policy makers and it is therefore considered an important area of research and of policy intervention. In addition, the literature shows that the risk of child obesity is not uniformly distributed across population groups in the U.K. as children from poorer backgrounds are more likely to become obese and disparities are already quite marked when children are 5 years old. While the presence of these disparities has been well established, at present we have a limited understanding about the reasons behind and mechanisms explaining them. To the extent that children who are obese are more likely to be obese in young and later adulthood – a condition which has been associated with a range of negative health outcomes and complications – knowing more of the family processes and dynamics that may help us understand why some groups of children experience higher rates of obesity than others is relevant. This is especially important from a policy perspective to the extent that some of these processes are amenable to interventions. This study aims to contribute to the extant literature and policy discourses around children's obesity in the U.K. by investigating which markers of the home environment are particularly relevant to explain social disparities in children's obesity and whether these patterns change as children transition into different stages of the life course.

The analyses are based on data from the Millennium Cohort Study, a U.K. nationally representative longitudinal survey. There are now 4 Sweeps available which were collected when children were respectively 9 months, 3, 5 and 7 years. Sweep 5 has already been collected and, since it is envisaged that the data will be released in February 2014, we are planning to also include this age group in the analyses. In each sweep a range of information on children's well-being and family (including but not restricted to socio-economic, demographic and health behaviours) characteristics has been collected making the MCS a particularly suitable dataset to address the research questions of this study. It is envisaged that the analyses are going to be primarily based on Sweep 3 and 5 of the MCS (when children are aged 5 and 11).

A measure of child obesity (at ages 5 and 11) is obtained by applying the International Obesity Task Force (IOTF) thresholds for BMI, which are age and sex specific, and social position is obtained by grouping families into income quintiles, which are equivalised for family size. Logistic models regressing child obesity on income quintiles enable to estimate the size of the unadjusted social disparities. Models progressively include indicators which measure family routines around diet (e.g. skipping breakfast), physical activity (e.g. frequency of sport per week), home environment (e.g. regular bedtimes) and health markers around the time of birth (e.g. mother smoked during pregnancy). In order to assess whether and to what extent different sets of indicators contribute to attenuate/explain social disparities in child obesity, for each model we look at changes in the magnitude of the income quintile coefficients and their significance levels before and after the inclusion of controls. The final model includes all set of indicators in order to reveal whether and to what extent social disparities in child obesity (at age 5 and 11) are explained or attenuated when all markers have been controlled for.

Ethnic differences in children's socioemotional behaviour: Findings from the Millennium Cohort Study

Afshin Zilanawala - *University College London*

Early childhood behaviour problems are consequential to children's academic success and a number of outcomes in adulthood, including educational attainment, employment, and health inequalities. In the United Kingdom (UK), ethnic differences in socioemotional behaviours have been documented, but little research examines these differences among young children. Emerging evidence in the UK indicates better psychological well-being among ethnic minorities in adolescence. Extant literature indicates better mental well-being among Black African and Black Caribbean adolescents, Indian and Pakistani children, and Bangladeshi origin adolescents compared to their White peers. One study examines socio-emotional difficulties in early childhood and finds greater difficulties among children from a South Asian background but not among Black African children.

Research thus far has grouped children within wide age ranges and has focused on adolescents making it difficult to disentangle the timing of better or worse psychological well-being or when ethnic variation emerges among children. The present study seeks to fill these gaps by examining ethnic differences in 7 year old children's socioemotional behaviour and the factors underlying any observed ethnic differences.

We use the Millennium Cohort Study (MCS) to examine ethnic inequalities in socioemotional behaviours. This allows for a detailed ethnic classification and a rich set of socioeconomic, cultural, and family and child characteristics to be taken into account. The MCS is a cohort study of 18,552 children born in the United Kingdom between 2000 and 2001. We used data collected from the fourth sweep of interviews which were conducted through home visits when the cohort child was approximately 7 years of age. During the interview, parents assessed children's behavior using the Strengths and Difficulties Questionnaire. The questionnaire comprises five scales: emotional symptoms, conduct problems, hyperactivity–inattention, peer problems, and prosocialbehavior. We collapse emotional symptoms, conduct problems, hyperactivity, and peer problems to create a total difficulties score. Emotional symptoms and hyperactivity measure internalizing behaviors, and peer and conduct problems measure externalizing behaviours.

We find Pakistani, Bangladeshi, and Black Caribbean children to have significantly more socioemotional difficulties as compared to White children. These disadvantages were reduced to nonsignificance after adjustment for socio-demographic factors. Adjustment for experienced racism, mother's mental health, and markers of the home environment partly explained these ethnic differences. In fully adjusted models, ethnic differences were no longer apparent. In models examining externalizing behaviours, we find Pakistani and Black Caribbean children to have higher externalizing scores than their White peers. After adjusting for socio-demographic factors, these higher scores were no longer significant. We find Pakistani, Bangladeshi, and Black Caribbean children to have significantly higher internalizing scores than White children. Socio-demographic factors attenuate the estimates for Pakistani and Black Caribbean children to non-significant levels, but only partly explained the differences for Bangladeshi children. In fully adjusted models, the Bangladeshi disadvantage remained unexplained. Lastly, we used Baron and Kenney models to examine maternal and home environment factors which may mediate the relationship between family income and socioemotional outcomes. We find maternal mental health to partially mediate the relationship between income and socioemotional difficulties, accounting for roughly 20% of the total relationship.

In future analyses we will examine mediation between family income and externalizing and internalizing behaviours. We will also use modified-mediated models to evaluate to what extent the mediation is modified by ethnicity.

Why do some children with externalizing problems develop internalizing problems in adolescence? Testing two developmental pathways in a genetically sensitive study

Jasmin Wertz - *King's College London*

Background: It has previously been shown that children with externalizing problems are at risk of developing internalizing problems as they grow older. It is not clear which developmental pathways underpin this association. We tested two processes that could explain why some children with externalizing problems develop new internalizing problems in adolescence: a "failure" model whereby the association between early externalizing problems and later new internalizing problems is mediated by negative experiences including maternal dissatisfaction, peer victimization and academic difficulties; and a "genetic" model, whereby a set of common genes influences both early externalizing and later new internalizing problems and thereby accounts for some of the association.

Method: We used data from the Environmental Risk (E-Risk) Study, a 1994-1995 birth cohort of 2232 twins born in England and Wales. Information from mothers and teachers was used to assess internalizing and externalizing problems at age 5 and 12, as well as maternal dissatisfaction, peer victimization and academic difficulties. We used linear regression analyses to test the "failure" model and multivariate behavioural genetic models to test the relative importance of genetic influences in explaining the association.

Results: Children with externalizing problems at age 5 were significantly more likely to experience new internalizing problems at age 12 (= .14, $p < .001$). The mediating effect of maternal dissatisfaction, peer victimization and academic difficulties was significant and explained some of the association between early externalizing and later new internalizing problems (37%, $p < .001$). The results of the behavioural-genetic analyses indicated that genes influencing early externalizing problems significantly influenced later new internalizing problems as well ($p < .001$).

Conclusions: The present study suggests that the "failure model" cannot fully explain why some children with externalizing problems go on to develop new internalizing problems in adolescence. In addition, our findings highlight the role of genetic influences in explaining the association.

Methods in health inequalities research

ABSTRACT TITLES

Exploring the inter-relationship between socioeconomic factors, internal migration and ethnic differences in health: evidence from the Samples of Anonymised Records in England
Fran Darlington - *University of Leeds*

A novel methodology for constructing ethnic majority life tables: an analysis of routine data from England and Wales
Melanie Morris - *London School of Hygiene and Tropical Medicine*

Using data smartly to identify sexual health areas of greatest need
Rosie Ilett - *NHS Greater Glasgow and Clyde*

Measuring health inequality at a local level using primary care data
Tanya Khera-Butler - *Camden and Islington Public Health*

FULL ABSTRACTS

Exploring the inter-relationship between socioeconomic factors, internal migration and ethnic differences in health: evidence from the Samples of Anonymised Records in England

Fran Darlington - *University of Leeds*

We live in an ageing and increasingly ethnically diverse society within which chances of good health are not equally distributed. Understanding the nature and extent of these differences is ever-more important within this context of demographic change as (a) health gradients may be steepening with age over time and (b) variations in health persist within and between ethnic groups. To further understand the extent of ethnic differences in health with the context of demographic change, this paper will therefore investigate an under-explored but increasingly discussed theory which attributes some (if not all) of persisting health inequalities to a process of selective internal migration.

Migration is an inherently selective process evident in the distinct characteristics of migrants compared to non-migrants. These characteristics vary over the lifecourse in line with changing propensities for migration by age since reasons for migration as a young adult are often very different to those of an older adult. Health is one such characteristic whereby a process of selective migration appears to occur: younger migrants are more likely to be in better health than their stable counterparts whereas the inverse is often true for older migrants. The movement of these differently healthy migrant groups may therefore influence health gradients through the sorting of different groups of people into different areas or socioeconomic circumstances. Although such research is receiving increasing academic attention, often leading to competing conclusions, less has been done to explore how a process of selective migration may vary not only by age but also by ethnic group. The selective act of migration, often selecting on health and other socioeconomic attributes, means that propensity for migration may vary by ethnic groups who are differently healthy and differently (dis)advantaged.

So, this analysis will explore whether chances of poor health appear to be explained by socioeconomic factors and migration, and whether this in turn varies not only by age but also by ethnic group. Using cross-sectional data from the 1991 and 2001 Samples of Anonymised Records, binary logistic regression models will first be run exploring the extent to which demographic and socioeconomic factors alongside a variable indicating migrant status can explain poor health at 1991 and 2001. To further assess whether the explanatory power of either socioeconomic factors or migrant status varies by age and ethnicity, separate models will be run for different age and ethnic groups. This will not only reflect a valuable contribution to our understanding as to the nature and extent of ethnic differences in health (and how they have changed between 1991 and 2001), but also pave the way for further theoretical and empirical work as to the role of selective migration in maintaining or widening health differences.

At the time of submission 2011 SARs data are not available. However, if the data are released before the conference the paper will be updated to include the latest available data.

A novel methodology for constructing ethnic majority life tables: an analysis of routine data from England and Wales

Melanie Morris - *London School of Hygiene and Tropical Medicine*

Background: Life tables are used to examine mortality by age and sex to calculate life expectancy in a specific population. The use of life tables is of public health interest to produce accurate estimates of mortalityfor sub-populations. In the UK, the mortality experience of ethnic groups has been difficult to ascertain as ethnicity is not routinely recorded on death certificates. We have produced ethnic life tables for England and Wales which can be used to assess the contribution of ethnicity to health inequalities.

Methods: Population data for all 175,434 output areas (OAs) in England and Wales were stratified by age group and sex. OAs are small, socially homogeneous areas that contain on average 300 people. These population data were matched to the number of deaths by age group and sex occurring in each OA in the years 2000–02. We used 2001 census data to establish the proportion of men and women, grouped into seven age bands, who were Black, White, or Asian in each OA, to the nearest 1%, and merged these with mortality and population data. These data were collapsed by age group, sex, and the proportion of each ethnic group in the area (100 groups), which resulted in separate datasets for each ethnic group, containing the number of deaths and the population by age group, sex, and ethnic proportion. We modelled the relation between mortality, age, and ethnic proportion by a multivariable Poisson model with regression splines. The models were adjusted by deprivation level to examine the contribution of socio-economic status. We used the predicted age- and sex-specific mortality rates for an area that contained 73% Black, 98% Asian, or 100% White people to construct ethnic majority life tables for each ethnic group. These corresponded to the maximum proportion of the specific ethnic origin reported in any OA in 2001.

Results: The model's prediction of overall mortality corresponded closely with existing national life tables, validating our estimates. The ethnic majority life tables highlighted important differences in mortality between the main ethnic groups: after adjustment for deprivation, life expectancy at 1 year was 71.4, 75.5 and 76.9 years for Black, White and Asian men respectively; and 78.4, 80.1 and 80.9 years for women. Up to age 45, the White population had the lowest mortality in both sexes. However, the Asian population had the lowest mortality from age 45 in women and from age 60 in men. The Black population had the highest rates throughout except for girls under 15. As an example of mortality rates: at age 60 years, mortality rates for Black, White, and Asianmen were 16.3, 10.1 and 9.1 per 1000 person-years; and for women were 10·3, 6.1 and 4.7 per 1000 person-years, respectively. The probability of surviving from age 60 to 80 years was lowest for black men at 50.0%, compared with 52.0% for White men and 60.5% for Asian men. For women, the figures were closer but followed a similar pattern: 65.9%, 66·7%, and 72·3%, respectively. Adjustment for deprivation explained some of the differences, but there was still an independent contribution of ethnicity to mortality.

Conclusion: Inequalities in health outcomes between deprivation groups are well documented, but there has been less quantification of the ethnic differences that may be the result of differential access to health care. We have adopted a novel method of constructing ethnic majority life tables that attempts to quantify the differences in mortality between ethnic groups. Our approach is ecological and thus only indicative of differences between the three different ethnicities. Furthermore, there will still be diversity within these three broad ethnic groups. However, our data show important residual differences in mortality risk between White, Black, and Asian people in England and Wales, even after adjustment for deprivation. These ethnic life tables can be used to inform public health planning.

Using data smartly to identify sexual health areas of greatest need

Rosie Ilett - *NHS Greater Glasgow and Clyde*

Objectives: NHS Greater Glasgow and Clyde (NHSGGC) has the largest integrated specialist sexual and reproductive health service in Scotland (Sandyford), which provides services for a population of 1 million. Four separate NHSGCC departments - health improvement, public health, Sandyford and information services - provide annual sexual health indicators for local areas across this geography to measure sexual health need and performance, and to help identify areas of potential need. Sandyford is currently planning its future service model to focus services on those that most need them, and to maximise their impact for which an innovative multi-level data mapping system has been developed.

Methods: A range of data sources have been collated to populate highly descriptive maps of the entire NHSGGC area to Intermediate Data Zone (IDZ) level. These maps illustrate the geographic proximity of specialist Sandyford and primary care services that provide long lasting contraception methods (LARC), plotted against current free condom distribution sites, population density of need (including proportions of reproductive age women, teenage pregnancy rates, socio economic deprivation and other local determinants of health and wellbeing), as well as maps that demonstrate the locations of other key population groups such as men who have sex with men and those who are HIV positive.

Results: At the time of writing the data is in the final stage of collation and is being used to work with local areas to guide planning of future sexual health services. Findings and subsequent actions coming from the process will be highlighted during the presentation, which will also demonstrate this innovative, multi-disciplinary approach.

Conclusions: This process has been undertaken as part of a review to identify service gaps and illustrates how previously disparate data sources can be used to more systematically match service to provision to greatest need and how public and population health methodologies can be applied to sexual health planning and to identify how best to meet health inequalities.

Measuring health inequality at a local level using primary care data

Tanya Khera-Butler - *Camden and Islington Public Health*

Health inequalities between deprived and less deprived areas are well recognised and a key aim for public health is to reduce this inequality gap. In order help target resources and monitor the gap, Camden and Islington Public Health used local data to quantify the relationship between deprivation quintiles and the diagnosis of long term conditions and access to health services.

Camden and Islington Public Health created a comprehensive GP Public Health dataset as of September 2012 using data extracted from all consenting GP practices in the boroughs (74 of 76 practices). This dataset was used to measure the inequalities gap and compare the relationship between IMD local deprivation quintiles and the diagnosis of fourteen health conditions and two health services (smoking cessation and NHS Health Checks) in Camden and Islington. The following absolute and relative inequality measures were used: absolute and relative range, slope index of inequality, relative index of inequality, population attributable risk, and concentration index.

The analysis found consistency between the different measures across the long term conditions and health services. The analysis showed that the diagnosis of diabetes, chronic obstructive pulmonary disease (COPD) and chronic liver disease (CLD) were consistently associated with the greatest inequality gap. For example in Islington the relative range shows that people residing in the most deprived areas have a 1.80, 1.67 and 1.72 greater chance of having diabetes, COPD and CLD respectively compared to people in the least deprived areas. It was calculated that 30%, 25% and 30% of diagnosis are attributable to deprivation for diabetes, COPD and CLD respectively. According to the regression equation for the relative index of inequality, prevalence among those in the most deprived areas are 0.64, 0.62 and 0.53 times higher than the average for diabetes, COPD and CLD respectively. A similar but starker pattern was found in Camden. It is well known that deprivation is linked to higher levels of obesity, physical inactivity and unhealthy lifestyles such as smoking and these in turn are strongly associated with the diagnosis of diabetes, COPD and CLD.

Further to this, there is a recognised gap between deprivation quintiles and the diagnosis of serious mental illness and learning disabilities, with a relative range of 1.72 and 1.63, a PAR of 25% and 23% and a relative index of inequality of 0.58 and 0.61 respectively in Islington. In contrast, there is no positive relationship between deprivation and the diagnosis of breast cancer and atrial fibrillation, with a relative range of 0.82 and 0.99, a PAR of -18% and -4% and a relative index of inequality of -0.18 and -0.03 respectively. The findings were largely similar for Camden.

The inequality measures show that the delivery of NHS health checks is successful in targeting people living in the most deprived areas of both boroughs. For example, in Islington, NHS Health Checks have a relative range of 1.25, a relative index of inequality of 0.27 and a PAR of 20%. The delivery of smoking cessation advice showed a similar pattern in Camden; successfully targeting people living in the most deprived areas, however this was not observed in Islington.

The findings from this piece of work will aid Camden and Islington Public Health addressing the inequalities gap in prevalence of long term conditions by targeting prevention services for the conditions with the largest inequality gaps. The relative range, the relative index of inequality and PAR will be used to monitor progress on reducing health inequalities for long term conditions and health services. These measures will be extended in the future to other inequality dimensions as well as additional services and long term conditions. ●

Migrant experiences in healthcare

ABSTRACT TITLES

Health and access to care for undocumented migrants living in the European Union: a scoping review and next steps
Aniek Woodward - *London School of Hygiene and Tropical Medicine*

African migrants' engagement with healthcare in Scotland: Preliminary results from a qualitative study
Matthew Smith - *University of Glasgow*

Abused No More? Challenges Faced by Refugee and Asylum-seeking Women When Accessing Health Services in the UK
Margaret Greenfields - *Buckinghamshire New University*

Health risks and healthcare experiences of trafficked migrants
Sian Oram - *King's College London*

FULL ABSTRACTS

Health and access to care for undocumented migrants living in the European Union: a scoping review and next steps

Aniek Woodward - *London School of Hygiene and Tropical Medicine*

Background: Literature on health and access to care of undocumented migrants in the European Union (EU) is limited and heterogeneous in focus and quality. Authors published a scoping review identifying the extent, nature and distribution of existing primary research (1990–2012), clarifying what is known and potential next steps that will be detailed further in the HERON presentation.

Methods: Authors used Arksey and O'Malley's six-stage scoping framework, with Levac, Colquhoun and O'Brien's revisions, to review identified sources. Results were summarised thematically: (i) physical, mental and social health issues, (ii) access and barriers to care, (iii) vulnerable groups, and (iv) policy and rights.

Results: Fifty-four sources were included of 598 identified, with 93% (50/54) published during 2005–2012. EU member states from Eastern Europe were underrepresented, particularly in single-country studies. Most study designs (52%) were qualitative. Sampling descriptions were generally poor, and sampling purposeful, with only four studies using any randomisation. Demographic descriptions were far from uniform and only two studies focused on undocumented children and youth. Most (80%) included findings on healthcare access, with obstacles reported at primary, secondary and tertiary levels. Major access barriers included fear, lack of awareness of rights, socioeconomics. Mental disorders appeared widespread, while obstetric needs and injuries were key reasons for seeking care. Pregnant women, children and detainees appeared most vulnerable. While EU policy supports healthcare access for undocumented migrants, practices remain haphazard, with studies reporting differing interpretation and implementation of rights at regional, institutional and individual levels.

Conclusions: The scoping review was an initial attempt to describe available primary evidence on health and access to care for undocumented migrants in the EU. It underlines the need for more and better-quality research, increased co-operation between gatekeepers, providers, researchers and policy makers, and reduced ambiguities in healthcare rights and obligations for undocumented migrants. Since publication of the review, authors have developed a funding proposal for a qualitative longitudinal assessment in the United Kingdom and the Netherlands.

African migrants' engagement with healthcare in Scotland: Preliminary results from a qualitative study

Matthew Smith - *University of Glasgow*

Background: Africans living in Scotland have the worst outcomes for HIV infection, primarily due to late diagnosis. To improve these outcomes a better understanding of the barriers to healthcare engagement is required. This PhD study seeks to investigate the heterogeneity of the African migrant diaspora in Scotland to examine how dimensions of diversity within the diaspora affect understandings and sensitivities to HIV testing and treatment. This is being explored within the context of Africans' general experiences of health engagement.

Methods: We conducted qualitative research, involving participant observation at two sites (an African religious group and an asylum seeker/refugee drop-in centre) and interviews with African migrants attending these and three additional sites (two advocacy charities and a student association), covering two major cities and two smaller towns (Glasgow, Edinburgh, Paisley and Kirkcaldy). We interviewed 27 Africans, including economic migrants (n=8), students (n=9) and asylum seeker/refugees (n=10). Representatives from organisations with high levels of African attendees were also interviewed (n=14). These include country associations, community organisations, advocacy groups, commercial establishments and religious based organisations. Thematic data analysis is ongoing and focuses on issues of identity in the diaspora, the nature of social networking for Africans in Scotland, the function of the organisations supporting the diaspora (in particular their facilitation of healthcare engagement), reports and understandings of healthcare engagement by the sample and experiences and conceptualisations around HIV.

Results: We will present preliminary results on the sample's understandings and experiences of the healthcare system in Scotland that may affect future willingness to engage with services. Our data suggest that there could be a wide variety of experiences and understandings of the healthcare system among African migrants in Scotland within the sample as a whole, but also to an extent by different subgroups within it. For example the healthcare needs of the asylum seeker/refugee group appear to be different from those of the students and economic migrants we interviewed. Whilst the majority of participants reported successful and satisfactory healthcare engagement, distinct barriers have also emerged. These include: understandings of rights and access to care based on African models of healthcare; the interplay of religious based understandings with ideas about access to healthcare; concerns around the trustworthiness and cultural empathy of health service practitioners; experiences of perceived discrimination; issues around communication; and assumptions and anxiety about the connections between visa status and health status. Other issues specific to the asylum seeker/refugee participants include: lack of resources; fear of engagement with official bodies; issues around the use or lack of interpreters; and health not being a priority in comparison to their needs for shelter, sustenance and navigating the asylum process.

Conclusions: The results suggest there are diverse experiences of healthcare engagement among first generation African migrants in Scotland. Perceived and experiential barriers to access have implications for addressing inequalities in the understanding of rights to access and actual use of healthcare for this population.

Abused No More? Challenges Faced by Refugee and Asylum-seeking Women When Accessing Health Services in the UK

Margaret Greenfields - *Buckinghamshire New University*

The presentation draws on an on-going user-led skills development and action research programme carried out at the Independent Academic Research Studies (IARS), a policy think-tank based in London, supported by academics from Bucks New University/IDRICS (Greenfields, 2013). The project aims to generate institutional change amongst health and legal services providers as well as increased gender sensitivity in the treatment of refugee and asylum-seeking women (RASW) through harnessing a combination of existing research and practice-based development to allow RASW to identify the problems they face in accessing services. The findings from the community led fieldwork carried out in Phase One by participating refugee and asylum-seeking women form the evidence-base for a training programme targeted at service providers. The programme focuses on enhancing practitioner skills in engaging with and supporting service users who have been victims of gender related violence and is delivered by women who have negotiated the maze of asylum seeking processes. www.youtube.com/watch?v=hun0eeqTJe0

A key finding from the fieldwork was the difficulty RASW experience in developing trusting relationships with GPs and other health practitioners. For this group of women, who have often suffered significant psycho-sexual trauma it can take a long time to develop trust in others, particularly those in authority, and/or male practitioners. Other significant findings included the need for all RASW to have consistent access to GP services and the importance of practitioner continuity in supporting disclosure of trauma and sexual violence, issues which may prove to key to accessing appropriate services, and/or prove to be fundamental in terms of asylum applications or appeals.

The experiences of the respondents to the study indicate that asylum-seeking women in particular commonly experience problems of registering with GP services. For example, some practices refuse to register new patients who are unable to provide proof-of-address documentation; while some refugee women indicate a lack of understanding on behalf of some reception staff about asylum-seekers' entitlements to primary health care and resultant refusal to provide free at the point of access services. Lack of time to build trust with practitioners, disclose traumatic incidents or discuss on-going health issues (particularly when using translation services in conjunction with medical appointments) led to the recommendation that RASW should be provided with double or longer appointment times when seeing GPs. Positive findings pertained to the high likelihood that professionals would offer specialist gender sensitive support when full disclosure of sexual violence and trauma were made.

The appropriate use of same-gender professionals in GP services was found to be crucial to a gender-sensitive approach to working with refugee women. There was an assumption amongst a significant proportion of the respondents that the gendered commonality of experience between themselves and female professionals resulted in an increased level of understanding; something that was not deemed to be as easy to achieve with male practitioners.

A further key finding from this study was that low levels of English language existed even amongst those research participants who had lived in the UK for 10 years or more. Emotional, social and stigma-related difficulties were repeatedly identified as associated with the use of informal interpreters, such as family members. Using children to interpret was identified as particularly problematic as potentialyl hindering open communication with GPs on sensitive topics. Access to language support proved especially difficult for those refugee women with no family or support networks in the UK in the wake of cut-backs in services.

Our study found that human rights-based principles of fairness, respect, equality, dignity and autonomy were key to positive experiences of health services for RASW. The research confirms the instrumental role of these principles as 'drivers' to improve experiences of service provision, particularly amongst vulnerable groups, such as refugee women who have experienced gender violence. The recommendations of this study should be seen in relation to the obligation of public authorities to act in accordance with the 1950 European Convention on Human Rights; and for officials to take human rights into account in their day-to-day work under the requirements of the Health and Social Care Act 2012 and in accordance with the Public Sector Equality Duty within the Equality Act, 2010.

Health risks and healthcare experiences of trafficked migrants

Sian Oram - *King's College London*

Background: Human trafficking is defined as the recruitment and movement of individuals by force, coercion, or deception for the purpose of exploitation. It is increasingly recognized as a significant violation of human rights and one of the world's fastest growing crimes. The UK government is further developing its response to human trafficking through the proposals in the Modern Slavery Bill. Evidence on the health risks and needs of trafficked people is, however, extremely limited. Such evidence is urgently needed to inform policies and services for trafficked people.

Objectives: This study aims to examine health risks and healthcare experiences among trafficked people.

Methods: Cross-sectional survey of trafficked men and women who have received support from statutory or voluntary services in England. The survey includes questions on socio-demographic factors, medical history and physical health, sexual and reproductive health, mental health, substance use, pre-trafficking and post-trafficking experiences (including violence and abuse), and current health and social needs. Qualitative questions at the end of each interview explore participants' experiences of using healthcare services in the UK.

Results: The survey is currently in progress; interviews have been conducted with 47 trafficked women and 22 trafficked men, ranging in age from 18 to 61 years. Participants were trafficked from over fifteen countries. A summary of socio-demographic characteristics and health risks (e.g. experiences of violence, living and working conditions while trafficked) and preliminary themes from qualitative analyses of healthcare experiences will be presented.

Conclusions: Trafficked migrants experience multiple health risks, and face difficulty accessing health services. Healthcare services should coordinate with local organisations providing support to trafficked people to assist them in accessing the range of healthcare services required.

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Patient and Public Engagement in research

ABSTRACT TITLES

Does patient and public involvement reproduce inequalities?
Christopher McKevitt - *King's College London*

Evaluating a UK natural experiment in community empowerment: The Big Local and its contribution to improving social determinants of health inequalities
Matt Egan - *London School of Hygiene and Tropical Medicine*

Assessing the effectiveness of complex neighbourhood-based health interventions: an evaluation of the North Lewisham Health Improvement Programme
Jane Miller - *Public Health Lewisham*

FULL ABSTRACTS

Does patient and public involvement reproduce inequalities?

Christopher McKevitt - *King's College London*

Background: Patient and Public Involvement (PPI) in health service development and health research is rhetorically positioned as producing improvements in the quality of health care, health research and evidence implementation; empowerment for patients and other citizens; and as an instantiation of the democratic process. Yet concerns are raised about the representativeness of those involved and the development of a cadre of professionalised lay experts. Little is known about those who take part in PPI processes. This study investigated European stroke survivors' awareness of and engagement with research.

Methods: We conducted a cross-sectional survey of stroke survivors participating in epidemiological stroke registers in six European centres. Questionnaires were distributed at 12-24 months post incident stoke.

Results: The response rate was 74% (481/647). Participants' reasons for taking part in stoke register research included responding to a clinician's request (56%) and the desire to 'give something back' (19 %). However, 20% were unaware that they were participating in a register. Research awareness was generally low: 57% did not know the purpose of the register they had been recruited to; 73% reported not having received results from the register they took part in; 60% did not know about any research on stroke care. Few participants (7.6%) used research evidence in their consultations with a doctor. Thirty-four percent of responders were interested in being involved in research processes while the remainder were not interested or unsure. Those who were interested were younger, more highly educated and already research aware. Unexplained differences across countries were observed.

Conclusions: Across Europe, stroke survivors who are already taking part in population-based epidemiological studies are not well informed about stroke research. This has implications for their capacity to engage in decision making about their own clinical care, as well as their readiness to participate in PPI processes related to research and evidence implementation. The finding that older people and those with lower levels of education were less engaged in research processes, suggests a need to ensure that PPI processes do not reproduce existing inequalities.

Evaluating a UK natural experiment in community empowerment: The Big Local and its contribution to improving social determinants of health inequalities

Matt Egan - *London School of Hygiene and Tropical Medicine*

Background: In the UK and elsewhere, the promotion of greater collective and/or personal control underpins many national and international strategies to promote population health and reduce inequalities in health. Big Local (BL) is an area-based initiative, developed and delivered by Local Trust with funding from Big Lottery. Under BL, 150 relatively disadvantaged neighbourhoods in England will each receive at least £1 million to spend over a fifteen-year period. The aim is encourage local people to take control over the way in which their communities' needs are defined and to develop, and actively engage in the delivery of, innovative solutions to 'make their neighbourhood even better places to live'. Although not explicitly seeking to improve the health of BL residents, the BL intervention is aimed at improving many of the social determinants of health with a focus on what the programme designers describe as 'the triple bottom line' – economic, social and environmental change. The National Institute for Health Research (NIHR) School for Public Health Research is therefore undertaking an evaluation of the impact on health and wellbeing of this complex 'natural experiment' in community empowerment. This presentation will describe the methods being used and discuss some of the challenges of involved in this evaluation.

Methods: The BL evaluation is designed to explore the pathways by which BL's approach to encouraging and resourcing collective decision-making by residents of BL areas leads to community-level changes affecting determinants of health inequalities (e.g. collective and individual-level control, environment, standards of living, social cohesion, etc) and health and wellbeing outcomes. It has a multi-staged, mixed-methods design in which conceptual and methodological approaches are developed iteratively in the eighteen months of the evaluation, leading to an evaluation of health and social determinant outcomes that extends for a further two years. The qualitative arm of the evaluation includes case studies of a sample of BL areas across England. We are conducting documentary analysis, participant observation and interviews with key local and national stakeholders such as residents; relevant third sector, local authority and public health practitioners; and nation-level BL implementers. Quantitative methods include using local data and GIS techniques to describe BL neighbourhoods and trace outcomes longitudinally using comparisons. The evaluation also includes engagement and knowledge translation activities to support health inequalities work in local public health systems.

Discussion: We will discuss opportunities and challenges associated with this ongoing evaluation. We will frame this discussion around continuing calls for more, and more robust, evaluations of social interventions affecting determinants of health inequalities. The evaluation exemplifies how we can utilise natural experiments and a combination of new empirical data and routine administrative data to explore the implementation and impacts of social and public health interventions within complex systems. We will also discuss how the evaluation fits with current political and public health strategies that afford community control a central role in tackling social exclusion and contributing to the regeneration of socio-economically disadvantaged areas. Findings will be relevant to the current government's programme 'Building the Big Society'. The evaluation will be highly relevant to local authorities as they deliverer on newly enhanced duties to encourage "community-level action" as a means of improving population health and wellbeing and reducing health inequalities.

Assessing the effectiveness of complex neighbourhood-based health interventions: an evaluation of the North Lewisham Health Improvement Programme

Jane Miller - *Public Health Lewisham*

Complex interventions are often used in public health to help improve the health of populations in a defined neighbourhood. They often consist of several interacting components and are subject to influence by a range of local factors that may vary from one setting to another. Consequently they present a challenge in standardisation of their design, delivery and evaluation, hence the lack of published evidence for their effectiveness. In this presentation, an evaluation of a complex intervention, the five-year North Lewisham Health Improvement Programme developed in two inner London electoral wards, is described to illustrate the health benefits of such an intervention and also how it can be evaluated.

The rationale of the programme was that strengthening community engagement, in addition to targeted increased investment, would be a catalyst to promoting health and reducing health inequalities. Using a community development approach, the programme was wide ranging, with inter-related initiatives such as; a multiagency stakeholder group that coproduced and oversaw the implementation of a local health improvement plan; collaborative projects between frontline health professionals and community volunteers to increase the uptake of health checks and to encourage people to present early to GPs with cancer symptoms; and a participatory budgeting initiative that engaged the community in designing and making decision on the funding of local projects that promoted healthy lifestyle.

An embedded evaluation methodology that included a range of qualitative and quantitative methods, as well as a framework for assessing the social return on investment was used. It entailed assessing how far the constituent parts of a programme met their individual objectives, and then assessing their contribution to the process and outcomes of the whole programme. It was designed to answer four main questions:

- What projects or initiatives were established?
- What objective[s] of the programme did they meet?
- What was learned about the process of the projects or initiatives?
- What were the outputs and outcomes of the projects or initiatives, and how did they contribute to improvements in the four overarching areas of the plan: knowledge, behaviour, disease prevalence and premature death?

The evaluation demonstrated that a range of processes and activities were coproduced by professionals and lay people. These generated health outcomes, including self-reported improvements in physical activity, improved diet, and improved mental well-being. Some additional and unexpected outcomes were also reported, including increased self-esteem, more energy, new friendships or social networks. There was a higher rate of smoking quitters in comparison with the average for other parts of the borough as a result of a social marketing project. These higher levels of quitters have been sustained beyond the lifetime of the project.

Primary care outcomes included improvement in GP recording of blood pressure, increased prescribing in the management of hypertension, a change in practice leading to a trebling of the number of cancer referrals per month, and improvement in the numbers referred within two weeks for breast, bowel and lung cancer by GPs.

The programme successfully targeted people from black and minority ethnic populations and women. The numbers of people with disabilities accessing projects were low initially, but action was taken to address this, particularly in projects developed through the participatory budgeting initiative, whereby higher numbers of people with disabilities accessed funded projects in later years. The reach of the programme was impressive. At least 10,000 people (approximately 1/3 of the population of the targeted wards) benefitted directly from the programme and many more benefitted indirectly through families and friends.

A return on investment of ratio ranging from 2:1 to 3:1 suggested good value for money. ●

SES and health inequalities

ABSTRACT TITLES

Social Class as Miasma: time to move on
Mel Bartley - *University College London*

Can we identify latent classes of socioeconomic status and what are the associations with mental health?
Laura Goodwin - *King's College London*

Ethnicity, health and unemployment in the UK: the mediating effect of unemployment on mental health outcomes
Natasha Crawford - *University of Essex*

Income inequality and use of dental services
Bishal Bhandari - *King's College London*

FULL ABSTRACTS

Social Class as Miasma: time to move on

Mel Bartley - *University College London*

For several decades since the UK "Black Report" research on health disparities or inequalities has relied on concepts of social position including income, education, occupational class and prestige. A great step forward was taken by Krieger, Williams and Moss who pointed out that indicators of social position should be more precisely defined before research could move from description to explanation (Krieger, N. Williams, D R. Moss, N E. Measuring social class in US public health research: Concepts, methodologies, and guidelines. Annu Rev Public Health 1997 (18) pp 341-378). Some subsequent research did more clearly distinguish between occupational class, prestige and material circumstances/income, and question whether education should even be regarded as a measure of social position. But the literature continues to include papers that use different measures in an imprecise manner, and the use of the term "socio-economic status (SES)" persists despite Krieger and colleagues' critique.

The presentation will argue that measures of social position, whichever we use, are now becoming obsolescent. There are no clear policy implications from the repeated demonstration of social inequality in health using such blanket definitions of inequality. At a time when large amounts of longitudinal data are available, with more added every year, it is possible to trace trajectories of exposures with sociological, psychological and biological plausibility. Future work needs to relate these exposures, which will be of biological (including the consequences of health behaviours), chemical, physical and psychosocial kinds, to unequal health outcomes at different stages of the life course. Using modern methods, it should become possible to identify the most promising points for intervention even when only observational studies are available.

The presentation will illustrate these arguments with examples taken from different longitudinal studies.

Can we identify latent classes of socioeconomic status and what are the associations with mental health?

Laura Goodwin - *King's College London*

Background/Objectives: Socioeconomic status (SES) can broadly be defined as comprising the different constructs of income and occupational status, housing tenure, and human capital i.e. educational attainment. SES is typically measured in epidemiological studies by a range of separate socio-demographic measures, with a focus on employment status and social occupational class. In this study we aimed to derive latent classes of SES which could be used in future epidemiological studies. The associations between these classes and mental health and alcohol misuse were explored.

Methods: This study used data from the South East London Community Health (SELCoH) study, which was a household study in the London boroughs of Southwark and Lambeth, including 1698 men and women. The measures of SES available were: social occupational class based upon current occupation; current employment status; household income; any debt in the past year; housing tenure; overcrowding in the home and whether they had moved house in the past 2 years. These data were analysed using latent class analysis (LCA) in MPlus and the goodness of fit of 2- to 7-class models were evaluated.

Results: A 6-class model provided the best fit and descriptively provided a good explanation of the data. The two most common classes were primarily defined by occupational class, including participants in employment, with 30% in class 1 'professional and managerial occupations' and 22% in class 2 of 'manual occupations', with further factors differentiating between these classes, such as housing tenure, education and level of debt. A third class predominantly included students, with 12% in class 3 and the three remaining classes included individuals who were not in employment. The latter three classes were 'economically inactive with low educational attainment' (class 4, 14%), 'economically inactive with mixed education/income and owner occupiers' (class 5, 9%) and 'unemployed and receiving benefits' (class 6, 13%). The prevalence of common mental disorder was found to be highest in classes 4 and 6, and alcohol misuse was highest in classes 1 and 3.

Discussion/Conclusions: This LCA identified six unique classes of SES, including three classes which differentiated individuals who were not in employment. CMD was highest in two of the three economically inactive groups, specifically in the classes including individuals with lower education and income, who were not owner occupiers. In this population, alcohol misuse was highest in students and in those in professional and managerial occupations.

Ethnicity, health and unemployment in the UK: the mediating effect of unemployment on mental health outcomes

Natasha Crawford - *University of Essex*

Ethnic differences have been identified for a range of health outcomes in both the US and the UK, with those from ethnic minority groups, on average, experiencing poorer health than the majority white population. While patterns of ethnic inequalities in health vary from one condition to another, on average, Pakistani, Bangladeshi and Caribbean groups have the poorest health in the UK (Nazroo, 1997; Sproston and Nazroo, 2001). Similarly, elevated rates of mental illness have been identified among some ethnic minority groups, with the rate of schizophrenia among the Caribbean group commonly reported at between three and five times that of the white population (Bagley, 1971). Such studies have, however, relied on contact with treatment services data which is problematic since such data may reflect illness behaviour rather than actual prevalence of mental illness in a population. Consequently, this reported increased incidence rate of psychosis has been contested (Blane et al, 1996).

Further, ethnic penalties in employment have been consistently documented in the UK with Bangladeshi, Pakistani, Caribbean and African groups consistently faring worse than the white British population in the labour market after adjusting for factors including education and local labour markets (Shields and Wheatley Price, 2003; Berthoud and Blekesaune, 2006; Bell and Casebourne, 2008; Nazroo and Kapadia, 2013).

Despite a well established negative association between unemployment and mental health (Bjorklund, 1985; Warr, 1987; Murphy &Athanasou, 1999; Steele, 2013) and an ethnic penalty in unemployment (Shields and Wheatley Price, 2003; Berthoud and Blekesaune, 2006; Bell and Casebourne, 2008; Nazroo and Kapadia, 2013), few studies have considered the potential mediating effect of unemployment when exploring ethnic inequalities in health. One exception is Ahmad's study of 215 white British and Asian individuals living in Bradford. While significant differences in perceived health were found between the two groups, with the Asian group scoring worse on a number of dimensions, this effect was reversed among some age groups after controlling for employment status (Ahmad, 1989). This therefore suggests that unemployment may indeed have a mediating effect in the association between ethnicity and health. This study was, however, neither longitudinal nor nationally representative.

Utilising data from waves 1 and 2 of Understanding Society: the UK Household Longitudinal Survey, this study seeks to explore ethnic differences in mental health outcomes and whether any association identified is mediated by unemployment.

Results identify differential outcomes according to ethnicity, with those from Bangladeshi and Pakistani groups reporting, on average, poorer mental health compared to those who identify themselves as White British. African women, in contrast, have lower odds of poor mental health in comparison to White British women. One potential explanation for this may relate to stronger social networks among this group, which has been associated with better mental health (Cohen & Wills, 1985; Gibney& McGovern, 2012). While we do not find that unemployment mediates the association between ethnicity and mental health it may be that it is not the occurrence of unemployment but unemployment duration that mediates this association. This will be explored in greater detail in future work given the present constraint of only two waves of data.

Income inequality and use of dental services

Bishal Bhandari - *King's College London*

Introduction: A number of ecological and multilevel cross-sectional studies suggest that dental conditions, such as dental caries, periodontal disease and tooth loss, are more prevalent in more unequal societies. Further research is needed on the underlying pathways. Reduced spending on health care could be an important mechanism linking income inequality to dental health as greater inequality may result in less spending in infrastructure and resources which are crucial for improving population health. Therefore, this research aimed to examine the association between income inequality and use of dental services at country level and to explore whether that association is explained by disinvestment in health in more unequal countries.

Methods: This study pooled national estimates for use of dental services among adults aged 18 years or older from the 70 countries that participated in the World Health Organization's World Health Survey (WHO/WHS) in 2002-2004, and aggregate data on Gross National Income (GNI) per capita, Gini coefficient, total health expenditure and dentist-to-population ratio from various international sources. The outcome was utilisation of dental services which was operationalised by exploring if the participants used the services in the last 12 months for their dental need. The association between income inequality (measured with the Gini coefficient) and use of dental services was explored using Pearson correlation coefficients and linear regression.

Results: Data from 63 countries, representing the 6 WHO regions, were analysed. Use of dental services was negatively correlated with Gini coefficient (Pearson correlation coefficient: -0.48, p<0.001) and positively correlated with GNI (0.71, p<0.001), total health expenditure (0.45, p<0.001) and dentist-to-population ratio (0.67, p<0.001). There was a 37.6%-difference in the proportion of adults using dental services between the most equal and the most unequal countries in our analysis. In regression modelling, the association between Gini coefficient and use of dental services was attenuated but remained significant when sequentially adjusted for GNI, total health expenditure and dentist to population ratio (regression coefficient: -0.22, 95%CI: -0.41, -0.03). This indicated that every 10%-increase in the Gini coefficient was associated with a 22% decrease in the proportion of adults using dental services when keeping all the other variables constant.

Conclusion: This study suggests that use of dental services is negatively associated with income inequality at country level. Furthermore, there was less spending on health services and the density of dentists in the population was lower in countries with greater income inequality, which seems to support the mechanism that greater income inequality may result in decrease spending in public services. ●

International health

ABSTRACT TITLES

TRAnslation of Ideas about Health Inequalities in Low and Middle Income Country Settings: a comparative study of policy responses in the UK, sub-Saharan Africa and South America (TRAILMICS)
Johanna Hanefeld - *London School of Hygiene and Tropical Medicine*

Private-Public Partnerships (PPP): Will involving other stakeholders (community and companies) be an answer to reducing the HIV and AIDS pandemic in Uganda?
NinahBakojja - *University of Edinburgh*

Reducing inequalities in adherence to antiretroviral therapy in people living with HIV and depression in Zimbabwe
Melanie Abas - *King's College London*

FULL ABSTRACTS

TRAnslation of Ideas about Health Inequalities in Low and Middle Income Country Settings: a comparative study of policy responses in the UK, sub-Saharan Africa and South America (TRAILMICS)

Johanna Hanefeld - *London School of Hygiene and Tropical Medicine*

The literature concerning the social determinants of health and health inequalities is extensive and growing on a daily basis. Yet, comparatively little of this research focuses on poorer parts of the world, despite the fact that health inequalities are a recognized problem for lower and middle income countries (LMICs) (Braveman and Tarimo 2002). As in other parts of the work, health inequalities are vast in sub-Sahara Africa (Rispel, de Sousa et al. 2009) and South America (Lancet) and, in the past 5-10 years, efforts have been made to explore and address health inequalities in both regions (Marmot, Allen et al. 2011).

Reflecting the growing international concern about health inequalities, the World Health Organization (WHO) commissioned the UK-based researcher Professor Sir Michael Marmot to chair a Commission on Social Determinants of Health (CSDH). This influential

Commission and its final report are framed as providing an international basis for global and national-level efforts to address health inequalities and the social determinants of health, including in LMICs (Marmot, Allen et al. 2011). The CSDH report is cited in policy debates across sub-Sahara Africa and South America (e.g. in the Mascot project in South America, and in national commissions on social determinants of health that have been established in countries such as Costa Rica and Peru). Yet, we know very little about how this report is being interpreted and translated within LMICs or, indeed, about how policymakers in LMICs themselves conceptualise and work to address health inequalities.

The CSDH report itself draws on multiple ways of conceptualizing and responding to health inequalities in policy terms. On the one hand, the report reflects the evidence-orientated framing of health inequalities that has been developed in the UK (Smith, 2013). This depends on the availability of evidence about 'what works' in reducing health inequalities (Smith 2013). On the other, the CSDH also positions the need to address health inequalities in normative/ethical terms, as a matter of social justice. Rather than focusing on the need for evidence of interventions that work to reduce health inequalities, this approach focuses on ethical and democratic rationales for addressing wider societal inequalities, such as those concerning citizenship and human rights (Almeida-Filho, Kawachi et al. 2003, Belizan, Cafferata et al. 2007).

The TRAILMICS project aims to understand how competing ideas about health inequalities are being constructed and translated in distinct social, political and economic LMIC settings and to examine their comparative success in reducing health inequalities. It explores these questions via a comparative analysis of responses to health inequalities in two low and middle income countries in two regions (sub-Sahara Africa and South America): Venezuela and Chile, and Kenya and Ethiopia.

This paper will present findings from initial desk based research conducted within the remit of the project which assesses the conceptualizations of health inequalities evident in the policy approaches developed in the final report of the WHO Commission on Social Determinants and Health and the extent to which these refer to LMICs, or are based on evidence created in LMICs. It will juxtapose findings of this analysis with evidence from an initial literature review on the kinds of policy approaches that appear to be having the greatest impact on health inequalities in study focus countries. Authors will reflect on the extent to which ideas and policy initiatives developed in HICs, particularly the UK, been promoted to audiences in LMICs as means of addressing health inequalities (e.g. via the CSDH)?

Private-Public Partnerships (PPP): Will involving other stakeholders (community and companies) be an answer to reducing the HIV and AIDS pandemic in Uganda?

NinahBakojja - *University of Edinburgh*

HIV and AIDS need not be a cause of deaths in Uganda and yet it is killing over 6000 people yearly (UNAID 2012). Uganda was among the first countries in Sub Saharan Africa to heed the call by WHO to set up national programs to fight the epidemic (Goodgame, 1999) and was applauded globally as a success story. The Uganda AIDS commission was set up; a great number of people were tested and over 6000 started on Anti Retroviral treatment (Avert, 2012). It is estimated (Kirby 2008; Barnett and Whiteside 2006) that the rate of HIV infection dropped drastically from 24% in 1992 to 7% in 2002. Kirby (2008) opinions that this was a result of intensive prevention efforts of directed and strategic national leadership plus widespread public awareness.

Research (WHO 2012) evidences that when started on ART early; people with HIV have reduced viral load and minimum infectious capacity. WHO has set new guidelines that require each individual that tests positive is started on treatment immediately to reduce new infections and facilitate the prevention-by-treatment agenda. This recommendation has not been reached in Uganda because of the cost implication. Currently only 577,600 of the 1,400,000 people with HIV/Aids in Uganda are on treatment and 5000 new infections arise every year. This coupled with condoms running out and people's low awareness (UNAIDS 2012). Uganda was in 2011 announced among the countries in Sub Saharan Africa, whose HIV prevalence rates were increasing (UNAIDS 2011). USA Secretary of State declared; "In 1990, Uganda had the best programme in the world. We saw how prevalence could drop drastically. However, I am here because I am worried. New infections are on the rise again." Hilary Clinton (The Observer , 2012)

Global Health Initiatives established rarely involve community participation. A gap exists in literature on how to engage the community and businesses in set government initiatives. Literature present concentrates on; How a successful Public Private Partnership (PPP) processes can be run and the governance structures required running PPPs. Multinational organizations, Government, religious sectors and community activists have been very instrumental in the fight against HIV-1. However, international aid is stagnating despite new and better technologies on HIV treatment sprouting up. USA, the largest contributor to global AIDS relief (Devex 2013), is gradually reducing HIV and AIDS spending in parts of sub-Saharan Africa due to economic slowdown. Withdrawal of aid by countries like Sweden, Netherlands because of the Anti Gay bill has affected some projects.

This situation requires faster and more vigilant resources to meet the challenge of the AIDS response and this could be contributed to by the private sector. Winnie Byanyima (Devex 2013) tasked businesses to join the public sector in the fight against HIV and community sustainability as their contribution can hardly be noticed.

PPP and community engagement is not a new phenomenon in Uganda. SABMiller a South African beverage company has been successful in providing farmers in Kapchorwa (Eastern Uganda) with sorghum seed, fertilizers and ready market for their produce. This has enabled farmers to become self reliant. Farmers also access health services through facilities that have been set up by Government, NGOs and supported by SABMiller. The partnership has facilitated over 5000 farmers and their families with Cotrimoxazole a prophylaxis that has enabled them to continue working and reduced impact of opportunistic infections. Tony Elumelu, a philanthropist (Rosencrantz, 2014), recommends such practices that are philanthropic and impact people's lives to create a self sustaining society that will not require aid a decade from now. Involving communities in research and HIV initiatives allows easier planning and implementation. It also eliminates bureaucracy, complications like condoms shortage (Bungudu, 2013) and drugs inaccessibility (Epilla 2012) because key stakeholders have been empowered.

Reducing inequalities in adherence to antiretroviral therapy in people living with HIV and depression in Zimbabwe

Melanie Abas - *King's College London*

As the HIV epidemic in Sub-Saharan Africa continues to evolve, many challenges remain. Foremost among these are ways to improve adherence to antiretroviral therapy (ART) for the approximately 25% of people on ART in Africa who fail to adhere (Mills et al. 2006). Adherence of at least 80% is needed to suppress the virus and prevent drug resistance and progression to AIDS (Bangsberg, 2002). This problem is critical in Sub-Saharan Africa given the prohibitive cost of second and third line medication.

Risk facts for poor adherence include individual barriers, such as forgetting and depression, complexity of regimens, contextual factors such as stigma, and structural barriers such poverty and poor supply of drugs (Mills, Nachega et al. 2006). Depression may increase poor adherence via symptoms and through impaired problem solving that comes about through low mood (Safren et al, 2002). In high-income settings, depression can be successfully treated among people living with HIV using cognitive-behavioural therapy and antidepressants, with improvements also in HIV-related health outcomes (Olatunji et al. 2006). Targeting depression could thus be a key to improving adherence to ART.

Selecting interventions for depression and for ART adherence in low-income African settings is challenging. There is a need to ensure that interventions are culturally appropriate and can be ultimately delivered by non-specialists given the paucity of mental health professionals.

In Zimbabwe we are following CDC guidance in order to adapt the LifeSteps evidenced based integrated 'CBT-Adherence' intervention to improve depression and adherence to antiretroviral therapy. We will outline two steps we have followed so far, which are Assessment of the target population in Zimbabwe, of the evidenced-based intervention and of local capacity to implement the intervention; and Preparation of the intervention materials which has included pre-testing the adapted materials with the target population, increasing agency capacity and developing collaborative partnerships to implement the intervention. From experience with the intervention, qualitative data will be presented on ways to get around individual and service-level barriers to adherence, thus reducing inequalities and improving mental and physical health in this vulnerable low-income population.

Next steps for 2014 will be a pilot randomized controlled trial of the adapted intervention. ●

Survival and mortality

ABSTRACT TITLES

Impact of the economic crisis on health inequalities in the European Union
Laia Maynou-Pujolras - *London School of Tropical Medicine*

Do South Asians show differences in colorectal cancer survival and trends in survival compared to non-South Asians in England?
Camille Maringe - *London School of Hygiene and Tropical Medicine*

The role of area-level socioeconomic status (SES) and gender in mortality risks among people with SMI
Chin-Kuo Chang - *King's College London*

A life course perspective on mortality risk at older ages
David Blane - *University College London*

FULL ABSTRACTS

Impact of the economic crisis on health inequalities in the European Union

Laia Maynou-Pujolras - *London School of Tropical Medicine*

The recent economic crisis has been an important shock not only to the economic sector, but also to the rest of the fields of society. Our main objective in this paper is to show the impact of the economic crisis on convergence, i.e. the reduction or equalising of disparities, among the EU-28 countries (including Croatia) in health terms. The aim is to observe whether the economic crisis (from 2008 onwards) has had an effect on health inequalities within the EU.

As dependent variables, we use life expectancy, total mortality and cause-specific mortality (ischemic heart disease mortality; cancer mortality; and larynx, trachea, bronchus and lung cancer mortality) in the regions of the EU-28 countries 1995-2011. Specifying a dynamic panel model with random effects (time, regions and countries), we estimate the convergence of the five dependent variables adjusting the model through the variables that, in turn, could influence economic convergence (i.e. GDP per capita growth rate). We are interested, in particular, in sigma convergence, i.e. the reduction of dispersion and inequalities over time. We use the coefficient of variation to measure the dynamics of dispersion levels of mortality and life expectancy, calculated out of the fitted model. The effects of the crisis are captured including a dummy variable in the model. Using other dummy variables, we also control for the enlargements in the EU, during the study period.

Although we found (beta) convergence on average, we also identified significant differences in the catching-up process both across time and regions. Moreover, the sigma convergence analysis, surprisingly, shows no reduction on average on dispersion levels. The dispersion levels of mortality and life expectancy continue increasing for the last periods. Consequently, if the reduction of dispersion is the ultimate measure of convergence, then, our study shows a lack of convergence in health across EU regions. In addition, we find a significant effect of the dummy variables included in the model to capture the effect of the crisis and the corresponding enlargements.

Do South Asians show differences in colorectal cancer survival and trends in survival compared to non-South Asians in England?

Camille Maringe - *London School of Hygiene and Tropical Medicine*

Background: People of Indian, Pakistani and Bangladeshi origin (South Asian) compose the biggest ethnic minority group in the UK, representing 4% of the population. South Asian migrants show lower incidence of all cancers combined, breast, prostate, lung and colorectal cancer than their host population but findings on survival vary.

Methods: We seek to determine how cancer survival in the South Asian population of England compares to non-South Asians. We also look at time trends and age and deprivation patterns in cancer survival in South Asians between 1986 and 2004 using national cancer registry data.

In this study, we focused on the most incident cancers in South Asians in each sex, but will report here the results on colorectal cancer. Due to their distinctive names, South Asian ethnicity could be flagged on cancer patients using SANGRA (South Asian Names and Group Recognition Algorithm), a validated algorithm. Analyses were restricted to the 997,104 patients eligible for analysis and aged 15-69 years at diagnosis; around 1% of which were of South Asian origin. Up-to-five-year cancer survival is estimated by net survival, the only survival metric enabling comparisons between populations with different mortality from causes other than cancer. Life tables specific to the general population of South Asians were constructed by deprivation and calendar year between 1991 and 2001 to adjust for deaths from other causes (overall mortality). Differences in overall mortality, known to exist between South Asians and non-South Asians, are therefore accounted for and we only estimate ethnic inequalities in survival from cancer. The effect of South Asian ethnicity, adjusted for age, deprivation and year of diagnosis was modelled on the excess mortality scale.

Results: In the period 1986-1995, South Asians had significantly higher age-standardised net survival for colorectal cancer in both men (54.7% vs. 43.5% at 5 years) and women (80.2% and 57.7% vs. 73.8% and 46.7% at 1 and 5 years respectively). In 1996-2004, 5-year net survival was still significantly higher in South Asian men compared to their non-South Asian counterpart: 58.9% vs. 53.6%. Short-term excess hazards were decreasing more rapidly in non-South Asian than South Asian men with calendar year of diagnosis, reaching similar levels by 2004: 0.21, CI: 0.18-0.25 and 0.19, CI: 0.18-0.20 and 0.12, CI: 0.10-0.14 and 0.13, CI:0.12-0.13 cancer deaths per person-year at 3 months and 1 year in South Asians and non-South Asians respectively. In men, the beneficial effect of South Asian ethnicity varied with time since diagnosis in the latest period (1996-2004): from same cancer mortality level than in non-South Asians until 1 year after diagnosis to a 50% reduction in excess hazard at five years. On the contrary, that beneficial effect remained constant in women, with South Asian women experiencing 80% of the excess hazard of non-South Asian women at all times after diagnosis.

Discussion: Various reasons have made survival patterns in South Asians look rather similar to non-South Asians in England by 2004. For colorectal cancer, steeper improvement in survival were observed in non-South Asians than in South Asians where survival only started to slightly improve from 1995. It is important to describe and understand the reason for varying trends in survival by ethnic group, especially at a time when the bowel screening program is being implemented. It is crucial to make sure that South Asians benefit from recent gains in colorectal cancer survival as much as the rest of the population.

The role of area-level socioeconomic status (SES) and gender in mortality risks among people with SMI

Chin-Kuo Chang - *King's College London*

Background: People with serious mental illness (SMI), including schizophrenia, schizoaffective disorder, and bipolar disorder, have been found at increased risks of mortality and reduced life expectancy in literature. The current analysis aims to explore the role of area-level socioeconomic status (SES) and gender in mortality risks among people with SMI.

Methods: South London and Maudsley NHS Foundation Trust (SLAM) is a single secondary mental healthcare provider in southeast London covering 1.23 million of residents in four London boroughs: Lewisham, Lambeth, Croydon, and Southwark. The Case Record Interactive Search (CRIS) system was established for the purposes of academic use of anonymised electronic medical records in 2006. Mortality and demographic data from 2007 to 2010 were retrieved from CRIS to calculate life expectancy at birth and standardised mortality ratios (SMRs) for people with SMI with age- and gender-specific mortality rates to compare with the general population. Stratified analysis by SES level, measured by the Indices of Multiple Deprivation which is developed by the National Office of Statistics combining various indicators to include a range of economic, social, and housing dimensions into a single deprivation score for each small area in UK was then performed.

Results: We identified 9,080 subjects aged 15 years or older with SMI diagnosed and 453 of them died during 2007-2010. The majority were schizophrenia (n=5,572) with a mean age of 44.3 (standard deviation, SD: 15.6) years old, followed by bipolar affective disorder (n=2,551; mean age: 44.2, SD: 15.4), and then schizoaffective disorder (n=957; mean age: 41.9, SD: 13.9). All psychiatric diagnoses and SES subgroups examined had significantly higher risk of general mortality than general population, with SMRs ranging from 3.15 to 6.21. Compared to UK national norms, people with SMI of all levels of SES had shortened life expectancies at birth reduced by 17.1 to 24.5 years in men and 16.6 to 22.3 years in women (statistically significant). In the stratified analysis, we revealed that the most vulnerable groups were men of higher SES and women of lower SES with life expectancy at birth reduced by 24.5 years and 22.3 years, respectively.

Conclusions; SMI has a high impact on mortality and life expectancy at birth in people of all SES, whilst the pattern of life expectancy across levels of SES at birth varies by gender, suggesting that the accessibility of premature mortality to SES might be modified by gender.

A life course perspective on mortality risk at older ages

David Blane - *University College London*

Longevity risk (living longer than expected) interests policy makers because it threatens pension schemes and undermines the annuities market and is interesting scientifically because it asks why life expectancy at middle age has increased more rapidly than predicted in recent decades. The presentation will apply a life course perspective to this problem, illustrated with UK data.

Several points are made. (1) The phenomenon is not disease-specific; deaths due to all of the most prevalent causes, bar one, have fallen by proportionately similar amounts. (2) The phenomenon is gender-specific; female mortality at age 65 years fell in a linear fashion across the whole 20th Century, it is male mortality which has fallen unpredictably. (3) Any explanation of the phenomenon must be socially and biologically plausible; a model of biological functioning is described which divides the life course into a phase of growth & development, a second phase of loss of functioning and decline, which ends in morbidity and death, and the ways I which the social context can maximise or stunt growth & development and accelerate or slow loss of function & decline. (4) The approach is illustrated for people born in UK during the 1930s, who currently are aged 85 years.

The approach suggests the importance of cumulative improvement in living conditions and that the importance of childhood should not lead to the relative neglect of adulthood and early old age. ●

Ethnic inequalities in healthcare

ABSTRACT TITLES

The ethnic density effect and antidepressant use – a link between neighbourhood ethnic composition and depression?
Peter Schofield - *King's College London*

Does ethnicity affect where people with cancer die? A population-based 10 year study
Jonathan Koffman - *King's College London*

What is a Culturally-complex Case? Expertise and Classification in Specialized Mental Health Services
David Ansari - *University of Chicago*

Patient explanations for non-attendance at diabetes structured education: is shame and stigma of diabetes a South London problem?
Kirsty Winkley - *King's College London*

FULL ABSTRACTS

The ethnic density effect and antidepressant use – a link between neighbourhood ethnic composition and depression?

Peter Schofield - *King's College London*

There is now an extensive literature documenting the link between neighbourhood ethnic composition and rates of severe mental illness. It has been consistently shown that members of some ethnic groups are more likely to be diagnosed with a severe mental illness if they live in areas where their ethnic group is less well represented. A similar "ethnic density" effect has been suggested for common mental disorders, such as anxiety and depression, although few studies have investigated this. We set out to investigate the ethnic density effect on risk of common mental disorders using an extensive collection of primary care records covering all (360,000) patients in Lambeth, South East London. Lambeth has a wide range of ethnic groups in varying concentration throughout the borough and is therefore ideally suited to this analysis. However, recent changes to the quality and outcomes framework (QoF) scheme, designed to reward practice performance, have meant that some GPs have a disincentive to record a diagnosis of depression. Therefore, as a proxy, we looked at whether anti-depressants had been prescribed in the past year. Our initial analysis shows that, after adjusting for patient age, gender and area deprivation, there was a marked inverse linear relation between area ethnic density and being prescribed anti-depressants for the black (census defined) population in Lambeth. An 10% increase in neighbourhood ethnic density corresponded to a 10% decrease in the odds of being prescribed anti-depressants, OR 0.90 (95% CI 0.86–0.95). This was even more marked for the Asian population where the odds decreased by around a quarter, OR 0.73 (0.59-0.90). Looking at more detailed ethnic groups we found the strongest ethnic density effect for the Indian ethnic group, OR 0.61 (0.50-0.75) and a distinct effect for the Black African ethnic group, 0.93 (0.89-0.98). However, Pakistani, Caribbean and Irish ethnic groups did not show a statistically significant linear effect. We also found very similar results when we looked at recorded depression diagnosis. We will also examine non-linear effects and possible explanatory factors at the area and practice level. We will discuss the possible aetiological implications of these results as well as implications for service use and access to treatment.

Does ethnicity affect where people with cancer die? A population-based 10 year study

Jonathan Koffman - *King's College London*

Background: Cancer is more common among older people with at least 75% of cases diagnosed among those over the age of 60 years. There are an increasing number of older members of black, Asian and minority ethnic (BAME) communities in the UK. The health-related experiences of those from BAME communities are recognised as a crucial 'tracer' for measuring the success in achieving patient-preferred outcomes in general, and specifically at the end of life. Place of death (PoD) is judged by patients, their families, health professionals and policy makers to be a central issue, particularly as there is increasingly evidence that most people, given the choice, would prefer to die at home or in a hospice. To date, only small descriptive and qualitative studies have examined the interface between ethnicity and location of death.

Aim: To conduct a population-based study of cancer deaths in London in order to examine and compare place of death among BAME groups and white British decedents.

Material and methods: Death registry data for 93,375 cancer deaths of those aged ≥65 years in London from 2001-2010 were obtained from the UK Office for National Statistics (ONS).Ethnicity is not directly collected on death certificates; we therefore used decedents' country of birth as a proxy for their ethnicity. The study focused on London to ensure large enough representation of people born outside the UK. Linear regression examined trends in place of death across eight countries of birth groups. Poisson regression was used to examine the effect of country of birth on place of death.

Results: 76% decedents (CI 75.7-76.3%) were born in the UK, followed by Ireland (5.9%, CI 5.7-6.0%), Europe (5.4%, CI 5.3-5.6) and the Caribbean (4.3%, CI 4.2-4.5). Most deaths (52.5%, CI 52.2-52.8) occurred in hospital followed by home (18.7%, CI 18.4-19.9). During study period (2001-2010), home deaths increased; for those born in UK (0.50%/yr, CI 0.36-0.64%, p<0.001), Europe (1.00%/yr, CI 0.64-1.30, p<0.001), Asia (1.09%/yr, CI 0.94-1.20, p<0.001) and Caribbean (1.03%/yr, CI 0.72-1.30, p<0.001), with a corresponding decrease in hospital deaths. However, time consistent gaps across the geographical groups remained. Compared to all other locations, with UK born as the reference group, hospital deaths were more likely for those born in Asia (including China) (PR 1.12 [1.08-1.15]) and Africa (PR 1.11 [1.07-1.16]). Hospice deaths were less likely for those born in Asia (including China) (PR 0.73 [0.68-0.80]), Africa (PR 0.83 [0.74-0.93]), and 'other' geographical regions (PR 0.90 [0.82-0.98]). Home deaths were less likely for those born in the Caribbean (PR 0.91 [0.85-0.98]).

Conclusions: Place of death from cancer varied according to decedents' country of birth. This may be influenced by ethnic or cultural patterning in accessing specialist palliative care services, including hospice and home care. Targeted palliative care strategies are needed to achieve greater equality between ethnic groups in place of death outcomes and to raise awareness of appropriate services to support communities in realising their preferred place of death.

What is a Culturally-complex Case? Expertise and Classification in Specialized Mental Health Services

David Ansari - *University of Chicago*

This paper considers the kinds of evidence that demonstrate cultural complexity in patient cases, and explores how clinical professionals in a specialized mental health service centre classify and become familiar with such evidence. Fieldwork was conducted for a six-month period from 2012 to 2013 in a mental health centre geared towards migrant groups in and around Paris. The data used in this paper draws on observations of patient assessment sessions, consultations between clinicians and patients, and mediation sessions. In addition assessing patient files, these practitioners also mediate between clinicians and patients in other centres when problems arise.

By analysing the selection of patients, I argue that clinicians at the centre demonstrate a form of medical and cultural expertise and classification. I describe how trainee therapists learn to identify culturally complex patients within a socio-political context in which cultural difference is not officially recognized. In other words, French mental health centres do not collect data on race, ethnicity, or religion. Migrant groups such as refugees and asylum seekers are generally not perceived to require specialized mental health services or consultations within medical institutions. As a result, little is known about the specific mental health needs or uptake of mental health services among these groups. This centre, recognized by the state for providing multilingual services, is well known by other organizations for dealing with the most 'culturally' complex cases of mental illness. Individuals deemed too difficult to work with are often referred, and these referrals reflect potentially stigmatizing attitudes of practitioners in other organisations. The centre can only take on a fraction of the patients referred, and therefore developed a unique process of taking on the most complex patients. As a result, the clinicians at this centre only take on patients who cannot access mental health services elsewhere. These clinicians often send patients back to the referring agencies, accompanied by an explanation as to why the referral was problematic.

The patient assessment and mediation sessions serve as a primary pedagogical exercise for medical, clinical psychology, and social work students undertaking their internships at this centre. The interns at the centre, referred to as thérapeutes en formation (TEFs), or therapists in training, are responsible for presenting the referred patient files to the group of senior clinicians. The TEFs spend hours immersing themselves in these files and preparing their presentations about each potential patient. During the meetings, the TEFs have only a few minutes to present each file and therefore must focus on the most pertinent information. The clinicians may ask for additional information, clarification, or they may quiz TEFs about diagnostic information. After each case is presented, the clinicians, in dialogue with the TEFs, determine which patients will come to the centre, which will be sent back to the referring organization, and which may require the services at yet another centre. In doing so, they learn how to value different pieces of evidence in each patient's file. As a result, TEFs learn about the kinds of patients that require specialized care, and the kinds of referrals that are problematic and stigmatizing.

This paper considers how student therapists in this centre learn to become cultural experts before moving on to take clinical jobs in more mainstream psychiatric and social service settings. By becoming intimately familiar with certain types of evidence, these clinicians and student therapists perform and transmit a form of cultural expertise within medical and social service institutions that do not recognize cultural difference. The performative approach of experts and experts-in-training highlights a unique perspective in debates of providing culturally competent care.

Patient explanations for non-attendance at diabetes structured education: is shame and stigma of diabetes a South London problem?

Kirsty Winkley - *King's College London*

Structured education for people with a new diagnosis of type 2 diabetes is widely available and associated with improved biomedical and psychological outcomes. Despite this uptake is low and the reasons for this are unclear and under-studied. We conducted a qualitative study to assess reasons for non-attendance at structured education in people with a recent diagnosis of type 2 diabetes.

Participants who had not attended structured diabetes education were sampled according to age, gender, self-reported ethnicity, and borough of residence from a population cohort of people with newly diagnosed type 2 diabetes, the South London Diabetes Cohort Study (SouL-D). Reasons for non-attendance were explored using in-depth semi-structured interviews. Interview data were analysed using a thematic framework method.

A multi-ethnic purposive sample of 30 people was interviewed. Three main themes emerged from the qualitative data explaining non-attendance at structured education sessions: (i) lack of information/perceived benefit of the programme, for example, not being informed about the course by their health professional, (ii) unmet personal preferences, such as, problems getting to the venue, parking, unable to attend because of salaried work/caring for others; and (iii) shame and stigma of diabetes, for example, not telling others of diabetes diagnosis which was particularly important for the Nigerian participants interviewed.

This is the first time that reasons for non-attendance have been explored in depth with patients who live with newly diagnosed type 2 diabetes. Results suggest that if we are to improve uptake, health professionals need to have a better understanding of the structured education programmes available and take a more active role in discussing individual patients' needs and support with diabetes self-management. Furthermore, whilst 2 of the3 themes have been reported in the literature, the third, that of shame and stigma of diabetes has not, suggesting that a local solution to the problem of non-attendance at structured education is also needed in South London. This may involve interventions that limit health-related stigma and improve diabetes self-management. ●

Stigma and discrimination in LGBT health

ABSTRACT TITLES

Structural stigma and all-cause mortality among sexual minorities in the United States
Mark Hatzenbuehler - *Columbia University*

Mental health of an inner London non-heterosexual population
Charlotte Woodhead - *King's College London*

Development and Audit of the Gender Reassignment Protocol for Scotland
David Gerber - *Sandyford*

Gay men and Inflammatory bowel disease: the unique intersections of queer life and chronic illness
Lesley Dibley - *King's College London*

FULL ABSTRACTS

Structural stigma and all-cause mortality among sexual minorities in the United States

Mark Hatzenbuehler - *Columbia University*

Stigma operates at multiple levels, including intrapersonal appraisals (e.g., self-stigma), interpersonal events (e.g., hate crimes), and structural conditions (e.g., community norms, institutional policies). Although prior research has indicated that intrapersonal and interpersonal forms of stigma negatively affect the health of the stigmatized, few studies have addressed the health consequences of exposure to structural forms of stigma. To address this gap, we assessed the impact of structural stigma—operationalized as living in communities with high levels of anti-gay prejudicial attitudes—on the mortality risk of sexual minority populations residing within that community over time (N=914). We constructed a measure capturing the average level of anti-gay prejudice at the community level, using data from the General Social Survey, which was then prospectively linked to all-cause mortality data via the National Death Index (GSS-NDI). The GSS-NDI is a multi-year representative sample of the US non-institutionalized population. Sexual minorities living in communities with high levels of anti-gay prejudice experienced a higher hazard of mortality than those living in low-prejudice communities (HR=3.03, 95% CI=1.50, 6.13). Results remained robust after controlling for individual-level (year of birth, self-rated health, race/ethnicity, household income, sex, nativity status, educational attainment) and community-level (collective average education level, income, proportion of individuals identifying as politically conservative) confounders. This result translates into a shorter life expectancy of approximately 12 years (95% C.I.: 4-20 years) for sexual minorities living in high-prejudice communities, which is comparable to life expectancy differences between high school dropouts and graduates. Analysis of specific causes of death revealed that suicide, homicide/violence, and cardiovascular diseases were substantially elevated among sexual minorities in high-prejudice communities. Strikingly, there was an 18-year difference in average age of completed suicide between sexual minorities in the high-prejudice (age 37.5) and low-prejudice (age 55.7) communities. These results highlight the importance of examining structural forms of stigma as social determinants of health among minority populations.

Mental health of an inner London non-heterosexual population

Charlotte Woodhead - *King's College London*

Background/Objectives: Higher rates of psychiatric disorder and substance abuse have been well documented within non-heterosexual populations. Greater exposure to both stressful life events and perceived discrimination have been investigated as risk factors yet there is limited research examining these factors within the same sample. This study aimed to 1) estimate the prevalence of common mental disorder (CMD), mental well-being (MWB) and substance use by sexual orientation; 2) to estimate the prevalence of both stressful life events and perceived discrimination; 3) to examine the effects of stressful life events and perceived discrimination on CMD, MWB and substance use. Hypothesis: inequalities will be observed by sexual orientation. These will be partially explained by greater exposure to stressful life events and perceived discrimination.

Methods: In a community health survey, CMD was measured using the Clinical Interview Schedule Revised, MWB using the Warwick-Edinburgh Mental Well-Being Scale, suicidal ideation/attempts through self-report, hazardous alcohol use using the Alcohol Use Disorders Identification Test and illicit drug use through self-report. Discrimination was a measure of everyday, lifetime major experiences and anticipation of unfair treatment. Stressful life events were a measure of both childhood adversity and lifetime exposure to serious life events. Prevalence of health outcomes, discrimination and stressful life events were estimated by sexual orientation. Odds ratios were calculated to assess the association between health outcomes and sexual orientation in adjusted logistic regression models. Confounders included socio-demographic and socioeconomic characteristics, discrimination and stressful life events.

Results: Non-heterosexuals reported greater exposure to both discriminatory experiences and certain stressful life events. Non-heterosexuality was associated with half the odds of positive MWB, more than twice the odds of CMD, more than four times the odds of suicidal ideation, hazardous alcohol use and illicit drug use. After adjusting for discrimination and stressful life events strength of associations between non-heterosexuality and CMD, suicidal ideation, hazardous alcohol use and illicit drug use were reduced, supporting the hypothesis.

Discussion/Conclusions: Discrimination and stressful life events were found to be risk factors for inequalities by sexual orientation but did not attenuate associations between non-heterosexuality and mental health. Mechanisms of discrimination and stressful life events that contribute to poor mental health should be considered in reducing inequalities but further risk factors need to be considered.

Development and Audit of the Gender Reassignment Protocol for Scotland

David Gerber - *Sandyford*

Background: In late 2010 the Equality and Human Rights Commission (EHRC) approached the Scottish Government (SG) following complaints they had received from trans people accessing gender reassignment services in NHS Scotland. The complaints were regarding the variation in service provision across the country. SG agreed to review Gender Reassignment (GR) services and to the development of the Gender Reassignment Protocol (GRP). The purpose of the GRP was to ensure equal and timely access to GR services across all health boards and improve patient experience. NHS Health Scotland was asked by SG to coordinate and manage the development of the GRP. To do this we established a working group made up of GIC clinicians, a plastic surgeon, National Services Division director, representatives from SG, the Scottish Transgender Alliance (STA) and trans community representatives.

The final protocol was submitted to SG on 30th September 2011 for approval and sign off. The GRP follows guidance within World Professional Association of Transgender Health (WPATH) version 7 Standards of Care and was shared with the EHRC, who were happy with it. The GRP was issued to health boards by SG in July 2012.

An audit of the GRP was performed assessing the period January-December 2013 to assess the impact of GRP on services.

Aims: The aim of the audit is to explore the degree to which local delivery of the GRP is equitable, effective, patient-focused and timely.

Further aims are to:
- Identify barriers to the implementation of the protocol.
- Make recommendations to enhance delivery of the protocol.

Methods: Information was gathered from services that deliver gender reassignment treatments and from members of the transgender community that have accessed gender reassignment services since July 2012. The data was gathered through the distribution of standardised questionnaires to clinical services involved in delivery of the protocol. Focus groups were conducted with the Transgender community and there was also an online survey for people unable to attend focus group meetings.

Results: All services that deliver gender reassignment treatments have completed implementation of GRP. Services reported implementation of GRP as having raised awareness of gender reassignment services amongst staff, allowed for multi-disciplinary team working, and better buy-in.

Services identified key improvements areas that are ongoing, such as:
- patient satisfaction survey/needs analysis
- improving hair removal services
- improving information services
- increasing staff complement

Areas highlighted as concerns by services that may need further development included:
- waiting times for all services remain long, but particularly for initial appointment with GIC
- delivery of services constrained by limited availability of all types of clinicians
- inclusion of Nationwide plastic surgery protocol pathway in GRP

Key findings from the focus groups and survey were:
- long waits for GIC appointments and distance to travel for people
- lack of information available on treatment options available and treatment plan from GICs
- lack of capacity of GIC admin staff
- variation in provision of hair removal across country
- variation in provision of cosmetic and Gender Reassignment surgery across health boards

Conclusions: The Audit demonstrates successful implementation of the GRP. However, numerous barriers to access still remain. The GRP however, is acting as a driver for change in this area and should continue to reduce inequalities of access to treatment for this patient group.

Gay men and Inflammatory bowel disease: the unique intersections of queer life and chronic illness

Lesley Dibley - *King's College London*

Inflammatory Bowel Disease (IBD) (including Crohn's disease and Ulcerative Colitis) is a chronic gastrointestinal disorder of uncertain aetiology. Onset is typically during adolescent or late adult years. The illness has a classic relapsing and remitting pattern. Relapse produces symptoms of profuse diarrhoea, dehydration, abdominal pain, and fatigue. Disease complications, and the colorectal surgery required to manage these, can disrupt normal ano-rectal anatomy and function.

As part of a study exploring the impact of IBD on LGBT lives (n=50), we interviewed 14 gay men about their experiences, recruiting from a wide range of sources including charity and social media routes. Interviews were audio recorded, professionally transcribed and thematically analysed.

Gay men were found to have many concerns similar to those of the general IBD population, and rank them similarly in order of importance. Disease symptoms are universal, and can be managed similarly, independent of sexual orientation or gender. Similar techniques are used to come out about IBD, as are used to come out about sexual orientation. Several themes unique to gay men were identified: although keen to impress that being gay was about more than just sexual activity, IBD was found to encroach on identity and activity in many cases. Body image was affected by abdominal scarring, and preferred sexual activities were disrupted or lost entirely. Some men adjusted better to these enforced changes than others. Previously well-documented concerns over receiving healthcare were also identified in this study, alongside concerns that others would make inaccurate associations between IBD and sexual orientation (assuming that the illness is a consequence of sexual activity), and uncertainty over the sexual activity options available to gay men. Specialist IBD nurses and doctors were viewed favourably but often failed to acknowledge men's relationships with their partners affecting the availability of partner support during acute and sometimes life-threatening medical events. Advice about sexual activity is lacking.

Gay men are affected by IBD in ways which do not impact on non-gay patients, and require sensitive support and advice from clinicians. There is a particular need to build the evidence base for sexual activity advice following colorectal surgery for gay men. ●

Impact of stigma and discrimination on health

ABSTRACT TITLES

FULL ABSTRACTS

A lifecourse approach to emerging health disparities in a US birth cohort (DISPAR)

Bruce Link - *Columbia University*

A strong precept of life course epidemiology tells us that adult health is the product of cumulative, sequenced relations between persons and environments. As powerful as this insight is the opportunity to enact its potential has been limited by the availability of data that allows its realization. We describe a study that provides an opportunity to examine a potential "dynamic interplay" between social conditions, cognitive abilities, and emerging health across the life course to explain mental health disparities by race and SES in adult life. The explanatory focus embedded in each of these factors such that the first emphasizes social factors, the second emphasizes cognitive factors, and the third emerging health itself. Our study brings these strands of inquiry together in one study to allow an examination of their "dynamic interplay" across the life course. We employ data from the Child Health and Development Studies (CHDS) that was ascertained in the Bay Area of California. This cohort provides excellent information from early life through adolescence on SES, on cognitive ability, and on the health domains we have chosen to study. In the current research, these novel data are brought to fruition to study the emergence of mental health disparities by race and SES in a sample of 603 CHDS cohort members at midlife.

Racism and resilience in young ethnically diverse Londoners: the Determinants of young Adult Social wellbeing and Health (DASH) longitudinal study

Ursula Read - *University of Glasgow*

Background: The negative impact of racism on mental health is widely documented. In a stress-coping framework racism can be thought of as a social stressor that triggers physiological or psychological responses. Social support and coping styles may mediate this process. There are few longitudinal studies of the impact of racism and discrimination on health over the lifespan. Repeated experiences of discrimination may erode resilience over time. On the other hand, resilience developed in childhood may have enduring protective effects.

The DASH longitudinal study has been following up over 4000 young people from diverse backgrounds in London since early adolescence. London presents an interesting lived experience for children. Neighbourhoods are culturally diverse, although ethnic minorities are generally more likely to live in deprived areas than their White British peers. In DASH, ethnic minority adolescents reported better mental health than White British, despite more economic disadvantage and more racism. Ethnic diversity in friendships, family life and parenting style were protective of mental health. The DASH cohort is now in their early 20s and we examined whether resilience continues and what might moderate the racism-stress response.

Methods: 6643 11-13 year olds from 51 London schools took part in the baseline survey in 2002/03 and 4,782 were seen again at 14-16y. In 2012-13 a sub-sample (600) aged 21-23y were surveyed. Mental health (the General Health Questionnaire (GHQ-12)), unfair treatment, and a range of other measures were collected using self-complete questionnaires. In-depth semi-structured interviews (42), informed by questionnaire responses, covered social relationships, identity, experiences of racism and discrimination and coping strategies. An iterative approach to analysis using longitudinal data from teens to twenties and qualitative data at age 21-23y was employed to identify deductive and inductive themes, optimising interpretive and contextual value.

Results: GHQ scores suggested tracking of resilience in some ethnic groups, in spite of more reported racism. Qualitative interviews revealed common experiences of perceived racism or discrimination across all ethnicities, including White British. These consisted of inter and intra group discrimination on the grounds of gender, sexuality, social class, as well as ethnicity and religion, and included insults, social rejection, difficulties in finding work, police harassment, and negative media stereotyping. Vicarious racism, experienced particularly by parents, was also reported by ethnic minority participants.

Ethnic diversity in schools, workplaces, neighbourhoods and citywide was perceived to moderate the likelihood of overt racism and provided exposure to alternative worldviews and lifestyles. Parents' experiences of coping with racism to pursue migration goals were reported to motivate aspirations and model coping styles. Neither racism nor discrimination was felt to significantly alter self-worth which was reinforced by strong family attachments, high aspirations, religious faith, fluid identities and neighbourhood belonging. This corresponded with positive responses to GHQ items on 'feeling worthless' and 'facing up to problems'. Participants with lower education, difficulties in finding work, problematic family relationships, and poor mental health appeared more vulnerable to the impact of racism.

Conclusion: The transition to adulthood can be stressful, but family life, aspirations and religious values, as well as complex but secure identities appeared to play an important role in nurturing resilience and to moderate the negative effect of racism. Exposure to diversity appeared to inspire worldviews characterised by flexibility and adaptability which may enhance coping. However structural discrimination, which was also reported, could prevent fulfilment of career aspirations and contribute to erosion of resilience as participants age.

Impact of stigma and discrimination on pathways to care: subjective experiences of young people at risk of developing psychiatric disorder

Petra Gronholm - *King's College London*

Background: Stigma and discrimination are proposed as critical factors contributing to the underuse of mental health services amongst young people in the literature; but these influences remain understudied. Existing research on stigma experienced by young people has focused on individuals in contact with mental health services or with a psychiatric diagnosis. Using a community sample, this study investigates subjective accounts of stigma during the early stages of mental health difficulties with regards to how difficulties are conceptualised, how disclosure and coping are considered, and how help-seeking from both informal and formal sources is approached.

Methods: In-depth qualitative interviews were conducted with 29 young people from the Child Health and Development Study (CHADS; Laurens et al., 2011) community cohort. Purposive sampling criteria are used to recruit participants who have reported early psychopathology of a persisting nature (emotional and/or behavioural difficulties at a clinical level, and psychotic-like symptoms), thus representing young people at-risk of developing psychiatric disorder. The interview data will be analysed according to the principles of thematic analysis.

Results: Themes emerging from the data will be presented. These consider specifically participants' coping strategies in relation to their difficulties and how other individuals are involved in this process. The themes also cover the meanings young people have assigned to help-seeking, barriers and facilitators of associated processes, and the functions social support and formal services are perceived to hold.

Conclusions: This study will provide a greater understanding of how stigma-related influences might impact on initial steps in young people's pathways to accessing care. Exploring this from a community perspective enables us to capture the experiences of young people who have not yet established contact with services despite the presence of difficulties, and to consider potential differences in service use determinants by service settings (e.g. health versus education settings) or by sources of support (e.g. family, friends, professionals). ●

Improving community access to healthcare

ABSTRACT TITLES

FULL ABSTRACTS

Service Mapping, Stakeholder & Needs Analysis for a Low-Threshold, Open-Access GP Service for Marginalised Groups in Limerick City

Patrick O'Donnell - *University of Limerick*

Introduction: Levels of homelessness and drug abuse have increased in Ireland over the last number of years. Our group, the Partnership for Health Equity, intends to establish a general practice (GP) service for drug addicted and homeless patients in Limerick city. This type of targeted, low-threshold medical service has been previously successfully introduced in Dublin and Cork, and has been effective at improving access to GP care for these patients. No such service exists in Limerick and there is only anecdotal evidence of the need for it. This formal stakeholder mapping and analysis aims to inform this GP service development in consultation with relevant stakeholders.

Methods: Stakeholder mapping was carried out to record existing services and their connections. Stakeholder analysis was then conducted to gauge the influence and importance that various groups had in relation to the proposed project. This was informed by 34 consultations over a ten week period with a purposeful sample of service providers (HSE and voluntary), homeless and drug using clients and their families. Interviews were analysed thematically. Mapping and analysis were carried out using internationally recognised resources.

Results: All stakeholders consulted were in favour of the project. There seemed to be a high level of medical card registration, but those with a card often faced barriers to actually receiving GP care. These perceived obstacles to care included the breakdown of the patient-GP relationship, embarrassment or shame and frequent change of patient address. Suggestions for services that should be provided included; vaccination and blood borne virus testing, mental health and addiction assessment and wound care. Unexpected suggestions included dental treatment and antenatal care. Provision of some of these facilities will require working closely with existing healthcare providers and services.

Conclusions: Marginalised groups, particularly homeless and drug users, have been shown to benefit from targeted GP care. The aim of this project was to generate evidence of the need for this type of service in Limerick. We analysed existing health services, and recorded the health issues that need to be addressed. This type of patient /service user and advocate involvement in the modelling of health services could be widely adopted.

Improving Access to Psychological Therapies for People with Psychosis and their Carers: Uptake of Psychological Therapies by Minority Ethnic Groups

Louise Johns - *South London and Maudsley NHS Foundation Trust*

Cognitive-behavioural therapy and Family Interventions for psychosis (CBTp&FIp) are clinically and cost effective (NICE, 2009), and receive high satisfaction ratings from service users and carers. NICE recommend that CBTp is offered to everybody with psychosis and that FIp is offered to all psychosis clients with a caregiver, however, current NHS provision is unable to meet demand (Schizophrenia Commission, 2012). Ethnicity, faith and language can place additional barriers to accessing psychological therapies for people from black and minority ethnic (BME) communities, leading to lower uptake of these therapies in BME groups (Bhugra, 2009). Furthermore, higher dropout rates and poorer outcomes from CBTp have been reported for BME service users (Rathod et al, 2005). One of the challenges within the NHS is to improve uptake of and engagement with evidence-based psychological therapies in these minority groups.

The Improving Access to Psychological Therapies for people with Severe Mental Illness (IAPT-SMI) initiative is part of the government's four-year plan to increase access to talking therapies, to improve provision of NICE-recommended psychological therapies for people with bipolar disorder, personality disorders and psychosis. South London and Maudsley (SLaM) NHS Foundation Trust is one of two IAPT-SMI Psychosis demonstration sites, offering a strategic approach to improving access to high quality evidence-based therapy (CBTp&FIp). This involves seeing more clients for therapy across a range of demographics, reducing waiting times, taking direct referrals, and conducting regular assessments of progress. Our IAPT-SMI service spans three psychosis teams: an Early Intervention team, a specialist recovery service, and a psychological therapy team.

The demonstration site started in November 2012. Since that time, we have increased therapy provision by 100% and have reduced waiting times by 40%. In terms of referrals accepted by the service, there have been no significant differences according to gender or ethnic minority status overall, with numbers representative of the local demographic. In the young adult (Early Intervention) group, the rates of BME referrals are around two times higher than non-BME referrals, for both males and females. In addition, the rates of therapy completion are similar across gender and BME group. We are collecting patient reported outcomes during and after therapy. Paired completion rates are very high and preliminary outcome data show similar positive outcomes for BME and non-BME clients.

The findings of this IAPT-SMI pilot demonstrate that it is possible to improve access to and uptake of psychological therapies for psychosis for BME individuals, with low drop-out rates and good clinical outcomes.

Accessing healthcare: inequalities and discrimination in Enfield

Elena Vacchelli - *Middlesex University*

The presentation is based on a research project that our team at the SPRC undertook in collaboration with EREC (Enfield Race Equality Council) in 2013. The study aims at assessing to which extent local health providers in Enfield are able to tackle differential access to health services of certain vulnerable groups and to which extent new bodies implemented as part of the NHS reform, such as CCGs, are aware of equality legislation and are able offer internal mechanisms to implement it. The project has been devised to reflect at a local level the larger scale comparative European project, Inequalities and multiple discrimination in access to and quality of healthcare funded by the Fundamental Rights Agency which our team has coordinated in 2011-2012. 'Accessing healthcare: inequality and discrimination in Enfield' aims at mapping existing health providers, health advocacy groups and charities/community organizations in Enfield in order to assess what services they offer and whether they are informed by equality legislation. Three different patient groups (women, elderly people and people with mental health problems) were interviewed as part of the project in order to assess whether they experienced problems in accessing healthcare, what the specific barriers to access are and how they can be overcome.

Preliminary findings suggest that responsibilities for gathering relevant data on equality and conducting equality impact assessments are unclear at a time of institutional reconfiguration of the NHS; information in this area is fragmented, patchy and difficult to access. From a database of GP practices in Enfield, it is evident that there is little or no knowledge about any kind of specific services offered to BMEs other than language. From a preliminary search, it is evident that there is a gap in knowledge about the following instances: (i) Local BME communities and their needs (ii) Equality and Diversity - what it is about and how it is relevant to GPs surgeries (iii) guidance about what GP surgeries can do to improve Equality and Diversity work and awareness about their communities (iv) medical needs/trend of specific BME communities.

At a local level, the study has confirmed that the three groups experience differential barriers to access according to the direct/indirect nature of these barriers. There is concern amongst some community representatives that newer arrivals and those groups who are not in contact with community organisations do not register with GPs and this is due to both lack of awareness of these services and cultural barriers. As a result, there is a tendency by these groups to access services only when they encounter acute health problems. Even BME people from more established communities, although registered with a GP, need guidance in order to access services. There appears to be a huge lack of knowledge and awareness of services offered by GPs and other medical practitioners in Enfield. Although it is unclear who will be in charge to inform BME groups on available health services, the role community groups remains central in passing health messages on to the communities they cater for, particularly when health promotion and prevention work is carried out. More outreach needs to be undertaken with BME and hard to reach communities to make them aware of health services and the benefits of using them. On the other hand, training needs to be undertaken by GPs, health practitioners and their staff on cultural issues and sensitive matters. ●

Resilience, adversity and young people's health

ABSTRACT TITLES

Evaluating the collaboration of youth workers in the Emergency Department at the Major Trauma Centres: the King's Model
James Pallett - *King's College Hospital*

Poverty, ethnicity and health inequalities in adolescents from deprived areas of London
Gopal Netuveli - *University of East London*

The mental health needs of young people involved in street gangs
Jane Padmore - *South London and Maudsley NHS Foundation Trust*

Stressful life events and mental health outcomes among youth in New Orleans
Denese Shervington - *Institute for Women and Ethnic Studies*

FULL ABSTRACTS

Evaluating the collaboration of youth workers in the Emergency Department at the Major Trauma Centres: the King's Model

James Pallett - *King's College Hospital*

King's College Hospital NHS Foundation Trust pioneered the first collaboration in the United Kingdom between a Youth Agency and the Emergency Department. Aiming to help young people break the cycle of violence, social science graduates employed by the charity Redthread, engage with injured young people attending the Emergency Department at the Major Trauma Centre. Situated in an area with a high prevalence of gang related violence, the Emergency Department offers a "teachable moment" where the young person is more willing to accept intervention and professionals can identify the unique risks and needs of the young person then link the individual with other third sector agencies through established community partnerships. This partnership at King's has featured in the 2011 and 2013 Home Secretary's Report, "Ending gang and youth violence" and is a recent recipient of 2 national youth work awards Children and Young People Now Awards 2013. As a result, the partnership has subsequently been replicated at other London Emergency Departments in order to prevent further serious injury or death in young people, improve the quality of their lives and reduce the associated healthcare and criminal justice costs. Despite this, the evidence-base for this complex intervention and a rigorous evaluation methodology has not been established in the United Kingdom. The department has recently analysed the patterns of local knife injuries in order to quantify the local demand for this intervention.1 The current focus to be presented is to establish the feasibility of a randomised controlled trial to evaluate the effectiveness of the intervention. The temporal patterns, demographics and disposition of adolescent violent injuries have been studied. The intervention pathway is defined which will allow replication at other Trusts and the practical issues of implementation addressed. The acceptability of the intervention has been analysed with a mixed methods methodology through quantitative assessment of recruitment to the intervention, retention and losses to follow up and a qualitative assessment by questionnaire of staff and participants. The practicality of randomisation and consent has also been addressed. The outcome domains in a future interventional study are proposed as; the future risks of re-injury, service utilisation, involvement with the criminal justice system, quality of life and economic evaluation. Defining these outcomes with validated measurements remains a challenge in this neglected area of academic research and a collaboration of the health sector, public health, third sector agencies and the criminal justice system is actively sought by the authors in order to propose an evidence-based rigorous evaluation of this complex intervention in the United Kingdom.

Poverty, ethnicity and health inequalities in adolescents from deprived areas of London

Gopal Netuveli - *University of East London*

Inequalities in children and adolescents are relatively less studied than those in adults. When studied, the outcomes tend to be educational or developmental and the exposures tend to be poverty or neighbourhood deprivation. Similarly, a few studies have noted the poor health outcomes in ethnic minority children. The aim of the present paper is to study the inter-relationship between poverty, ethnicity and health inequalities in adolescents living in the more deprived London boroughs. For this purpose we use data from the Phase I of the Well London Study. The Well London program included community-based projects with the aim of increasing physical activity, healthy eating, and mental health and wellbeing in 20 of the most deprived neighbourhoods in London. Adolescents (school year 7 to year 11) from 68 schools in these neighbourhoods were surveyed using a pen and paper questionnaire. The primary outcomes used in this study were the strength and difficulties questionnaire scores (SDQ scores, used as a continuous measure) and adolescents self reported health. The main exposures were ethnicity and poverty. Ethnicity was noted as White British, White other, Black African, Black Caribbean, South Asians, Other Asians, mixed and Other. We used the response to a question “During the week how often you go to bed hungry?” as a measure of poverty. Responses ranged from “hardly ever” to “every day”. In addition, we used a commonly used measure of socio-economic position in adolescent surveys, Family Affluence Scale (FAS), derived from whether children have their own bedroom the number of family holidays, the number of cars or vans and the number of computers the family owns. It ranged from 0 to 8. In addition, We converted both these exposures to riddit scores by computing the cumulative frequency of the sample ordered from the lowest to the highest and each category was assigned a score equal to the mid-point of the range it occupies on the cumulative distribution. Regressing the outcome on the ridit score yields the relative index of inequality (RII). We computed the RII for the whole sample and for each of the ethnic group separately. Our results showed that while the poverty measure showed significant inequalities for the whole sample, the SEP measure did not. There was a difference of more than six SDQ units between the poorest and the richest. There were differences in the level of the inequalities among different ethnic groups with the Afro-Caribbean and other Asian groups reporting the highest. This study is in progress, and further analyses which include testing the hypotheses that these ethnic differences are due to behaviourral and acculturation factors are in progress and will be reported.

The mental health needs of young people involved in street gangs

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Mental health difficulties in childhood and adolescence, particularly within the offender population, warrant attention due to the long term impact on the individual, the family and wider society. Young offenders commit crime and partake in antisocial behaviour in isolation and in groups which may or may not be classified as ‘gang related crime.’ Gang related crime and associated antisocial behaviour continue to be of concern both nationally and internationally.

Young people involved in gangs, by definition, offend and are known to have more negative outcomes than non-gang offenders. It is not clear whether there is also an increase in mental health problems for these individuals as ‘mental health’ is not discussed extensively in literature about gangs.

Aim The aim of this study was to determine if there was a difference between the mental health difficulties experienced by young people:

- Involved in gangs
- Non-gang offenders
- General population.

Method: This cross-sectional survey, conducted in two inner city secondary school and one Young Offender Institution used a questionnaire that incorporated two instruments: the Eurogang Youth Survey [EYS] and the Strengths and Difficulties Questionnaire [SDQ]. The primary analysis compared the mental health needs of young people involved in gang members, non-gang offenders and the general population.

Results: The questionnaire was completed by 506 young people (449 schools, 57 YOI). Gang members reported significantly higher levels of inattention and hyperactivity and lower pro-social behaviour scores than both the non-gang offenders and the general population. In addition, gang members who scored as either borderline or abnormal for inattention and hyperactivity were more likely to report frequent and serious offences. Gang members had significantly more emotional problems than the general population but not more than non-gang offenders. These non-gang offenders did not have significantly different emotional difficulties from the general population. Gang members also scored significantly higher for total difficulties than both the general population and non-gang offenders.

Stressful life events and mental health outcomes among youth in New Orleans

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Introduction: Exposure to traumatic life events has been associated with adverse mental health outcomes such as depression and PTSD in youth. In New Orleans the traumatic carryover from Hurricane Katrina may act as a catalyst for the way young people experience pre-existing and additional complex traumas. Pre-Katrina, Louisiana ranked 49th in overall childhood wellbeing and in New Orleans there was an extreme shortage of mental health services. Post-Katrina many young people in New Orleans who were most affected by the storm particularly in low-income and predominantly African American communities, experienced disparate injustices in the recovery period. Now many of these young people live in an environment with normalized violence, a fractured educational system and increasing gentrification, with limited access to mental health services. In order to gather more information, the Collective for Health Communities (CHC) – the division of community wellness and resiliency at the Institute of Women and Ethnic Studies (IWES) - developed the Emotional Wellness Survey (EWS), a classroom-based tool to implement with young people in New Orleans. The information gathered from the survey is utilized to identify youth who need more extensive mental health services as well as to aggregate the survey results to demonstrate the need for mental health services in New Orleans.

Methods: From November 2012 - July 2013, surveys were conducted with youth aged 11-15. The survey was comprised of validated screening tools for depression and PTSD as well as surveys for stressful and/or traumatic life events including questions around seeing, experiencing or worrying about various forms of familial and community violence. All surveys were implemented with the support of a trained mental health professional. Parents consented to their children participating in the EWS as part of a larger youth sexual health and wellbeing program. Data was analyzed using SPSS. Bivariate analyses were conducted to investigate associations between items on the survey accounting for clustering of schools. Home residences of youth participants were then geographically mapped using Quantam GIS to investigate clustering of symptoms by census block.

Results: A total of 557 youth who completed the survey were deemed eligible. Of the youth surveyed, 45.4% were male and 54.6% were female, and the average age of youth surveyed was 13.63. Of the young people surveyed 54.7% had experienced at least 3 stressful life events including murder, assault and domestic abuse. The most common experiences were reporting someone close to them had been murdered (56.6%), and seeing someone get shot, stabbed or beaten (40.7%). Youth also reported being worried about being shot, stabbed, beaten, murdered or sexually assaulted (48.8%). Bivariate analyses between survey items showed that youth who endorsed symptoms of depression were more likely to report seeing domestic violence between parents/guardians (p = .025) and be worried about not being loved (.000) and about being assaulted (p=.001). Youth that endorsed symptoms of current PTSD were significantly more likely to report experiencing domestic violence between parents/guardians (p= .000), experiencing murder of someone close to them (.035), and be worried about not being loved (.000) and being assaulted (p=.000). Results around specific clustering of events by census block (s) are to follow.

Discussion: Youth in New Orleans are facing a mental health crisis due to multiple lifetime and current traumas and a complete lack of access to care. The findings from the EWS should be a call to action for policy makers, health providers, educators and social justice advocates to fight for policies which promote healthy and safe communities to prevent stressful life events, while ensuring access and availability of mental health services to youth in need.

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