Health Inequalities Research Network Conference 2018

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HERON

Health Inequalities Research Network

HERON is an international public engagement network aimed at people involved in action and research in inequalities in health and health service use. It brings together people from the community, local charities, public health researchers and health practitioners with a vision of having a collaborative approach to research in the community.

The aims of the network include:
- to provide a forum in which health practitioners, researchers and community members can share their experiences and information in order to further understand the problems affecting health
- to empower individuals within their neighbourhoods and communities by providing an environment to voice their opinions and contribute to a dialogue on health inequalities
- to highlight health inequalities through a variety of mediums and work towards reducing these inequalities

For more information on specific HERON activities please visit www.heronnetwork.com, follow us on twitter @heronnetwork or email heron@kcl.ac.uk

Keynote Session

Current and future directions in health equity research and action

Dr Denese Shervington
Institute of Women and Ethnic Studies, New Orleans, US

Cllr Jacqui Dyer
Black Thrive, London, UK

Dr Rakhee Shah
Association of Young People's Health, London, UK

Dr. Shervington has an intersectional career in public health and academic psychiatry. She is the President and CEO of The Institute of Women and Ethnic Studies (IWES), a community-based translational public health institute in New Orleans. At IWES, she directs a community-based post-disaster mental health and emotional resiliency recovery program, and a federally funded trauma-informed Teenage Pregnancy Prevention Program. Dr. Shervington is also a Clinical Professor of Psychiatry at Tulane University. Her focus at Tulane is residency education and training. Dr. Shervington is a graduate of New York University School of Medicine. She completed her residency in Psychiatry at the University of California San Francisco and is certified by the American Board of Psychiatry and Neurology. Dr. Shervington received a Masters of Public Health in Population Studies and Family Planning from Tulane University School of Public Health. In 2018, she received the Award for Excellence in Service and Advocacy from the American Psychiatric Association. In 2012, she received the Jeanne Spurlock Minority award from the American Psychiatric Association. Dr. Shervington is a member of the American College of Psychiatrists. She has authored several papers in peer-reviewed journals addressing health disparities, the social determinants of health and resilience in underserved communities.

Cllr Jacqui Dyer is a member of the founding team at Black Thrive. She also serves as the Chair of the Black Thrive Steering Committee. As an experienced counselor, trainer, group facilitator, mental health service user, carer and elected local councillor representing Vassall Ward, Jacqui brings many insights to Black Thrive. Recently, as vice-chair of NHS England's Mental Health Taskforce, Jacqui co-led the Five Year Forward View for Mental Health strategy and is currently a member of the Ministerial Advisory Group for Equalities in Mental Health.

Dr Rakhee Shah is a paediatric registrar based in London and is a research assistant at the Association for Young People's Health (AYPH). Rakhee was a co-author on AYPH's 2017 edition of Key Data on Young People, which is a national publication that consists of a compendium of health specific data for young people aged 10-24. Rakhee is also a co-author on The Health Foundation's recent 'The social determinants of young people's health' paper.

Young People's Health

Key Data on Young People: A Spotlight on Health Inequalities
Rakhee Shah - *Association for Young People's Health*

Discovering Complexity and Unmet Need Within Lambeth and Southwark: Baseline Data of Patients Entering the Children and Young People's Health Partnership (CYPHP) Model of Care
James Newham - *King's College London*

Children and Young People's Mental Health Research: Identifying Priorities
Thomas Kabir - *The McPin Foundation*

Child Health inequalities: Making Data Relevant for Policy Makers
Keith Clements - *National Children's Bureau*

FULL ABSTRACTS

Key Data on Young People: A Spotlight on Health Inequalities
Rakhee Shah - *Association for Young People's Health*

Background: The life course approach is often used to try and understand the longer-term impacts of socioeconomic disadvantage and inequalities experienced by people at various stages of development. However, the focus of research on health inequalities using this approach has largely remained on the antenatal and postnatal stages of life and in the under-five age group. Adolescence is a distinct developmental stage which provides unique opportunities for developing capacity, promoting health and wellbeing, and is not merely a period of transition between childhood and adulthood. The period between 10-24 years plays a key role in confirming and extending inequalities that then last a lifetime. However, patterns of inequalities for this age-group are rarely considered separately from those for younger children or older adults.

Aims: To identify and draw attention to inequalities faced specifically by young people age 10-24 in the UK.

Methods: We present a descriptive cross-sectional study using the most-up to date publically available datasets in 2017 to define the pattern of health inequalities experienced by young people aged 10-24 in the UK. Only datasets that draw on significant sample sizes, provide generalisable data on young people and use reliable survey instruments were used.

Results: Health inequalities relate both to income deprivation and also to particular living circumstances of some groups of marginalised young people. Those living in the most deprived areas are almost four times more likely to be killed or seriously injured on roads, two times more likely to be obese, two times more likely to smoke regularly, two times more likely to be admitted to hospital with conditions such as asthma and epilepsy, and two times more likely to have a teen pregnancy when compared to those in the areas of least deprivation. Young people with diabetes aged 20-24 living in the most deprived areas had twice the number of unplanned emergency admissions to hospital compared to those living in the least deprived areas. In addition, inequalities in certain areas appear to be widening in the 10-24 age-group with obesity prevalence being a good example of this. Young carers, looked after young people, lesbian, gay, bisexual and transgender youth are all at risk of inequalities in health outcomes. In addition, inequalities compound in marginalised young people who may fall into several categories of risk, making the health of these groups of young people significantly worse.

Conclusions: Young people aged 10-24 face a particular pattern of health inequalities relating to their life stage. Designing and implementing policies that particularly focus on reducing deprivation and improving the social determinants of young people's health should be the overarching goal for policymakers. Multi-sector policy recommendations also need to focus on vulnerable groups in order to reduce health inequalities amongst young people. Further research is required into understanding the impact that health inequalities in adolescence have in later life and on subsequent generations using a life course perspective.

Discovering Complexity and Unmet Need Within Lambeth and Southwark: Baseline Data of Patients Entering the Children and Young People's Health Partnership (CYPHP) Model of Care
James Newham - *King's College London*

Background: Children and young people (CYP) in Lambeth and Southwark (L&S) have poor health outcomes and increasing A&E and hospital outpatient use. To address these problems, the Children and Young People's Health Partnership (CYPHP) has developed and is rolling out a new model of care as part of a service quality improvement initiative. As part of a cluster Randomised Controlled Trial design, patients registered to GP practices in L&S are randomised to be offered either the CYPHP model of care (intervention) or enhanced usual care. An innovative intervention within the CYPHP model of care is to offer preventative healthcare to all children with tracer conditions (constipation, asthma, epilepsy, eczema) by providing self-management advice and public health promotion alone to low-risk patients, and triage of high-risk patients to CYPHP's multi-disciplinary health team (MDT). The CYPHP Health Check was developed as part of a proactive case-finding approach to identify patients,

support triage, and tailor care by collecting data on the level and complexity of needs.

Aim: To provide initial data on the physical, mental and social wellbeing of patients completing the CYPHP Health Check.

Methods: Parents of CYP with tracer conditions are invited to complete the CYPHP Health Check, a questionnaire about condition-specific disease severity, and general emotional wellbeing, and social factors. Health Checks are distributed at GP practices and community events. Validated questionnaires were used where possible: Asthma Control Test and Patient Oriented Eczema Measure to assess disease severity for asthma and eczema respectively, and the Strengths and Difficulties Questionnaire to assess mental health. Where validated questionnaires were unavailable, extensive consultation with practitioners and patients was conducted to develop bespoke questionnaires that could assess constipation and epilepsy severity and relevant social factors (e.g. parental mental health, social deprivation). A summary of the CYPHP Health Check scores is added to patients' GP records. Parents and children who complete the Health Check receive a summary of the results and a CYPHP Health Pack with self-management support, health promotion information and behavioural advice on how to manage the CYP's condition. In intervention practices, health checks are used to triage and tailor care for CYP.

Results: Over a 13-week period, 219 Health Checks have been returned. Of the 219 CYP, 32% were from white backgrounds and 52% were male. The proportion by age bracket was 13% 0-2 year olds, 19% 3-4 year olds, 47% 5-10 year olds, and 21% for 11-15 year olds. Twenty-four patients had more than one condition (11%), with asthma and eczema being the most prevalent combination (n=15). Of 72 asthma patients, 61% had poorly controlled asthma. Of 25 constipation patients, 72% had clinically significant symptoms. Of 115 eczema patients, 76% had 'moderate' to 'very severe 'symptoms. Across patient groups, 28% had 'high' to 'very high' scores on the SDQ, 38% reported housing concerns, 8% reported not having enough food, 25% reported problems paying household bills, and 12% of parents expressed concerns about their own mental health.

Conclusions: Patients were predominantly black and minority ethnic groups and experiencing symptoms that warranted clinical intervention. Many parents completing the Health Check also expressed concerns about social factors and their own mental health that may not have been raised in a clinical appointment. GPs and the CYPHP MDTs' access to summary information from the Health Check prior to an appointment may help prioritise the most relevant concerns of the patient and their family. The next step of roll out is contacting all patients registered with a GP in L&S with details on how to access the Health Check online. As this process is implemented we will start to see whether the same level of complexity and unmet need is observed at a wider population-level.

Children and Young People's Mental Health Research: Identifying Priorities
Thomas Kabir - *The McPin Foundation*

Background: Over half of mental health problems in adult life start by the age of 14 and seventy-five per cent by age 18. However, a recent survey showed that mental health professionals feel the services offered to children who are struggling with their mental health are inadequate. There has been growing recognition of the importance of young people's mental health with the green paper on 'Transforming children and young people's mental health provision', and the establishment of a 'Children and Young People's Mental Health and Wellbeing Taskforce' in 2015. Given that the recent ten year mental health research framework led by the Department of Health highlighted a priority area for children and young people's mental health research, there is still relatively little support available for children and young people to get involved in mental health research. As a result of this lack of support children and young people do not have a strong voice in research. Despite the apparent rise in mental health difficulties, young people's mental health receives comparatively little research or funding. While it is important that more is spent on research, we want to make sure that the few resources we have are used effectively to answer the questions that matter the most.

Aim: The aim of this project was to identify the ten research questions for children and young people's mental health that matter most to young people and the people around them. This project aimed to give young people and families a voice in identifying where the important research gaps are in this field in order to influence which research is funded, and ultimately improve the mental health of children and young people. A key focus of this project has been the equity, rather than equality, of involvement opportunities of young people throughout.

Methods and Results: We utilised a National Institute of Health Research (NIHR) James Lind Alliance (JLA) methodology, with a JLA advisor throughout to provide guidance, chair meetings, and to facilitate the input of all project steering group members equally. The project comprised a consultation stage, two public surveys, qualitative data analysis, workshops, and was steered by a consortium of stakeholders and a young people's advisory group. The initial public survey was designed to gather questions that young people and those around them had for mental health research, gathering 5,600 individual responses from 2,500 respondents. These responses were then cleaned, grouped, themed and any duplicates removed before progressing to the second public survey. This second survey presented a random selection of 40 research questions, asking the responder to select the 10 most pressing questions in their opinion. The most popular 25 questions are then presented at a workshop to be prioritised using a Delphi

method. Attending the workshop were young people, parents, healthcare and social work professionals, and teaching professionals. Throughout the project we sought to involve members of our young people's advisory group (YPAG) as equal stakeholders and steering group members through a range of methods. Holding YPAG meetings in advance of steering group meetings, requiring any decision to include at least two young people from the YPAG (if not a consensus of the YPAG group) and one parent, and providing training in research methods to the young people in advance of steering group meetings or project decisions regarding methodology.

Conclusions: The main output of this project is a list of the 10 most pressing research questions for children and young people's mental health research, identified by young people, clinicians, and those around them. This is perhaps the first time such a list has been produced across the world. We hope that the list will shape the agendas of research funders, policy makers, and others, leading to a real difference to lives of young people everywhere.

Child Health inequalities: Making Data Relevant for Policy Makers
Keith Clements - *National Children's Bureau*

This presentation will set out the findings of research by a leading children's charity into health inequalities in the early years, and how the research and dissemination activities were designed to maximise impact.

The existence of a social gradient in health is well established, as is the efficacy of intervening early in the life course to tackle this. Policy makers, however, especially elected politicians, may struggle to conceptualise exactly how these issues impact on their constituents. Clear messages about what health inequalities mean for the immediate outcomes of children can be lost in the complexity of confounding factors and national data sets.

The National Children's Bureau, a voluntary sector organisation, works to support the development and implementation of evidence based policy and practice. This includes working with practitioners' commissioners and policy makers to improve the services and support children receive. In 2015, we came to the view that what was needed to provoke action on health inequalities was not knew knowledge and evidence per se. What was needed was new deployment of existing evidence to instil greater sense of agency and urgency amongst policy makers.

Inspiration was taken from articles published by an academic collaborator, who in 2013 compared the standardised mortality rates of Western European countries and found that the United Kingdom had 1951 excess yearly deaths amongst 0-14 year olds compared to Sweden (Wolfe et al, 2013). We sought apply a similar approach to inequalities in health outcomes in the early years. The resulting Poor Beginnings report (NCB 2015)

provided a visually stimulating illustration of inequalities by geography and deprivation, focussing on obesity, tooth decay, injuries and child development.

This presentation will take delegates through the design of the report and the secondary analysis it was based on, explaining at each step how the prevailing political context and decision making structures influenced this. For example, we will discuss how engagement with parliamentarians and local and national press alongside the use of infographics and interactive mapping were used to support effective dissemination. Three years on from the publication of the report, the presentation will tell a story about the impact of the report and what we have learned about this approach to using evidence to influence change ●

Ethnicity and Health

FULL ABSTRACTS

Social Care Datasets, Ethnicity, and Access to Services
Jo Moriarty - *King's College London*

The need to routinely record ethnicity when monitoring access and take up of social care services was widely recognised in local authorities from at least the late 1990s. However, researchers have noted the variability in recording practices and the lack of explicit links between recorded data on ethnicity and the development of services designed to improve knowledge about and take up of services.
This presentation takes as its starting point the differential use of different types of social care services by different ethnic groups. Evidence on this topic has been improved with the development of NHS Digital which has expanded the availability of national data to researchers, commissioners, planners and service providers. At the same time, there are clear gaps in the quality of these data.

Using examples from the Adult Social Care Outcomes Framework and the Survey of Adult Carers in England, the presentation will highlight apparent differences in response rates by ethnicity and the way that ethnicity data are categorised in their public form.

Researchers have identified links between ethnic diversity among organisations delivering services and take up of services so the presentation will then discuss the potential for the National Minimum Data Set on Social Care (NMDS-SC) to inform our understanding of ethnicity within the social care workforce.

The presentation will conclude by considering what steps might help create improvements in the evidence on ethnicity. These include:
- Better recognition of why differences in take up and satisfaction rates for social care appear to exist, including the risks of routine data on satisfaction levels concealing inter-ethnic and intra ethnic differences
- Better use of qualitative research to inform Improving the process by which routine data sets report ethnicity
- More transparent information on the process by which surveys are sent to subsets of users by local authorities
- Better reporting of ethnicity data by social care and health researchers, including recording if no people from a black or minority ethnic group were recruited to a study.

The Ethnic Density Effect and Psychosis – Why Do Generational Differences Matter?
Peter Schofield - *King's College London*

Background: Living in an area with few people from the same ethnic background has been shown to be related to increased psychosis incidence (the ethnic density effect) for many minority ethnic groups. However, it is unclear whether this applies equally to new migrants compared to those who are more established. Knowing for which generation this effect is most salient can help shed some light on the ethnic density effect and help us better understand the increased psychosis risk shown for some migrant and minority ethnic groups.

Methods: Analysis of a population-based cohort (2.2 million) comprising all those born 1st January 1965, or later, living in Denmark on their 15th birthday. This included 90,476 migrants from Africa, Europe (excluding Scandinavia) and the Middle East, with 55% first generation and the rest second-generation migrants. Neighbourhood co-ethnic density was determined at age 15 and we adjusted for age, gender, calendar period, parental psychiatric history and parental income.

Results: For first-generation migrants from Africa, there was no statistically significant difference (p=0.30) in psychosis rates when comparing lowest with highest African ethnic density quintiles, whereas the second generation showed a 3.87-fold (95% CI 1.77 - 8.48) increase. Similarly, for migrants from the Middle East, the first generation showed no evidence of a corresponding ethnic density effect (p=0.94) while the second showed a clear increase in psychosis when comparing lowest with highest quintiles, incidence rate ratio (IRR) 2.43 (95% CI, 1.18 - 5.00). For European migrants, there was some limited evidence of an effect in the first generation, (IRR) 1.69 (95% CI, 1.19 - 2.40), with this slightly raised in the second: IRR 1.80 (95% CI, 1.27 - 2.56). We then compared the risk of psychosis for each migrant group to that of native Danes. For the second generation, there was no longer an increased risk of psychosis for African

migrants, IRR 1.19 (95% CI, 0.71 – 2.00), in the highest ethnic density quintile and those from the Middle East were at a reduced risk, 0.58 (95% CI, 0.37 – 0.91), compared to native Danes. However, first generation migrants were still at an increased risk even in high ethnic density areas; including migrants from Africa, 1.83 (95% CI, 1.22 - 2.76), and the Middle East, 1.40 (95% CI, 1.08 - 1.81).

Discussion: We found strong evidence for an ethnic density effect on psychosis incidence for second-generation migrants but only weak or no evidence for the first generation. As both generations experienced increased rates of psychosis this suggests different causal processes at work. For the first generation, increased incidence may relate to the migration process itself while for the second generation this may be more likely related to the social context in which they live post migration. In fact, our analysis in Denmark showed that, for some groups, the increased risk among the second generation could be fully explained by the effect of neighbourhood ethnic density. In this presentation we will discuss the implications of these findings for our better understanding of psychosis incidence among migrant groups and, in particular, the role of acculturation and how this might help explain these generational differences.

Factors Influencing the Mental Health Help-Seeking Amongst Black and Asian Minority Ethnic (BAME) University Students: A Multi-Site Comparative Qualitative Study

Victoria Olaniyan - Aston University

Since the early 2000s, the UK Royal College of Psychiatrists have been predicting that the level of mental health problems among students would increase, as the government was increasing their efforts to encourage more students from a wider sector of society to attend university e.g. lower socioeconomic status and ethnic minorities. This is because, students from these 'non-traditional' backgrounds can potentially find it more difficult to adjust to the university environment, due to a lack of ethnic diversity on some campuses, or due to financial constraints. Which may in turn, lead to adverse effects on their mental health. Indeed, a 2007 study found that students from these backgrounds especially Black and Asian ethnic minority (BAME) students are more likely to report mental health problems, however they are less likely to seek professional help. This reflects reports on the general BAME population in the UK who have been found to be between three to five times more likely than the White population to develop a severe mental disorder yet are less likely to seek professional help.

However, it is of great concern that despite this pre-existing knowledge, and the increasing number of BAME students now attending UK universities, only a small number of studies have examined the mental health experiences of BAME students. In fact, most of the literature available on the mental health and help-seeking of BAME students is based in a US

context. US literature has provided a wealth of information about the prevalence of mental illness among BAME students, and the various systemic and sociocultural predictors of help seeking behaviour e.g. treatment preferences, stigma, acculturation, and ethnic identity. Although, it is not without its limitations, for example, these studies utilise primarily quantitative methodologies, their findings often have conflicting and contradictory findings and usually lack in the variety of topics covered. Therefore, leaving many theoretical questions unanswered and potentially important factors unexamined e.g. diversity of the university environment, racism and discrimination, or the influence of 'elite' university status on mental health and help-seeking.

Using approaches from sociology, psychology, education and public health this study will provide much-needed knowledge about UK domiciled BAME student mental health issues and their help seeking and non-help-seeking experiences. To explore the effects of the aforementioned factors, the study will recruit students from three universities (Aston, Bristol and Keele) with varying levels of ethnic diversity, elite or Russell Group status, and activity within the government's widening participation agenda. This study is the first comparative qualitative study to explore the perceptions and experiences of BAME students in UK universities to develop student-centred recommendations for policy and practice around the issue of mental health and mental health support provision.

A Future Research Agenda for Ethnic and Religious Inclusion in Public Services

Ghazala Mir - *University of Leeds*

Background: Disadvantaged ethnic and religious groups experience exclusion and inequalities globally and there is a particular lack of research relating to this issue in countries eligible for Official Development Assistance. The Inclusive Cities Network was established to develop a future research agenda that supports social inclusion, conceptualising health, education, local government and police services as mechanisms for creating an inclusive culture at city level. The agenda aims to increase awareness and understanding of the need for change, inform research funding strategies and promote positive change and egalitarian relationships that empower people from disadvantaged ethnic and religious groups, who often experience the widest inequalities in areas that determine health, including healthcare services.

Methods: The agenda was coproduced with advocacy organisations, policymakers, practitioners, academics and research funders. It was developed from a series of literature reviews and engagement with over 200 expert participants in 22 workshops and key stakeholder interviews in India, Kenya, Nigeria, Vietnam and the UK. Evidence gaps were identified in relation to key drivers of ethnic and religious exclusion and strategies for inclusion in public services. Intersectional

disadvantage, relating to the additional impact of gender, age and migration, was also specifically explored.

Results: The agenda conceptualises social inclusion as a human right and exclusion as a denial of this right. The need to move away from vague terminology and to specifically define ethnic and religious groups that experience exclusion is highlighted, to ensure that interventions are focused on those that most need support. The agenda also promotes robust research methods that support effective evaluation of inclusion initiatives and that model inclusive practice. Three themes on which future research should focus are specified:

(i) Achieving inclusion and understanding the dynamics of change - exploring diverse explanations for inequalities and how to counter negative understandings amongst different stakeholders, particularly key influencers of public services. Research with under-represented or 'hardly reached' groups, as well as under-researched public service areas, is also promoted.

(ii) Multilevel, multiagency interventions - multifaceted interventions at macro, meso and micro levels are needed to address the complexity of disadvantage experienced by some ethnic and religious populations. The cumulative impact of disadvantage experienced simultaneously across different public services adds to this complexity. Multidisciplinary, multisector studies that reflect and engage with the lived experience of disadvantage are advocated, as well as research into how such collaboration can be achieved and what contributes to, or detracts from, the effectiveness of such partnerships.

(iii) Policy development and the political context – understanding the role of policymakers, public service providers, excluded communities and other social groups in policy development and harnessing legal and political processes that can support effective inclusion. Ways of reducing the fear and sensitivity surrounding such research and legitimising work in this field are also needed.

Conclusions: The research agenda promotes greater social ownership of 'inclusive societies' through research that would help transform the current landscape. With support from funders it could play a key role in reducing health and social inequalities. ●

Improving health services

The Associations Between Deprivation and Hospital Service Use for Children and Young People Locally and Nationally: Learning from Research to Inform Innovative Service Delivery and Tackle Inequalities

Roshan Das and Julia Forman - *King's College London*

Group Clinics for Young Adults with Diabetes in an Ethnically Diverse, Socioeconomically Deprived Setting (TOGETHER study): Participatory, Mixed Methods Evaluation

Chrysanthi Papoutsi - *University of Oxford*

Mind The (Satisfaction) Gap – What Can We Learn from Sierra Leone?

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My Story: Our Future; Understanding the Life Stories of People Who Use Early Intervention Services for Psychosis

Rose Thompson - *The McPin Foundation*

FULL ABSTRACTS

The Associations Between Deprivation and Hospital Service Use for Children and Young People Locally and Nationally: Learning from Research to Inform Innovative Service Delivery and Tackle Inequalities

Roshan Das and Julia Forman - *King's College London*

Background: Children and young people in the UK have poor and unequal health outcomes, and increasing and unequal dependence on hospital services. To improve health outcomes and tackle inequalities in health and service use in Lambeth and Southwark, the local Clinical Commissioning Groups, Local Authorities, and Healthcare Providers formed The Children & Young People's Health Partnership (CYPHP). CYPHP is delivering an innovative model of care to children and young people, improving equity through pro-active case finding and services tailored to the patient's family and social context.

Aims: (i) to analyse the relationship between deprivation and secondary care use among children and young people; (ii) to quantify the scope and magnitude of the CYPHP ambitions to reduce inequalities, by describing the associations between deprivation and secondary care use in Southwark and Lambeth before introduction of CYPHP services; (iii) to compare local inequalities in service use with national data.

Methods: Cross-sectional data on English general practices (n=7244) were compared with local data from the 86 GPs in Southwark and Lambeth. Data were extracted from the Public Health England Fingertips Tool National General Practice Profiles in July 2018. The Income Deprivation Affecting Children Index (IDACI) and Index of Multiple Deprivation (IMD) were used as measures of deprivation, based on 2015 data. Hospital activity (during 2013/14 – 2015/16) for under-18s was measured by A&E attendance rate, outpatient first attendance rate, and emergency hospital admission rate. Linear regression was used to estimate the dependence of each hospital activity measure on each deprivation measure. In the national data set, GPs with the highest 1% of A&E use were identified as outliers and excluded from analyses.

Results: GP practices in Southwark and Lambeth have higher deprivation indices (mean IMD 29.7, 10th percentile 21.9, 90th percentile 36.4; mean IDACI 30.0, 10th percentile 19.9, 90th percentile 36.4) than the national averages (mean IMD 20.0, 10th percentile 8.3, 90th percentile 33.4; mean IDACI 23.6, 10th percentile 9.8, 90th percentile 40.2). The mean A&E attendance rate in Southwark and Lambeth for under 18s (426 per 1000 person-years, 10th percentile 340, 90th percentile 532) is higher than the national rate (386 per 1000 person-years, 10th percentile 247, 90th percentile 549). The mean outpatient and emergency admission rates in Southwark and Lambeth for under-18s (Outpatient: 236 per 1000 person-years; Emergency admissions: 53 per 1000 person-years) are marginally lower than the national means (Outpatient: 261 per 1000 person-years; Emergency admissions: 68 per 1000 person-years). In Southwark and Lambeth, A&E and outpatient attendances were positively associated with deprivation indices. A&E results: IMD regression coefficient 3.9, 95% confidence interval 1.2, 6.8; IDACI regression coefficient 3.9, 95% confidence interval 1.5, 6.3. Outpatient results: IMD regression coefficient 0.6, 95% confidence interval -0.6, 1.9; IDACI regression coefficient 0.3, 95% confidence interval -0.8, 1.5. Emergency admissions did not show a clear dependence on deprivation. Nationally, all three hospital measures were significantly associated with the deprivation indices. The magnitude of the regression coefficients for A&E attendance and Outpatient use were similar to the Southwark and Lambeth values. The regression coefficients for emergency admissions were 0.5 and 0.6, for IMD and IDACI respectively.

Discussion: Future research and action A&E attendances for under-18s in Southwark and Lambeth exceed the national rate. Of the three measures of under-18 secondary care use, A&E attendances show the greatest disparities. Further observational work will identify drivers of high and unequal A&E use. The evaluation of CYPHP services will assess the impact of innovative services to reduce A&E attendances and improve equity of service use and ultimately of health outcomes.

Group Clinics for Young Adults with Diabetes in an Ethnically Diverse, Socioeconomically Deprived Setting (TOGETHER study): Participatory, Mixed Methods Evaluation

Chrysanthi Papoutsi - *University of Oxford*

Background: Young adults with diabetes face a range of poor health outcomes across clinical and psychosocial parameters. This is compounded by barriers to regular clinic attendance and engagement, such as diabetes-related psychological distress, lack of care continuity and poor satisfaction with the health service, lack of developmentally appropriate consultations and fear of complications. Alternative ways of engaging young adults in diabetes care are urgently needed. Our ongoing NIHR-funded project examines how group-based care may be developed and delivered to meet the complex and distinct needs of young people living with diabetes in socio-economically deprived settings.

Methods: We developed a new, co-designed model of group-based care for young adults with diabetes (16-25 years old) and implemented this in an east London NHS hospital. Using a 'researcher-in-residence' approach, we are currently in the process of formatively evaluating this group-based model of care, using qualitative (ethnographic observations in 13 group clinics, 5 standard care appointments, project meetings and training sessions, 10 patient and staff interviews, document analysis, various informal discussions) and quantitative methods (e.g. biological markers, patient enablement instrument, diabetes distress scale). Our analysis is underpinned by ecological theories of supported self-management and theoretical work on patient expertise and experiential knowledge.

Results: So far our findings show that group clinics are valued when they facilitate connections between young patients and when they support useful exchange of experiences. Experiential knowledge sharing results in increased learning as young patients are able to tailor advice to their own personal circumstances. Carefully crafted therapeutic relationships among patients and health professionals are based on flexibility, openness, non-judgmental language and understanding of developmental goals and competing priorities. However, positive peer relationships do not emerge automatically within group clinics. A proactive approach is required to support patients with different personalities and styles of engagement. This includes 'challenging' behaviours that often seem counter-productive but may eventually lead to beneficial outcomes. Potential risks are also present, such as reinforcement of negative behaviours between young adults. Substantial clinical, operational and emotional work is required to develop and deliver successful group clinics for young adults. Resource implications, impact on pre-existing processes and infrastructure requirements need to be accounted for. Healthcare professionals delivering group clinics also have a range of training needs in order to be able to

harness and facilitate group interactions effectively with a view to support health equity. Ongoing challenges with patient engagement require constant responsiveness and improvisation to fulfil different needs.

Conclusions: Project findings will directly inform current and future service re-design to better meet the needs of young adults with diabetes in socio-economically deprived areas. Lessons learnt will shape engagement strategies to tackle inequalities in service access by adapting existing models of care. By drawing on life stage-, context- and culturally-sensitive approaches, group-based clinical care could be a useful way to overcome barriers to regular clinic attendance and engagement, leading to improved health outcomes.

Mind The (Satisfaction) Gap – What Can We Learn from Sierra Leone?

Temitope Ademosu - *King's College London*

Black and minority ethnic (BME) communities in the UK experience inequalities within the mental health (MH) system. A number of government policy initiatives have attempted to close these gaps in equity. However, BME individuals continue to experience barriers to accessing services, including limited awareness of the service landscape, and a mismatch in cultural communication with service providers. Service provision is further impeded by a cycle of fear and distrust (Sainsbury., 2002), contributing to low satisfaction in MH service use amongst BME service users. New innovations are required in the UK MH system, to ensure quality services are available to all who need it, in spite of their race and ethnicity.

The field of global mental health has embraced the notion of knowledge transfer. Here, improvements in MH care involves high-income and low-income countries (LIC) learning from each other. I have spent the last 3 years shadowing and working in Sierra Leone, a LIC, since the outbreak of Ebola challenged its fragile MH system. In this presentation I will share my reflections as a UK Child and Adolescent Mental Health (CAMH) specialist, considering innovations in Sierra Leone which can be translated to the context of the UK MH system, accelerating attempts to close this satisfaction gap for future services.

Sierra Leone has a weak formal MH system. With over 7 million individuals, there is only one national psychiatric hospital, two psychiatrists, and 19 mental health nurses. As a result, there is a 98% 'treatment gap,' the percentage of people needing treatment but unable to access it (Yoder et al., 2016). This gap is profound for children, with CAMH services virtually non-existent. In spite of these limited formal services, many who live with mental illness are supported by informal, social support structures which work well within existing cultural support frameworks.

MH care has a strong reliance on understanding of patients in order to determine their individual needs. Gaps in the

understanding of BME individuals may contribute to the racial disparities that exist in service use. Formative research informing my PhD project included setting up workshops with a range of stakeholders in Sierra Leone. In addition, I shadowed the country's only CAMH nurse, in his outreach work. My reflections led me to compare the approach of Sierra Leonean colleagues with my practice in CAMH services. I identified a number of interesting contrasts - and an opportunity for learning.

Across many countries in West Africa, mental health is conceptualised as a curse with a supernatural causality. As a CAMH specialist, I made little reference to patient's spirituality or religious beliefs. In contrast, religious leaders and traditional healers explained they were 'first line of treatment' as they worked actively within individual's explanatory models of mental illness. Settings for conversations were important. Mohammed, the CAMH nurse, met families in their homes and actively involved extended family in assessments and interventions, minimising power imbalances. Mohammed worked closely with community stakeholders, engaging religious leaders and traditional healers in case discussions and consultations. He also worked within families understanding of mental illness and tailored his care-plan and psychological interventions to patients and families' needs.

Identifying and implementing reverse innovations into the UK context has not yet been fully explored. However, it is necessary for MH services in the UK to universally adopt more culturally appropriate ways of working with individuals within BME communities. Paying attention to families' explanatory models; actively seeking collaboration and input from trusted groups such as religious and traditional groups, and an understanding of verbal and non-verbal communications, tailored to specific cultural groups, can contribute towards closing this gap in equity.

My Story: Our Future; Understanding the Life Stories of People Who Use Early Intervention Services for Psychosis
Rose Thompson - *The McPin Foundation*

The 'My Story: Our Future' project aims to understand the lives of people who have used early intervention services for psychosis (EIP services), and the lives of people who care for them. This project has been led by service users, and we draw on an adapted 'Oral Histories' methodology. In doing so we ask people describe their experiences of living with psychosis in their own words. The project was funded by the London Office for Clinical Commissioning Groups (CCGs) and Certitude.

Our research team has included three researchers with lived experience of using EIP services. Throughout the project, researchers have used their lived experience to shape the methodology and build rapport with storytellers. They have suggested and developed the use of creative materials within interviews, which enables storytellers to think about the parts of their story they wish to share with us (and the parts they do not). Recruitment to the project will be completed by September 2018. At the time of writing, we have interviewed nine people who used EIP services and five people who cared for others who have used EIP services. The sample includes storytellers from a range of ages, ethnic backgrounds and economic circumstances. Our interviews with these individuals revealed rich and complex stories that cannot easily be condensed using traditional thematic analyses. Our analysis also used creative approaches including collage to explore themes and familiarise ourselves with data. We have found that this helped to facilitate discussion within the research team, reflecting on the lived experience of those within the team, and identifying broad themes or core narratives across the data.

Preliminary findings suggest that people who use EIP services may face multiple forms disadvantage and have experiences of trauma at an early age. We heard stories of difficulties in work and school, of insecure housing and homelessness, childhood trauma, and of complicated friend and family relationships. Several of the stories we heard suggested that services could be helpful and supportive, but there were difficulties in accessing the right services when needed. Stories also revealed the resourcefulness of people who use EIP services in exploring how to support their own recovery. Storytellers were eloquent in explaining how creativity, nature, friends and family, and faith were important and sustaining for them. Involving researchers with lived experience at all stages of the research process had a positive impact on how we worked with participants and with their stories. ●

Community Voices

Finding Ways to Involve People in Mental Health Research
Dan Robotham - *The McPin Foundation*

Integrating Mental & Physical Healthcare – The Importance of Patient Voice in Guiding Healthcare Priorities and Research
Sanchika Campbell - *King's College London*

How Should Mental Health and Well-being Researchers Work with People Going Through the Asylum Process?
Sohail Jannesari - *King's College London*

FULL ABSTRACTS

Finding Ways to Involve People in Mental Health Research
Dan Robotham - *The McPin Foundation*

Research needs the public as much as the public needs research. It is only useful when it informs and improves our understanding of the world, changes practice, or improves people's lives. Research cannot exist in a vacuum. We believe that research can be improved by involving 'the public', most importantly by involving people who have direct experience of a condition (or experiences of a set of life circumstances). The McPin Foundation champions the expertise of people who experience mental health difficulties. People with experience of a condition or situation are ideally placed to develop and inform future research on such topics.

We have compiled examples of research and evaluation projects which benefitted from such involvement, and highlight ways in which projects have changed as a result. These examples are drawn from our past and present work. Mechanisms for involvement that we shall describe include the use of Lived Experience Advisory Panels (LEAPs) to act as 'critical friend' to university-based study teams, embedding researchers with relevant lived experience into study teams, and co-developing research projects/ideas with people who are use their lived experience.

However, we acknowledge broader limitations to the involvement of people with mental health difficulties in research. Often, the methods used in 'Patient and Public Involvement' (PPI) are inclusive of some people at the expense of others. A common criticism of PPI is the over-reliance on the 'usual suspects' to inform and develop research. These criticisms are direct relevant to health inequality, since a relatively small group of people have a disproportionate amount of input into helping shape and develop future research. People from Black and Minority Ethnic (BME) groups, for example, are overrepresented in the mental health system, but are underrepresented when it comes to being involved in mental health research.

In order to optimise how 'the public' improves research, it is important to understand what is meant by 'the public'. New approaches may be required in order to ensure that people from a range of backgrounds can be included. Research informed by a few trusted confidants is likely to be less useful than research informed by a broader range of people. In order to improve future research we need to find ways to make research involvement more accessible. We must identify problematic practices which reinforce inequality and those which may inadvertently exclude people from being involved.

Integrating Mental & Physical Healthcare – The Importance of Patient Voice in Guiding Healthcare Priorities and Research
Sanchika Campbell - *King's College London*

Background: Over 15 million (30%) people in the UK live with long-term conditions (LTC) and are almost 3 times more likely to develop common mental disorders. A collaborative, integrated care model can improve patient outcomes. Many healthcare services fail to address their patients' emotional needs. Integrating Mental & Physical healthcare: Research, Training & Services (IMPARTS) is primarily a clinical tool to improve mental healthcare provision across medical settings using an integrated approach including: 1)Electronic screening questionnaires on mental and physical health during their appointment. Results are uploaded to Electronic Patient Records in real-time to help guide the consultation; 2) Referral pathways are developed to address identified needs; 3) Mental health skills training for clinical staff; 4) Bespoke self-help materials; 5) Database for research and audit/service evaluation. Whilst there has been a movement toward service user involvement in mental health services, patients' perspectives in physical healthcare settings are often missing. In March 2018, IMPARTS set-up the Integrated Care Consultation Partner Group (ICCPG), a partnership between patients, service users and carers who live with chronic illnesses. The group draws on patients' voices to contribute to and direct the priorities of IMPARTS.

Methods: In setting-up the group, we sought advice from professionals leading on patient involvement activities. We incorporated feedback from a patient advisory group on the ICCPG information sheet, interest form and Terms of Reference (ToR). Members of the ICCPG were recruited via clinical services using IMPARTS, advertisements in local hospital publications, from the King's Health Partners (KHP) networks and patient involvement group, and via

IMPARTS public engagement events. Applicants completed an interest form on their experiences and motivations to join the ICCPG. We met informally with each applicant to discuss the group, the ToR, and answer any questions. All 11 applicants were recruited. The first ICCPG meeting was attended by 10 members and included introductions, an overview of IMPARTS, training on patient and public involvement, agenda items and an evaluation form.

Results: The ICCPG focuses on patients and carers with LTCs, many of whom live with co-morbid illnesses. The expectations of the group were clearly defined in the ToR. A dedicated IMPARTS member of staff set-up, leads and co-ordinates the ICCPG and maintains regular contact with patient/service user and carer members. To encourage learning and trust, meetings include open discussions and members are invited to share/chair agenda items e.g. supporting carers. One member co-chairs the ICCPG meeting, and evaluation forms are collected to improve and steer future meetings. Two members have hosted an IMPARTS talk for patients and shared an IMPARTS video at Lambeth GP surgeries. Another two members have participated in an IMPARTS Massive Open Online Course (MOOC) on depression and anxiety. One member leads the IMPARTS Research Oversight committee, an important step to becoming partners in research. Our group's contributions and the benefit to healthcare systems are rooted in our incorporating their valuable feedback (e.g. disseminating the MOOC, supporting carers, seminar ideas, and reaching patients with learning difficulties).

Conclusions: The ICCPG emphasises the value of patients' lived experiences in guiding IMPARTS' priorities and how we can improve healthcare systems using an integrated approach. It provides a forum for mutual learning and developing awareness between patients/service users and researchers. Drawing on patients' perspectives as part of health equity research and healthcare priorities are fundamental, and the ICCPG takes a step forward in this direction. However, much work remains to evaluate the impact of engagement overtime and the lessons we can learn from patients'/service users' vital contributions in healthcare settings.

How Should Mental Health and Well-being Researchers Work with People Going Through the Asylum Process?
Sohail Jannesari - *King's College London*

Background: People seeking asylum in the UK enter an application process which described by some academics as adversarial (e.g. Anderson and Hollaus 2014, Jubany 2011, Banks 2008). Research from such academics find an 'immigration service subculture... informed by a meta-message of disbelief and deterrence' (Jubany, 2011) which criminalises applicants (Banks, 2008). Applicants may, therefore, feel powerless in the face of the Home Office system (Jannesari, unpublished). Moreover, in search of

support during the application process, they often enter into compassionate, yet disempowering, charity spaces when seeking support (Rainbird 2011, Darling 2007). It is crucial that research with people seeking asylum does not replicate the power imbalances they are already experiencing. Ideally, research should provide an empowering space of agency for participants. Unfortunately, this is not always the case and research on asylum has been criticised by former participants as exploitative, re-traumatising and opaque (Pittaway et al. 2010). Pittaway et al. (2010) suggest that participatory action research might be a way to address these concerns. This study employs participatory action research in a project on mental health and well-being with an Afghan community group and an Iranian community group. Through ethnographic observations and interviews during the participatory project, the study reflects on how researchers should work with people going through the asylum process in an equitable and empowering way.

Methods: I will work with organisations to develop a participatory action research project on mental health. A half day discussion event will be held to inform preferred research questions, methods and outputs. Discussion will be sparked by a video, song, poem, or image. At the event, service users will be asked if they are interested in joining a charity research team to help conduct the research. I will meet with the charity research team to design a project on the basis of what was said at the discussion event. The design will be circulated around the charity for feedback. This research will need to undergo its own ethical approval procedure in accordance with charity standards. While working with the charity research team, I will be observing their interactions with myself, the rest of the team, staff members working with the team and others involved with the charity. I will also reflect on my personal learning and transformation during the research (Hoey, 2014). Moreover, I will ask key members of the organisation and charity research team to a one-to-one interview at the beginning and end of the project to explore their thoughts on the research project in more depth. ●

Addressing Multi-Morbidity

The (Unequal) Journey to Multimorbidity
Mark Ashworth - *King's College London*

"When Other People Try to Understand" – Exploring the Experiences of People with Learning Disabilities who also have Mental Health Problems
Sasha Mattock - *King's College London*

Does Syndemics Offer a New Direction to Understanding and Addressing Inequalities in Multimorbidity? A Systematic Review of Reviews
Cecilia Vindrola-Padros - *University College London and Camden & Islington Public Health*

Multimorbidity and Community Resource – A Call for Reconceptualisation
Maria Kordowicz - *King's College London*

FULL ABSTRACTS

The (Unequal) Journey to Multimorbidity
Mark Ashworth - *King's College London*

Introduction: Multimorbidity places a considerable burden on both patients and health care organisations. However, little is known about the health inequalities related to multi-morbidity and the acquisition of multimorbidity within an urban context. We aimed to study data to explore the relationship between multimorbidity and age, social deprivation and ethnicity; also to explore the role of possible determinants of health inequalities.

Methods: We conducted a study of multimorbidity in Lambeth using patient-level data obtained from Lambeth DataNet, an anonymised source of data derived from the electronic health records of patients registered at GP practices in Lambeth (n = 390,000). Multimorbidity was defined as the presence of 3 or more specified Long Term Conditions (LTCs), selected from a group of 12 Long Term Conditions. The definition of multimorbidity used in this study was aligned to the definition used by Lambeth CCG as part of their 'Care Coordination' initiative, aiming to direct additional services to those with greatest healthcare needs. Longitudinal data were analysed using univariable methods; multiple logistic regression was used to further explore associations.

Results: The sample consisted of 320,000 patients aged 18 years and over, of whom 5596 (1.7%) fulfilled the criteria of 'multimorbidity'. The most common LTCs of those with multimorbidity were: Diabetes (62.3%); Chronic Pain (42.2%); Chronic Kidney Disease (41.3%). Just over a third (34.6%) were aged <65 years. Patients in the most deprived quintile of deprivation acquired their multimorbidity status 12 years younger than those in the least deprived quintile. Patients in the black ethnic group acquired their multimorbidity 11 years younger than those in the white ethnic group; South Asians acquired their multimorbidity 8 years younger than than those in the white ethnic group. After adjustment for age, gender and associated risk factors (), these inequalities related to social deprivation and ethnicity were re-calculated. The Odds Ratio for multimorbidity was reduced in the black ethnic group (OR 0.81; 95%CI 0.74, 0.88); was raised in the South Asian group (OR 1.33; 95%CI 1.17, 1.52); was only slightly increased in the most deprived quintile (OR 1.16; 95%CI 1.02, 1.30). Other factors more strongly associated with the acquisition of multimorbidity were: Hypertension (OR 4.12; 95%CI 3.78, 4.49); moderate obesity (OR 2.75; 95%CI 2.55, 2.96); smoking (OR 2.00; 95%CI 1.85, 2.15).

Conclusions: We observed a health inequality gap of just over 10 years related both to social deprivation and ethnicity in the acquisition of multimorbidity. However, after adjustment for health related risk factors, the black population had a lower risk of acquiring multimorbidity than the white population. Multivariable analysis suggested that much of the apparent increased risk in black and socially deprived communities was related more to differences in the prevalence of hypertension, obesity and smoking than to ethnicity or deprivation this urban multi-ethnic population

"When Other People Try to Understand" – Exploring the Experiences of People with Learning Disabilities who also have Mental Health Problems
Sasha Mattock - *King's College London*

Recent guidelines from The National Institute of Health and Care Excellence (NICE) highlight that individuals with intellectual disabilities (ID), and co-occurring mental health problems rarely get the opportunity to share their experiences of the mental health services. They state that there is currently 'no high-quality evidence or ongoing research' within this area. They highlight that research should explore the 'experiences [of] people with learning disabilities [within] services designed to prevent and treat mental health problems and how this relate[s] to clinical outcomes.'

Over the past 20 years, policy documents have stated that these individuals must be included in their care. However, research suggests that this is not the case. Therefore, the aim of this research was to create a space for service users (SUs) to share their experiences of mental health services, and what they found helpful.

A focus group was held with five SUs, one carer, two psychologists and two researchers exploring the statements 'feeling well/good in your mind and feeling less well' and 'experience of support/services for mental health'. The findings were then fed back to service providers. The audio recording was transcribed and analysed using Braun and Clarke's (2006) method of thematic analysis. Four main themes were identified 'Relationships with Others', 'Being in Control?' 'Expressing, Coping and Recovering from Mental Health Problems' and 'Loss'. This focus group highlighted that although sometimes the SUs felt supported, they reported having little control in their lives, had very mixed experiences with staff members and family and wanted to be listened to. These findings suggest that SUs do not feel included in decisions made around their care which could be improved through training staff how to communicate and work with individuals with ID so that they understand their care plans. Including a SU in the planning and facilitation of the focus group would have made this research more inclusive.

This paper highlights many areas within the mental health services that need to be improved to ensure the SUs' needs are prioritised thus reducing isolation and stigma within this population. These included: providing training for staff to enable them to communicate effectively with SUs, creating social networks for people with ID so that they are able to share their experiences and support each other, including family members within the care plans so that they have a better understanding of what is happening and more positive relationships with SUs, help with saving money, financing and finding work and providing accessible information about medication to SUs. Through addressing these issues implementing these suggestions SUs will be more integrated in their own care, and will be given more control over their own lives. As a consequence they will feel part of society and more empowered about their own lives.

This presentation fits within 'Discrimination and health or health service use' as it is exploring people with learning disabilities experiences within mental health services which is a vastly under-researched area. Much of the research which has been carried out highlights the lack of control and lack of equity within this area with many of the service users stating that they feel stigmatised and not treated fairly. I believe it fits within the overall theme as this research highlights directions for future research within this area - carrying out more focus groups and getting more of an understanding about what services users with learning disabilities need in order to include them within society and help them feel more supported. It also highlights actions that need to be made to include people with learning disabilities to move towards equity, creating social spaces for people with learning disabilities, providing specialised training for staff members, working with families to create more positive interactions.

Does Syndemics Offer a New Direction to Understanding and Addressing Inequalities in Multimorbidity? A Systematic Review of Reviews

Cecilia Vindrola-Padros - *University College London and Camden & Islington Public Health*

Background: The rising prevalence of multimorbidity in high income countries (HIC) is well documented. Multimorbidity can lead to poorer quality of life and a higher risk of dying prematurely. Yet, the healthcare system has been largely built around single diseases, and it is increasingly recognized that different approaches may be needed, both to understand and manage multimorbidity. In particular, there are some well recognised social inequalities in prevalence and risk from multimorbidity but little understanding of how to tackle them. A recent series of papers has introduced the concept of syndemics to a general medical audience (The Lancet 2017). It highlighted important contrasts with conventional approaches to public health and healthcare delivery based on the concept of multimorbidity (Mendenhall 2017). Syndemics has been defined as "multiple, co-terminus and interacting epidemics developing under conditions of health and social disparity" (Singer et al. 2006). It is based on the idea that health and social factors are co-occurring and mutually enhancing, creating an excess burden of disease.

Aim: Review existing applications of syndemics in order to assess the potential for syndemic theory to understand and reduce inequalities in multimorbidity in high income settings.

Methods: We undertook a review of systematic reviews following PRISMA reporting guidelines. We searched for articles in peer-reviewed journal through MEDLINE, EMBASE, CINAHL Plus, Web of Science and ProQuest Central with no limits by language or date. We included reviews on studies that explored syndemics empirically, focused on more than one disease/condition and where at least one of the diseases was a long-term condition. The review explored the main characteristics of reviews using the syndemic approach in health research, definitions of syndemics, the empirical exploration and operationalisation of syndemics, and strengths and limitations of the reviews. We assessed the quality of the reviews using AMSTAR.

Results: We identified eight articles that met our inclusion criteria. Most articles were recent (2011-2017), focused on gender and sexuality, and considered HIV as one of the disease outcomes or processes. Syndemics was variably conceptualised across the reviews, with differences in

understandings of the synergistic relationship between conditions, levels at which risk was considered and definition of epidemics. All reviews reported evidence of syndemic interactions, but the mechanisms through which these were identified were unclear. There was a focus on vulnerable populations, but limited use of the syndemics concept across the social gradient. Excepting two studies, all reviews scored poorly on the AMSTAR.

Implications: The syndemics concept could be useful for expanding current work on multimorbidity by exploring social and cultural issues and their synergistic interaction with health conditions. However, its value is limited so far by factors such as: 1) low quality of existing reviews (per assessment by AMSTAR), 2) non-alignment with conventional disease epidemiology appraisal approaches, and 3) focus on narrow segments of society and little consideration of the differential effects of multimorbidity interventions by socioeconomic position. We also identified potential benefits in the integration of syndemic theory in healthcare delivery, such as the development of programmes capable of screening for social factors, able to consider health issues beyond the individual level (i.e. at the neighbourhood level), and reliant on multidisciplinary input.

Multimorbidity and Community Resource – A Call for Reconceptualisation
Maria Kordowicz - *King's College London*

Background: The findings of a qualitative study into the understandings of multimorbidity, interventions and community resources in a densely populated diverse area of London are presented. Multimorbidity is an ever-increasing health burden, strongly associated with socioeconomic deprivation. There have been calls for new approaches to multimorbidity in primary care and the community, including greater integration across services, moving away from a single-disease focus, and a need for learning from beyond the biomedical lens when designing interventions to tackle inequalities in multimorbidity prevalence.

Methods: A rapid ethnography approach was used, which included a synthesis of patient stories, stakeholder interviews, policy analysis and appraisal of local community resource. These were analysed for overarching themes.

Results: Themes pertain to patients' multimorbidity journeys, lack of resource in primary care to provide tailored interventions throughout these journeys, the shortcomings of services organised around individual diseases, as well as the role psychosocial considerations play in helping to build patients' sense of control over their own wellbeing. Community resources were recognised as key in helping to tackle the multimorbidity 'crisis', especially in deprived areas.

Conclusions: Syndemic discourse, as well as frameworks for designing effective community interventions, are drawn on to conceptualise study findings. Conclusions concern a need for reconceptualising multimorbidity and the important role resources have in not only supporting primary care, but also as freestanding interventions beyond the biomedical model. ●

Housing, Homelessness and Health

Addressing Health Inequalities Through Developing Peer Based Legal Support for homeless people in London; Considering the Health Impacts and Future Directions
Martin Burrows - *Groundswell*

Nurse-led Innovation and Collaboration as a means to Improving Homeless Healthcare
David Parker-Radford - *The Queen's Nursing Institute*

Exploring Future Health Services and Public Health Strategies for Homelessness and Urban Exclusion in London
Andy Guise - *King's College London*

FULL ABSTRACTS

Addressing Health Inequalities Through Developing Peer Based Legal Support for homeless people in London; Considering the Health Impacts and Future Directions
Martin Burrows - *Groundswell*

Considerable evidence exists for how poor health is associated with facing multiple legal problems. That the homeless experience considerable legal challenges and obstacles is a core factor in the health inequities this group experience. Whilst legal support is widely used for homeless people, there is limited evidence for specific interventions and particularly their impact on health, linked to uncertainty over the pathways through which homelessness, health and justice interlink.

The Legal Education Foundation (LEF) are supporting Groundswell, a London based charity, to provide legal support to homeless clients and peer advocates. Through an ongoing action research study, we are exploring the pathways to impact and potential outcomes of this novel intervention. We are using an action research approach: research is within the context of ongoing efforts to implement and address programme questions.

In this presentation we will explore the developing programme of legal support, including challenges and successes in implement-ation, and then how this is linked to furthering health access. We will then link this to discussing future opportunities for how legal support could form an integral part of a community based response to health inequities experienced by homeless people.

Nurse-led Innovation and Collaboration as a means to Improving Homeless Healthcare
David Parker-Radford - *The Queen's Nursing Institute*

The Queen's Nursing Institute (QNI) supported by Oak Foundation, agreed to fund 10 nurses up to £5000 to test innovative interventions to help improve healthcare for homeless people (and other inclusion health groups such as prisoners, Travellers, and asylum seekers) over a year-long period during 2018.

This presentation will implement the idea of professional-led innovation and collaboration as a means of addressing health inequalities while presenting the interim results of the effectiveness and impact of these innovations for patients.   These projects varied in scope and included: targeted health checks in homeless hostels, improving access to vaccinations, widening access to hepatitis C or tuberculosis testing, street nursing, homeless health champions, structured collaborative wellbeing workshops, self-harm patient awareness, new clothing prescriptions to target skin infections caused by rough sleeping, and targeted identification of deprived children at risk of poor oral health outcomes in Traveller communities. Each project set themselves patient and health-focused outcomes and aimed to reduce health inequalities, improving access to health through skilful application of nursing care.

The presentation will also address the wider work of the QNI'S Homeless Health Programme. The Programme is a series of learning and networking events, publications and policy research in the field of healthcare for homeless people. The Homeless Health Network is a national network of health professionals focused on improving healthcare for people who have some of the poorest health outcomes and highest needs for healthcare (homeless people, refugees, gypsies and travellers and sex workers). The programme has also visited homeless health services around the country to gain insights into practice. It works on multi-partnership homeless health research, policy, practice development and campaigns at a national level. These include membership of the NIHR Study Steering Groups on Homeless Primary Care and Hospital Discharge (King's College London). The programme of work is supported by an advisory group of specialist homeless health nurses, and a Homeless Health Network who together have created specialist health assessment tool and guidance and 8-chapter learning resource for use by health professionals working with people experiencing homelessness. Other key resources produced by the programme include:
- Homelessness Chapter of 'All Our Health' resource (with Public Health England)
- Oral Health and Homelessness
- Epilepsy and Homelessness
- Foot care and Homelessness
- Children, young people and families in Homelessness Toolkit and Learning Resource for Public Health Nurses

(with Homeless Link and Association of Young People's Health and Public Health England)

The programme's lead David Parker-Radford has written articles for Nursing Times, Primary Health Care, British Journal of School Nursing, Journal of Community Nursing, Journal of Family Healthcare, British Dental Journal and Practice Nursing. He has presented to conferences including Journal of Health Visiting National Conference 2018, and the Faculty for Homeless and Inclusion Health International Symposium, and given lectures at King's College London and Kingston and St George's University. David planned, managed and organised the 2016 Nursing for All Homeless Health National Conference. David believes that we should gather as much evidence as possible about what sustains and improves health across the whole population as a way of preventing future health inequalities and tackling existing ones. He believes we can learn a lot from the work happening with people who have 'marginalised' social status, as a way of improving healthcare for all.

Exploring Future Health Services and Public Health Strategies for Homelessness and Urban Exclusion in London

Andy Guise - *King's College London*

The combination of homelessness with experiences of drug use, mental ill-health and urban exclusion are linked to severe ill-health. London is facing an increasing challenge of such multiple exclusion homelessness. These experiences are generating a range of innovative responses from across the health and social sector. An evolving research agenda is essential to support ongoing development of this policy response.

The contribution of social science research to health policy is currently limited. Developing this role for social science could bring new insights and directions in the response to multiple exclusion homelessness. This effort links to the King's College London Social science for Urban Public Health Institute (SUPHI). The institute aims to address the limited role for social science in contributing to effective interventions and policy responses.

In this presentation I will draw on insights from recent and ongoing social science studies on urban exclusion and health. I will aim to explore and create discussion with interested stakeholders around theoretical developments that could support health service and public health responses. The intention of the presentation is to generate dialogue between researchers, practitioners and policy makers to inform future social science research.

The presentation will focus on three areas of potential future interest, building on linked studies in implementation: remote and self-testing for infectious disease care, developing the role of peers (those with current or past experience of homelessness and exclusion) in service delivery, and structural interventions that seek to create an enabling environment for health. Across each of these I will explore how a social science perspective could help in fostering new strategies. A particular focus for reflection will be in exploring how we can respond to the social and structural forces of the urban environment that produce experiences of homelessness and ill-health. ●

Poverty, Income and Health

Understanding the Association Between Income Inequality and Mental Health Problems: Mechanisms and Potential Interventions

Wagner Silva Ribeiro and Sara Evans-Lacko - *London School of Economics and Political Science*

Is the Social Patterning of Alcohol Use Explained by Mental Health or Drinking to Cope with Stress?

Laura Goodwin - *University of Liverpool*

How are Health and Wellbeing Referral Hubs in the London Boroughs of Islington and Camden Delivered and What are the Experiences of Staff and Local Residents?

Effie Argyropoulos - *Camden and Islington Public Health*

Food Poverty in Camden & Islington: Understanding the Local Picture through a Health Needs Assessment

Alexandra Smith (Camden and Islington Public Health

Understanding the Medicalisation of Mental Distress in Low Income Communities: Researchers and Residents Working Together to Co-Create Alternative Responses

Lorraine Hansford - *University of Exeter*

FULL ABSTRACTS

Understanding the Association Between Income Inequality and Mental Health Problems: Mechanisms and Potential Interventions

Wagner Silva Ribeiro and Sara Evans-Lacko - *London School of Economics and Political Science*

Studies on the association between income inequality and mental health problems have shown mixed results, possibly because of methodological heterogeneity between studies. To address this, we performed a systematic review and meta-analysis to examine the relationship between income inequality and mental illness-related morbidity. Our results showed that, albeit the effect sizes were small, greater income inequality was associated with higher prevalence/incidence of any mental disorders (Cohen's d = 0.06; 95% CI: 0.01 – 0.11) and in particular, depression (Cohen's d = 0.12; 95% CI: 0.05 – 0.20).

Two main mechanisms have been proposed for how income inequality affects health outcomes – a material mechanism states that income inequality affects health through poverty and deprivation, which are prevalent in highly unequal societies, lead to increased distress and reduce access to health care. A psychosocial mechanism states that greater income inequality increases status competition and insecurity and, therefore, leads to social problems such as low levels of social cohesion and trust, increased violence, deterioration of community life and lack of social support. All these factors increase chronic distress and reduced self-esteem, which can lead to mental health problems.

This presentation will: a) describe the evidence for the association between income inequality and mental health problems; b) summarise theories and evidence on the mechanisms and pathways through which income inequality influences mental health; and 3) discuss potential interventions which could be implemented to tackle the effects of income inequality on mental health, taking into account potential mechanisms and pathways.

Understanding the association between income inequality and mental health problems and the mechanisms underlying this association could have major societal and public health implications. It could provide evidence to support advocacy of social policies designed to reduce income inequality. A better understanding of the mechanisms through which income inequality affects mental health would provide evidence for the implementation of psychosocial interventions to reduce mental health problems and improve well-being of people living in unequal society.

Is the Social Patterning of Alcohol Use Explained by Mental Health or Drinking to Cope with Stress?

Laura Goodwin - *University of Liverpool*

Background: The alcohol harm paradox highlights that whilst individuals of higher socioeconomic status (SES) consume the most alcohol, that those of lower SES experience the greatest alcohol harms. There are a number of explanations for this paradox, including the consequences of poorer mental health in those of a lower SES. We previously took an intersectional approach to define multiple indicator classes of SES using latent class analysis, which identified common mental disorder (CMD) to be most prevalent in the 'economically inactive, renters' class. The current study will explore the association between these classes of SES with alcohol misuse and examine the interplay with CMD and drinking to cope with stress.

Methods: Data is from phase 2 of the South East London Community Health (SELCoH) study (n=1052). SES data on income and occupation, educational attainment and housing were previously analysed using latent class analysis in MPlus. Alcohol use was measured by the Alcohol use Disorders

Identification Test (AUDIT), with hazardous use defined as scores of 8 to 15 and harmful use as 16 and above. CMD was assessed by the Revised Clinical Interview Schedule (CIS-R). Participants were asked whether they drank alcohol to cope with stress. Adjusted associations were examined using multinomial regression (for the alcohol outcomes) and logistic regression (for the drinking to cope outcome).

Results: After adjustment for sociodemographic factors, the prevalence of hazardous alcohol use was not associated with SES, but harmful use was more common in the 'professional, renters' (MOR=3.76, 95% confidence intervals (CI) 1.22-11.63), in the 'economically inactive, renters' (MOR=2.95, 95% CI 1.03-8.44) and in 'economically inactive, homeowners' (MOR=3.62, 95% CI 1.03-12.72). The latter two associations diminished and became statistically insignificant after adjusting for CMD (which was independently associated with harmful use). Reporting drinking to cope with general stress was strongly associated with increased odds of both hazardous (MOR=7.48, 95% CI 4.77-11.75) and harmful alcohol use (MOR=61.07, 95% CI 14.07-265.00), yet this coping mechanism was most common in the 'professional, homeowners'. Adjustment for drinking to cope did not explain the association between SES and harmful drinking and the effect sizes increased after this adjustment.

Conclusions: This study highlights the important role of mental health when considering those most at risk of alcohol harms. Whilst drinking to cope with stress was associated with harmful drinking, this coping mechanism was not most common in those SES groups at greatest risk of alcohol harms. It appears that the alcohol harm paradox is not explained by the social patterning of using alcohol as a maladaptive coping strategy.

How are Health and Wellbeing Referral Hubs in the London Boroughs of Islington and Camden Delivered and What are the Experiences of Staff and Local Residents?

Effie Argyropoulos - *Camden and Islington Public Health*

Background: Excess seasonal morbidity and mortality in London, UK, is associated with a variety of health and social factors. Such as living with a long term condition, being over 75 years of age, poor housing conditions, and debt and/or poverty. In efforts to prevent poor health and wellbeing in vulnerable populations by increasing access to multiple available evidence-based interventions and services, the National Institute for Health and Care Excellence (NICE) recommended the delivery of single-point-of-contact referral services in 2016. There is likely to be a rise in the development and delivery of health and wellbeing referral services (or 'hubs') by local government and commissioners across the UK to reduce health inequalities during extreme temperatures. However, further research is required to establish whether staff and service users will find these services accessible and acceptable.

Aims: This project aims to identify the processes by which two existing single-point-of-contact referral hubs in London, UK, are delivered, who the services reach, and to assess perceptions of accessibility and acceptability from the point of view of staff and service users.

Methods: A mixed methods approach will be used. The number and demographic of local residents referred to the hubs will be used to assess the reach of the services in relation to the target audience. Delivery of the services will be assessed using ethnographic observations with each service. An online survey, informed by the King's Fund GP referral quality review (2010), will be used to assess the accuracy of referrals sent by each service to onward service providers. A survey will also be sent to establish service user satisfaction and the degree service users have taken up the advice given to them. Reasons for uptake or non-uptake of onward referrals will be explored in semi-structured interviews with a sample of service users. Acceptability of the services from the service user and staff perspective will be measured using semi-structured interviews with both groups. Qualitative content analysis will be used to identify, analyse and report patterns within the data from staff and service-user interviews.

Results: This project is currently in progress. Interviews exploring acceptability of delivering the services have been conducted with 11 staff. A total of 400 service users will be sent a postal survey based on a required sample size of 278, and a typical return rate for postal surveys. A total of 60 onward service providers will be sent a survey. Ethnographic observations of telephone and home assessments have been made on two occasions; one at each service. The project is expected to recruit 16 service users, 8 from each service, for interviews. Results will be presented at the conference.

Conclusions: Identifying the processes involved in the delivery and receipt of health and wellbeing referral hubs, who the services reach, and whether such services are found to be accessible and acceptable by staff and service users, will inform the development and delivery of future similar services across UK local government and commissioning.

Food Poverty in Camden & Islington: Understanding the Local Picture through a Health Needs Assessment

Alexandra Smith (Camden and Islington Public Health

Background: Food poverty is 'the inability to afford, or have access to, food to make up a healthy diet'. From food insecurity to crisis-level hunger, this vital public health issue causes major health impacts throughout the life course. Food poverty highlights gross population inequities, both of diet and of diet-related ill health. Causes of food poverty are often financial, such as unemployment, but also include poor access to affordable food and lack of cooking or budgeting skills. Measuring food poverty is challenging,

with no routine data collection systems to assess prevalence or trends. Local assessments are therefore urgently needed to inform action.

Methods: Data were triangulated from multiple sources, including:

- Food poverty levels estimated using secondary data including research, surveys, service uptake and proxy measures such as income deprivation.
- Geographical mapping using QGIS to identify areas with high-risk food environments.
- A call for evidence to engage stakeholders, map local services and identify gaps.
- Qualitative interviews with residents (n=6) about their experiences of food poverty, and professionals (n=9) about their work with people experiencing it.
- Anonymous resident surveys (n=13) to explore other residents' experiences of food poverty.

Results: Over 40,000 Camden and Islington residents are estimated to experience moderate to high food insecurity; such experiences range from compromising the quality and variety of food consumed, to reducing quantities or skipping meals, to experiencing hunger. Evidence from professionals, residents and foodbank usage indicate the problem is increasing locally. Qualitative evidence vividly described residents' experiences of food poverty, affecting many vulnerable groups including the elderly and children, with financial causes predominant. Mapping showed deprived areas with poor supermarket access and clusters of fast food outlets in deprived areas and in close proximity to schools. Gaps in services included poor communication, and barriers to access, including stigma.

Conclusion: These results demonstrate high levels of local food poverty with many population groups affected, emphasising the need for a system-wide approach to prevention. Disadvantaged groups were shown to be at particularly high risk of food poverty, especially those living in poverty or on low incomes. Poor access to affordable healthy food increased the risk of food poverty, and mapping results indicated poorer food environments in more deprived areas. Residents faced barriers in seeking help with food, most commonly stigma, such as feelings of pride or shame; and issues faced with services, such as lack of knowledge of services or restrictive criteria, increasing the inequities observed due to food poverty. Key targets for future work include improving service coordination, raising awareness across frontline staff to decrease stigma, and working to improve accessibility of services to vulnerable population groups who face barriers to access (eg residents with disabilities and the homeless). These findings will be developed into a food poverty action plan by a multi-agency stakeholder group in each borough.

Understanding the Medicalisation of Mental Distress in Low Income Communities: Researchers and Residents Working Together to Co-Create Alternative Responses

Lorraine Hansford - *University of Exeter*

Providing effective treatment and support for mental health is a stated aim of the UK government. Yet whilst it is well recognised that poverty and deprivation create and exacerbate distress, current strategies frame distress as a pathological problem of the 'self' that can be 'corrected' through medical or therapeutic intervention, masking the factors that are often the root causes of suffering e.g. unemployment, poor housing and social isolation. The prescribing of anti-depressant medication is higher low income communities, raising important questions about the medicalisation of distress related to social or economic factors.

DeStress is a 2.5 year qualitative study exploring how moral narratives of responsibility impact on the ways that people in low-income communities perceive and respond to mental distress caused by poverty, particularly in the current climate of austerity and welfare reform. Whilst most mental health research is carried out in a clinical setting, the DeStress project has engaged with very low income communities in two study sites in the South West to work with them to explore the lived experience of poverty-related distress. Sixteen focus groups and eighty interviews with residents have been conducted, creating a rich body of narrative data that give prominence to the voices and experiences of an under researched population. This has been supplemented with interviews with GPs to understand the challenges they face supporting people experiencing poverty-related distress. Findings indicate that in the absence of other support services, people experiencing poverty related distress increasingly turn to their GPs, and that GPs are struggling to cope with the increasing demand from patients. Both patients and GPs have identified that current treatment options for mental health are often not suitable or helpful, leaving some patients feeling helpless or further alienated after failing to access appropriate support from healthcare services.

The study brings together local residents, health practitioners and academics who have worked collaboratively at each stage of the research process to design and steer the project, and to analyse findings. An important strand of the project has been to collectively identify the potential for alternative responses to mental distress that can benefit patients and assist practitioners and policy makers seeking to support low-income communities.

One element of this engaged approach has been the creation of a working group involving local residents, researchers, GPs and service providers to produce new training materials which help GPs improve the quality of consultations relating to poverty-related distress. In this presentation (to be presented jointly by a researcher and resident from the group) we will demonstrate how

a participatory approach has allowed space for creative dialogue in which we have been able to identify some of the common assumptions, attitudes and belief systems present in interactions between GPs and low-income patients, and ways in which the consultation can be improved for the benefit of both patient and health professional. We will describe the emerging process, and the inherent tensions in using this co-created knowledge to develop training resources that are true to the authentic voices and views of the local community to support GPs and other healthcare professionals working within constraining systems to respond in a way which is helpful and offers appropriate support in low income communities. ●

Marginalised Status and Health

SESSION 4B – 14:15–15:30

Health at the Border: Concepts & Practices – An intersectional Analysis of the Health Related Response to Refugees and Migrants at Greek Border Spaces During 2015-2018
Anna Gkiouleka - *University of York*

Rebalancing Act: Place-Based Approaches to Reducing Health Inequalities Among People Who Come into Contact with the Criminal Justice System
Christina Marriott - *Revolving Doors*

How is Cancer Care Best Provided to Patients in English Prisons? The RECAP Study (Researching Cancer in Prison
Elizabeth Davies - *King's College London*

Using IPD Meta-Analysis to Explore Health and Care Inequalities among Lesbian, Gay, Bisexual and Transgender People
Dylan Kneale - *University College London*

FULL ABSTRACTS

Health at the Border: Concepts & Practices – An intersectional Analysis of the Health Related Response to Refugees and Migrants at Greek Border Spaces During 2015-2018
Anna Gkiouleka - *University of York*

Between 2015 and 2016, more than a million migrants and refugees crossed Europe's external borders via the Aegean Sea (UNHCR). During the summer of 2015, the unpreparedness of the Greek state to facilitate the first reception of the arriving populations (Cyril & Renzaho, 2016) forced the UNHCR director for Europe to describe the situation in Greece as a humanitarian emergency happening in Europe and asked for urgent Greek and European response (UNHCR, 2015). Since that time, numerous state and non-state actors have been involved in the reception of refugees, migrants and asylum seekers at Greek border spaces offering shelter, catering, transportation, healthcare and psychosocial services. The

current paper aims to offer an evaluation of the health related response to that heterogeneous populations on the move as it evolved from the summer of 2015 till the summer of 2018 on the Greek border spaces.

Scholars have been stressing the importance of migration and asylum as determinants of health (Castañeda et al., 2015; Fleischman et al., 2015; Isaacs, 2018) associating them with experiences of loss, change and uncertainty (Carta et al., 2005; Isaacs, 2018). However, literature on migrants and refugee health focuses on individuals and groups who have been settled in their destination for a substantial period (Kakalov et al., 2018) and on strictly defined healthcare and health related social entitlements and services. Less is known about the health of populations on the move and their needs as well as about the effectiveness of health related services beyond those regulated and offered by state actors. The study explores how health has been conceived in this frame of 'refugee emergency'; which actors have shaped these conceptions; whose health needs have been addressed; what kind of health related services have been offered and who have been the recipients; and how the asylum scheme intersects with the employed concepts and practices related to immigrants' and refugees' health.

The study adopts intersectionality as critical inquiry (Collins & Bilge, 2016) and will thus contribute to one of the main themes of the conference focusing on intersectional approaches in health equity research and action. An intersectional framework is considered of crucial importance for the study of a group (refugees, asylum seekers and migrants on the move) occupying "border spaces" literally but also symbolically (Schulz & Mullings, 2006). Such a framework allows us to unpack and understand complex intersections between humanitarian aid and border control, how concepts about migrant and refugee health intersect with the asylum process, and what health inequalities are (re)produced at the particular context due to the concepts and practices employed. Moreover, it enables us to put refugee and migrant health in the historical context of power relations in Europe (Mayblin, 2018) and to uncover how concepts of health and vulnerability inform and are informed by the structures and the categories of 'refugee' and 'asylum seeker'.

The study integrates Verloo's 'frame analysis' and Hankivsky's 'intersectionality based analysis' to analyse documents concerned with migrants and refugee health produced by the Greek state, the UNHCR and the six most important organisations involved in health related services for migrants and refugees at border spaces (i.e. ARSIS, International Federation of Red Cross, ISRAaid, Médecins Du Monde, Médecins Sans Frontieres, PRAKSIS). In the frame of the study, health related services include physical and mental healthcare as well as services related with social determinants of health such as living conditions and psychosocial services.

Rebalancing Act: Place-Based Approaches to Reducing Health Inequalities Among People Who Come into Contact with the Criminal Justice System
Christina Marriott - *Revolving Doors*

In recent years there has been a growing awareness that people in contact with the criminal justice system face significant health inequalities, including multiple health and social care needs and social disadvantages such as long-term unemployment, persistent poverty and housing problems – all wider determinants of health.

Low levels of help-seeking behaviour can be compounded by a range of other obstacles to effective engagement with other services, sometimes including inaccessible, poorly designed, and/or restrictive services. These can lead to missed opportunities for early detection, monitoring, and treatment of problems, and result in the health needs of this population going unmet and in increased use of relatively expensive emergency services.

These social determinants of offending can, over the life course, adversely affect health outcomes, offending behaviour and other outcomes. This may include an individual's vulnerability to crime, difficulty at school, lower educational attainment, limited functional and life skills and distance from the labour market. Furthermore, causality can often flow in both directions and interact in complex ways, so that social exclusion can be both a cause and a consequence of offending, as well as a cause and a consequence of poorer health.

The links between inequalities, social exclusion and involvement in the criminal justice system are complex. Addressing inequalities, including health inequalities, as well as directly meeting the health and social care needs, including those around mental health will also help to improve outcomes for other people, including those not in contact with the criminal justice system – the community dividend.

In this presentation, Christina Marriott, Chief Executive of Revolving Doors Agency, will outline the key health inequalities experienced by this population and some of the associations between health and social care needs with offending and reoffending behaviour. She will discuss the emerging place-based approaches including commissioning and delivering programmes jointly with partners across the system, including developing early intervention and prevention programmes. The presentation will also include examples of emerging good practice, including how people with lived experience of crime and personal crisis are informing the work of the Department of Health, the NHS, and Police and Crime Commissioners across the country.

How is Cancer Care Best Provided to Patients in English Prisons? The RECAP Study (Researching Cancer in Prison

Elizabeth Davies - *King's College London*

Background: More than 200,000 people are imprisoned each year in England and Wales and these individuals often have significant health needs. There is little research on cancer care in prisons but recent Ombudsman reports highlight suboptimal service provision. Our NIHR-funded study will assess the burden and cost of cancer in English prisons, equity of access to, and experiences of care in order to develop recommendations to inform local services and English prison cancer care policy.

Method: Our study will employ a mixed methods approach. We will use national cancer registry and Hospital Episodes Statistics data to examine comparative national trends (1997-2016) for cancer incidence in people aged >16 serving a prison sentence. Disease stage at diagnosis, treatment received, days spent in hospital, survival rates and cause of death will be determined. We will estimate the prevalence of cancer among this population, the comparative cost of cancer care in prison and of alternative care pathways. We will undertake in-depth qualitative interviews with 15-20 recently diagnosed or treated patients to understand experiences of diagnosis, treatment and care. The 2010-2016 National Cancer Patient Experience Survey (CPES) results for patients in prison will be compared with those reported for all English cancer patients. Interviews with 30 clinical and custodial staff working in the community or in prison will identify barriers to care and examples of good practice.

Results: Cancers registered from English prisons increased from 426 during 2000-2004 to 811 over 2010-2013, representing around 200 new diagnoses annually. Most occurred in males (665/811, 82%) where commonest types were non-melanoma skin and prostate cancers.

Conclusion: Detailed study of how cancer affects people in prison is warranted given consistent reports of poor service provision and the absence of robust evidence about care. This mixed methods study is anticipated to reveal new knowledge to inform recommendations that can lead to improved outcomes.

Department of Health and Social Care disclaimer: The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health and Social Care.

Inequalities among Lesbian, Gay, Bisexual and Transgender People

Dylan Kneale - *University College London*

Background: Modelling the health and care trajectories of lesbian, gay, bisexual and transgender (LGBT) is essential to identify health inequalities and support needs, yet because of the small sample of LGBT people in any one survey, current evidence relies on studies that have poor generalisability and low power. This lack of data results in knowledge gaps for decision-makers seeking to plan health and care services for LGBT people.

Aims: This presentation will (i) describe differential ageing trajectories followed by older LGBT people through presenting the results from a scoping review; (ii) demonstrate how different approaches to identifying LGBT people in large surveys leads to a differential understanding of public health challenges; (iii) assess health inequalities facing older people, using exemplar evidence on alcohol consumption and wellbeing from Individual Participant Data (IPD) Meta-analysis of UK data.

Methods: IPD meta-analysis allows more flexible, complex statistical analysis of study data. Use of IPD meta-analysis to explore LGBT health and care differentials is a novel application to exploring issues of health and care equity based on sexuality in later life, and the results for measures of quality of life and alcohol consumption will be presented, based on pooling a wide range of different UK data sources.

Results: Early results suggest that inequalities in health are particularly visible for older LGB women. Furthermore, the wellbeing of this group may be compromised further by other age-related transitions, such as the adoption of family caring duties at a much earlier age. Measurement issues around the identification of people as being LGBT within large scale surveys are also examined, and the implications for generating evidence for public health decision-making from IPD meta-analysis of minority populations will be considered in full.

Conclusions: IPD meta-analysis holds great promise for understanding the health trajectories of minority groups, although measurement and identification of minority groups across survey data presents new challenges not encountered (as frequently) in reviews of experimental data. ●