The South East London Community Health (SELCoH) Study

The SELCoH study is an epidemiological study of randomly selected households and was designed to collect information about the health of people living in Southwark and Lambeth. With an emphasis on mental health, the SELCoH study allows us to improve our understanding of the health needs of the community; to determine the social factors that contribute to inequalities in health and health service use and to provide information that enables service providers to plan and improve services more effectively. SELCoH phase 1 (2008-2010) included 1698 adults aged 16 years and over from 1076 randomly selected households who took part in a survey that aimed to provide locally relevant prevalence estimates of common mental disorders, such as depression and anxiety and long-standing illnesses, as well as screen for less common psychiatric outcomes such as eating disorders and psychosis (Hatch et al., 2011). SELCoH phase 2 (2011-2013) included participants who agreed to be re-contacted from phase 1 and aimed to continue to identify factors contributing to health inequalities and specifically to investigate the contribution of discrimination to inequalities in social functioning, common mental disorders, physical functioning, and health service use (Hatch et al., 2016). The overall sample was similar to the 2011 UK Census demographic and socioeconomic indicators for the catchment area and no key differences between boroughs were identified. Importantly, public engagement has been heavily emphasised in SELCoH with ongoing community interactions supported by our HERON network (https://heronnetwork.com/).

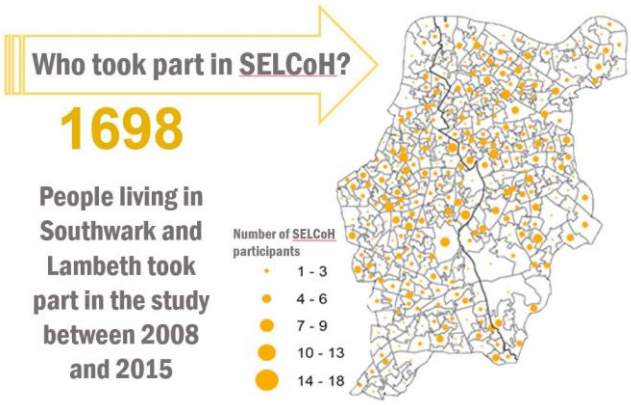


Figure 1. Number of SELCoH participants per area.

Figure 2. Number of migrant and ethnic minority SELCoH participants.

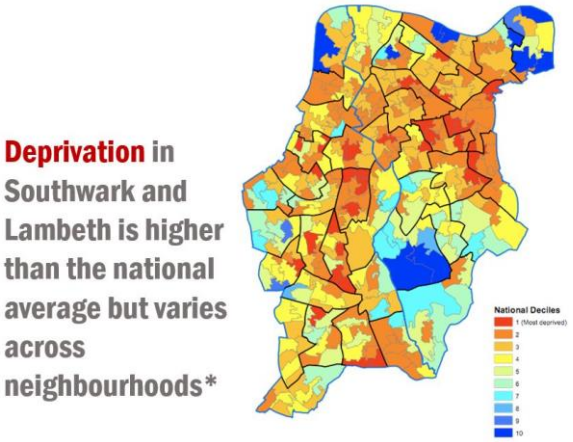


Figure 3. Deprivation levels of SELCoH participant neighbourhoods.

Local versus national comparisons

To ensure our ability to make local and national comparisons, SELCoH applied similar methods to the Adult Psychiatric Morbidity Study (APMS) 2007 in England and collected comparable data on key health indicators (Hatch et al., 2012). Our initial comparison showed that there was a higher prevalence of CMD, and a nearly four-fold greater proportion of depressive episodes in SELCoH than APMS. Illicit drug use in the past year was also higher in SELCoH, with cannabis and cocaine the illicit drugs reported most frequently in both samples. However, the prevalence of hazardous alcohol use was higher in the national sample. In comparisons of the SELCoH sample with the APMS England sample and the APMS sample from the Greater London area in combined datasets, these differences remained after adjusting for demographic and socioeconomic indicators for all outcomes.

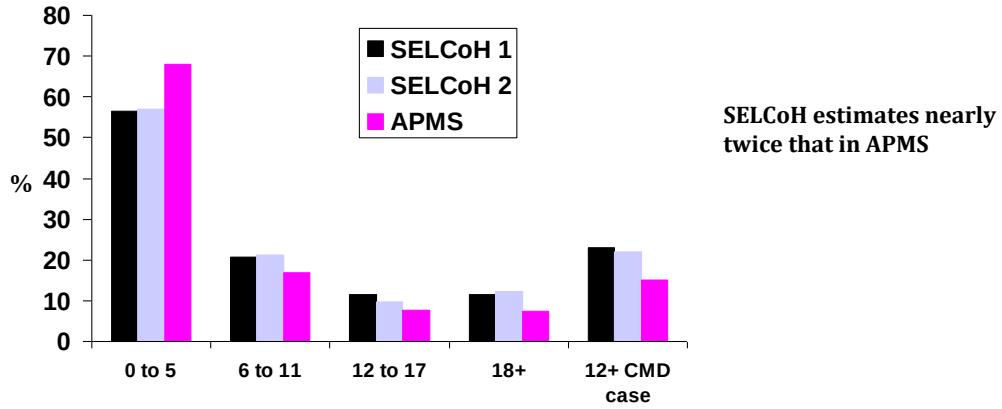


Figure 4. Prevalence estimates of common mental disorders in SELCoH and APMS 2007. (Hatch et al., 2012)

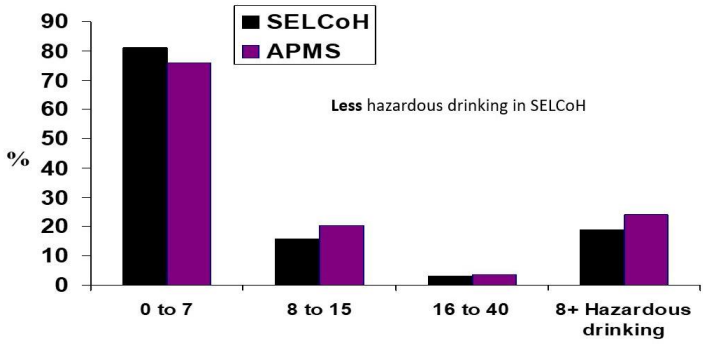


Figure 5. Prevalence estimates of hazardous alcohol use in SELCoH 1 and APMS 2007. (Hatch et al., 2012)

Approximately 23% of participants at phase 1 and 22% at phase 2 met the criteria for common mental disorder (CMD, i.e., symptoms of anxiety and depression). In general, SELCoH participants from higher socioeconomic groups (those with higher income and/or more education) were less likely to meet the criteria for CMD, to rate themselves as having fair or poor health and to report long standing illness. However, this same group reported higher levels of hazardous alcohol use. Those with financial debt were particularly of interest in SELCoH; debt has negative consequences on mental health, but it is relatively understudied compared to other socioeconomic indicators, such as unemployment and income. Our findings illustrated that approximately 37% of participants who reported debt at phase 1 and 47% at phase 2 also experienced CMD and those with concurrent exposure to debt and CMD at Phase 1 were at greater risk of CMD at phase 2. Further, reporting any

debt at phase 2 or debt at both time points were strongly associated with mental health service use in the past year (Gunasinghe et al., 2018).

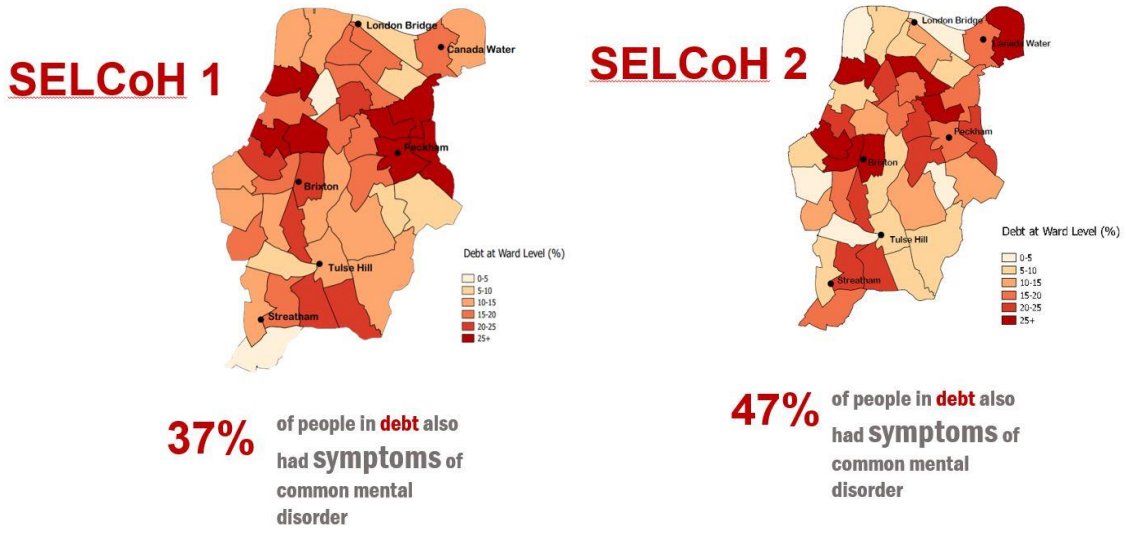


Figure 6. Debt and concurrent CMD. (Gunasinghe et al., 2018)

Identifying high risk groups for CMD is not always straightforward. We found no difference in CMD by ethnicity or migration status when considered separately. However, taking an intersectionality approach to consider the simultaneous experience of these identities revealed two groups at high risk for CMD: a group characterised as migrant, mixed ethnicity and low socioeconomic status and a group characterised as UK-born, white ethnicity and low socioeconomic status (Goodwin et al., 2017). Further, the effects of discrimination on CMD were most pronounced for individuals who had recently migrated to the UK, an ethnically heterogeneous group, and black ethnic groups (Hatch et al., 2016). We were also able to identify adverse mental health outcomes among non-heterosexual individuals compared to heterosexual individuals, with more pronounced disparities in the SELCoH sample in comparison to national data (Woodhead et al., 2016). Notably, only 40% of those who met the criteria for CMD in phase 1 had engaged in formal help seeking and approximately 34% had only sought informal help from friends, family and religious leaders (Brown et al., 2014). However, we were able to identify that self-referral to IAPT reduced disparities in pathways to care based on ethnicity, age, gender and benefit status (Brown et al., 2014).

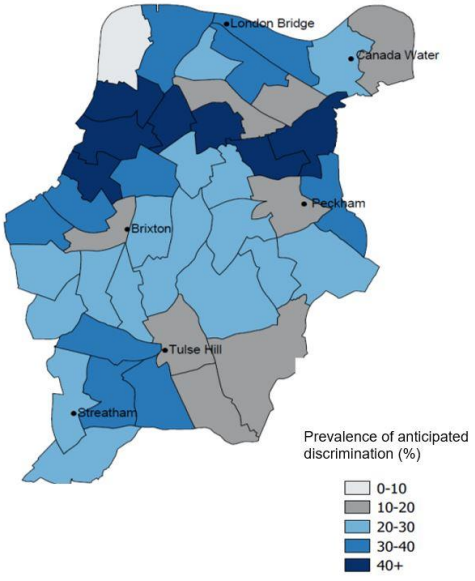


Figure 7. Prevalence of anticipated discrimination in SELCoH 2 (Hatch et al., 2016)

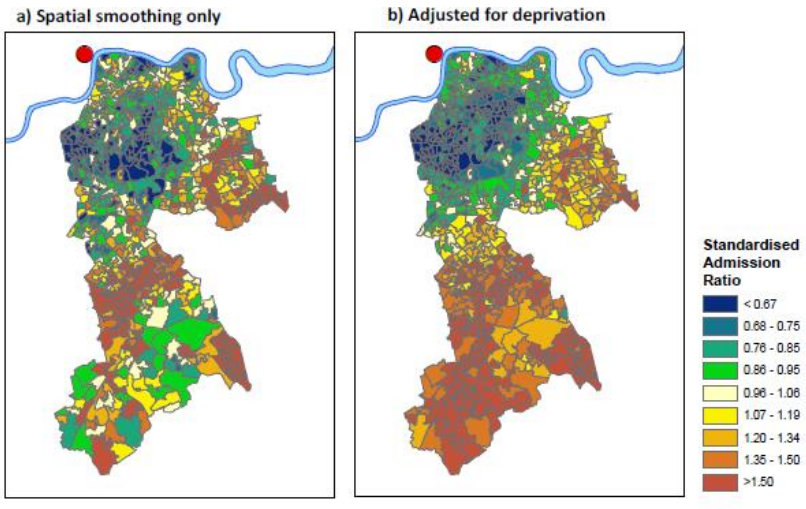
The South East London Community Health (SELCoH) Study

Neighbourhood violence and mental health

With regards to neighbourhood experiences, data from phase 1 (Polling et al., 2014) showed that concern about neighbourhood disorder, experiencing and witnessing violence are all independently associated with greater odds of CMD. Levels of concern about neighbourhood disorder, particularly crime, are high in Lambeth, especially in the youngest age group (16-24-year olds) and those who are unemployed. Concern about disorder was found to be greater in income deprived areas, with this acting as a more important predictor of concerns than the area's reported crime rates. In our data, we approached the complex relationship between exposure to violence and mental disorders by examining the interrelationship between violence perpetration, being a victim of violence and witnessing violence. Kadra et al. (2014) found that witnessing violence in the past year was associated with current CMD and posttraumatic stress disorder (PTSD) symptoms. Violence perpetration in the past year was associated with current CMD, PTSD symptoms and illicit drug use in the past year; whereas victimisation in the past year was associated with lifetime and recent drug use. Lifetime exposure to two or more types of violence was associated with increased risk for all mental health outcomes, suggesting a cumulative effect (Kadra et al., 2014). Frissa et al. (2013) also found a higher prevalence of trauma experiences and PTSD symptoms in SELCoH than the national data, with migrating for asylum or political reasons also being identified as risk factors. We have also confirmed the persistent relationship between exposure to violence and abuse, particularly in childhood, with experiences of psychotic symptoms in adulthood (Bhavsar et al., 2017; Morgan et al., 2014).

Area deprivation, self-harm and suicidal behaviours

Finally, area deprivation has been known to be associated with rates of self-harm. Despite this, Lambeth has rates of self-harm hospital admissions that are less than half those of England as a whole (Public Health England, 2017). Data from SELCoH (Aschan et al., 2013) also suggest suicidal behaviours may be lower locally than in England; suicidal ideation in the last year at 3.6% in SELCoH vs 5.4% in APMS and suicide attempts in the last year among 0.4% in SELCoH vs 0.7% in APMS (McManus et al., 2016), although the differences are not as extreme as those seen in admissions data. Area rates of admission for self-harm vary considerably across Lambeth and while deprivation remains associated with self-harm in the borough, it only partially explains these differences (Polling et al., 2018). The proportion of non-white ethnic minorities in an area's population is not associated with rates of self-harm admission once deprivation has been accounted for. However, data from SELCoH (Aschan et al., 2013) suggests that a more nuanced consideration of ethnicity may be useful; it found a much lower proportion of Black African respondents reported lifetime suicide attempts (3.7%) than the White British respondents (8.6%), while a greater proportion of Black Caribbean (10.6%) respondents did so. The corresponding proportion for England from APMS 2014 is 6.7% (McManus et al., 2016). Ongoing work in Lambeth is examining these findings in greater detail.



Boundaries: Office of National Statistics (2001) Census: boundary data (England and Wales) [English Lower Layer Super Output Areas, 2001] UK Data Service. Digitised Boundary data.

Figure 9. Residual age, sex and year standardised admission ratios for self-harm in South East London (Lambeth, Southwark, Lewisham and Croydon) 2007-2016. (Polling et al., 2018)

Acknowledgements

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