London Borough of Redbridge

Annual Public Health Report 2023/24

STIGMA

and its impact on access TO SERVICES

MENTAL HEALTH DEMENTIA **DOMESTIC ABUSE**

OBESITY HOMELESSNESS POVERTY HIV

Contents

Foreword

From the Director of Public Health

It is my pleasure to present this annual public health report which addresses a very important and often under-recognised issue: stigma. Stigma stems from the unjust attribution of negative characteristics to a group of people, often leading to discrimination and impacting on people's abilities to access health and care services.

We often discuss how inequalities and the wider determinants of health, such as housing and income, affect our residents and contribute to inequalities within our borough. This report wants to highlight how stigma, a somehow less well studied topic, can also affect our residents, the support they receive, and ultimately their health.

Last year's Annual Public Health Report was written on the theme of good sexual and reproductive health, and an action plan was produced in response to the recommendations. I have been pleased to be able to present the progress against this action plan to the Health and Wellbeing Board, the Health Scrutiny Committee, and the Redbridge Place-based Partnership Board in recent months.

I look forward to working with our partners to implement the recommendations from this year's public health report.

I am grateful to my team and many colleagues from the Council and other organisations for their support and contributions to this year's report.

Gladys Xavier

Director of Public Health

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Foreword

From the Chair and Vice Chair of the Health and Wellbeing Board

We know that stigma is a major driver behind health inequalities, and we are pleased to see this being addressed in this year's Annual Public Health Report. This report outlines the many challenges that stigma can bring for all our residents in building happy and healthy lives.

Stigma can be one of the drivers which build and sustain health inequalities. Our health and care partnerships in Redbridge see identifying and addressing health inequalities across our communities as one of our primary priorities for our work into the future.

This year saw a renewed commitment from health and care partners in Redbridge to improving health and wellbeing at every stage of life and tackling these health inequalities. Our Integrated Care Board for North East London brings together health and care, local authority, and community and voluntary organisations in a powerful partnership to maximise the benefits of all our resources. The Redbridge Place-Based Partnership plays this same role at a Redbridge focused level. Tackling health inequalities is at the very heart of our Partnerships' priorities.

We look forward to working together, in partnership, to support the reduction of health stigma for all within our borough.

Cllr Mark Santos

Chair of the Health and Wellbeing Board

Dr Anil Mehta

Vice-Chair of the Health and Wellbeing Board

Executive Summary

Stigma refers to the unjust attribution of negative characteristics to a group of people. This leads to discrimination and impacts on people's abilities to access health and social care services, making stigma an important and often under-recognised public health issue.

Stigma is a very wide concept which can be applied to several different conditions. For this annual report we have chosen to focus on how stigma impacts on mental health, obesity, poverty, homelessness, HIV, domestic abuse, and dementia.

Mental health

1 in 6 adults in the UK are affected by mental health issues; there are more people live with a mental health condition in Redbridge compared to those with diabetes and cancer combined. Some people are more likely to experience mental health conditions, such as those who live in deprived areas, those who are homeless or unemployed, women, and those who identify themselves as LGBTQ+.

9 in 10 of those with a mental health condition report experiencing stigma and discrimination. This can result in delays in diagnosis and treatment, with only 1 in 3 of those experiencing mental health symptoms in the UK receiving treatment in the form of medications or talking therapies. Women who are pregnant and those who had a baby within the last year are more likely to experience mental health symptoms; stigma often results in delays seeking support with potential serious consequences for both mother and child.

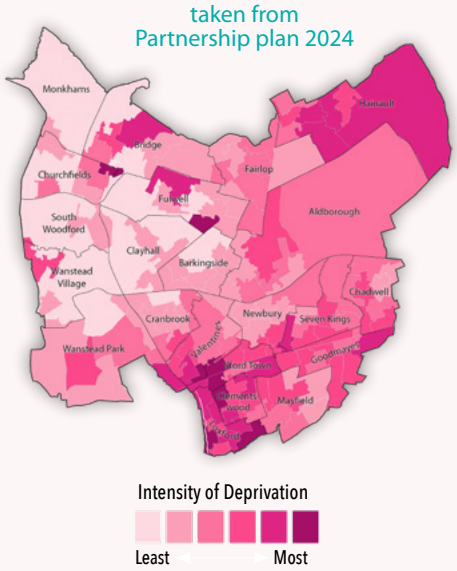
Obesity

2 in 3 adults living in England are either overweight or obese; obesity is highly prevalent within Redbridge, where 1 in 3 children aged 10-11 years are obese. Obesity is associated with several health conditions such as diabetes and cardiovascular diseases; severe obesity can shorten life by up to 10 years. Obesity is closely linked to deprivation, which in turn affects the food environment we live in. The so called "obesogenic environment", where fast foods proliferate and healthy fresh food is difficult to find, is one of the main drivers of obesity. Still, many people ignore the wider determinants of health and see obesity as something completely within individuals' control and responsibility. This assumption contributes to perpetrating stigma and delaying access to effective treatment: it takes an average of 9 years for patients to discuss their weight with a professional, and very few people are referred to secondary services such as bariatric surgery.

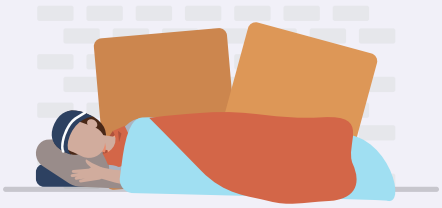
Executive Summary

Poverty

1 in 4 adults and 1 in 3 children in Redbridge live in poverty. Poverty is closely related to life expectancy and is therefore a public health issue. In England, those who are born in the least deprived areas can expect to live up to 10 years longer compared to those who are born in poorer areas. Those living in poverty experience widespread stigma related to accessing services aimed at supporting those on low incomes. The causes of poverty are often structural; however, media often portray it as being the result of poor individual choices, further perpetrating stigma. Stigma affects policy making, with those living in poverty often having to overcome significant barriers before being able to access the advice and support they are entitled to.



Homelessness



The number of rough sleepers in London has almost quadrupled over the past few years. There are 247 people sleeping rough in Redbridge; 71 of them have no recourse to public funds. Homelessness is associated with reduced life expectancy; the average life span of those sleeping rough is 45 years for males and 43 years for females. Rough sleepers are more likely than the general population to live with both physical and mental health issues, however they are less likely to access support. Stigma means that registering with a GP is not easy for those who are homeless; long phone queues and strict appointment timings are additional barriers faced by those who only have very intermittent access to phones. Lack of a fixed address for correspondence means that hospital appointments are often missed, further perpetrating inequalities and stigma.

Human Immunodeficiency Virus (HIV)

There are about 105,200 people living with HIV in the UK; 2 in 5 live in London. 1 in 16 of those living with HIV does not know they carry the virus. With modern treatment, HIV has become a chronic disease with a life expectancy similar to that of the general population. Still, those living with HIV are often discriminated, leading to delays in diagnosis and reduced adherence to treatment. This is especially problematic given that HIV treatment should be started early and taken regularly to be most effective. Stigma can result in social isolation, as people might worry about how their family and friends might react if they knew of their HIV-status. Some people feel they are treated differently during hospital visits, which might lead to patients not wanting to engage with services and access life-saving treatment.

Domestic abuse

Domestic abuse is defined as an incident or pattern of abusive behaviour between two people who are personally connected, with the perpetrator often being a partner or an ex-partner. 1 in 20 adults in the UK experience domestic abuse each year; in Redbridge, it is estimated that 10,000 people experience domestic abuse from an intimate partner every year. Stigma affects victims, who are often perceived as willingly remaining in an abusive relationship; this means that they might not feel comfortable disclosing their abuse and accessing support. Some women are stigmatised by their community for accessing support, and risk of being estranged from their support network if they disclose their abuse. Fear of not being believed is another common issue, particularly when the abuse is not physical or when the victim is a man. Stigma can result in delays in accessing treatment, with potentially very serious consequences for families where the abuse takes place.

Dementia

Dementia is a broad term which refers to several diseases which cause issues with memory, language and other thinking abilities that are severe enough to interfere with daily life. There are about 900,000 people living with dementia in the UK, and more than 3,000 in Redbridge. Internalised stigma often leads to feelings of anxiety and low self-esteem, whilst public stigma often results in loss of status and independence, and exclusion from decision making. Courtesy stigma means that those who care for people living with dementia might also be discriminated. Stigma results in delays in diagnosis and accessing support; it is estimated that 1 in 3 of those living with dementia never received a formal diagnosis, and 1 in 3 carers has hidden the diagnosis of a person with dementia.

Conclusions: What can we do to address stigma?

Stigma can be deep rooted within society and manifest in many different forms and multiple interventions are needed to address it. People often experience multiple disadvantages and are exposed to multiple layers of stigma. An example might be somebody who is a new parent, with a mental health problem, living in poverty making it challenging for them to discuss or access support.

Education plays an important role in reducing stigma, focusing on both professionals and the general population.

Continued effort should be made to understand how stigma impacts on our residents and how they seek support so that we can adapt our services and ways of working.

Talking openly about how residents might be impacted by stigma is a useful starting point where we hope will contribute to raising awareness around this important topic.

RECOMMENDATIONS

- Health and Wellbeing Board to consider the implications of this report on how the evidence and best practice included can most effectively influence local policy.
- Health and Wellbeing Board to ensure this report and its key messages are shared widely and effectively across the Redbridge Place-Based Partnership.
- LBR Public health Team to develop an action plan for the consideration and agreement of the Health and Wellbeing Board.

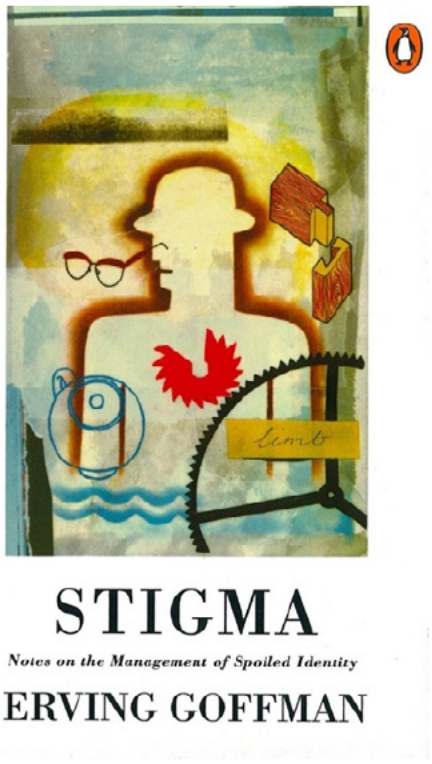
Introduction

What is stigma?

The origins of the word "stigma" come from ancient Greece, where the word was used to refer to a mark which was burned on the skin of criminals, traitors, or slaves to make them visibly recognizable and identify them as morally polluted people[1].

Ervin Goffman, a Canadian sociologist, talked about stigma in his work "Stigma: Notes on the Management of spoiled identity" published in 1963[2]. He considered this as a "situation of the individual who is disqualified from full social acceptance", typically because he bears one or more characteristics which are deeply discredited by society.

Goffman divides society into three categories: the stigmatised (those who bear the stigma), the normal (the stigmatisers, those who do not bear the stigma) and the wise (those amongst the normal who accept and understand the stigmatised)[2]. The stigmatised experience prejudice and discrimination, often resulting in poor physical and mental health outcomes. Stigmatisers, on the other hand, often benefits from their behaviour by enhancing their self-esteem by comparing themselves to less fortunate others[2].



Stigma is strongly influenced by temporary cultural and societal value systems, meaning that the same individual can be stigmatised and stigmatiser at different times and under different circumstances.

Goffman writes "Some jobs in America cause holders without the expected college education to conceal this fact; other jobs, however, can lead to the few of their holders who have a higher education to keep this a secret, lest they are marked as failures and outsiders. Similarly, a middle-class boy may feel no compunction in being seen going to the library; a professional criminal, however, writes [about keeping his library visits secret[2]]".

Stigma is public health issue

Today, we typically use the word "stigma" to refer to the unjust attribution of negative characteristics to a group of people. Stigma is known to affect health by acting as a barrier to health-seeking behaviour, engagement in care and adherence to treatment across a range of conditions.

Stigma leads to discrimination and impacts on people's abilities to access health and social care services, making it an important and often under-recognised public health issue. Stigma ultimately affects physical and mental health outcomes and is relevant to a range of public health priorities including poverty, mental illness, substance misuse, obesity, and HIV.

Stigma exists in many different forms. Individuals might be stigmatised for several reasons including their ethnicity, sexual orientation, religion, mental or physical health condition, lifestyle, and economic circumstances. Individuals are often subject to multiple types of stigma, with negative consequences on their ability to attain the resources they need to achieve optimal health, education, employment, and housing.

Why Stigma?

We decided to focus the annual public health report for Redbridge on stigma because we felt this is an important issue that is not discussed enough. Stigma is context and situation dependent, with cultural backgrounds playing an important role with regards to how specific conditions are perceived.

Redbridge is a very diverse borough; according to the latest census, half (47.3%) of our residents identified their ethnic origin as "Asian, Asian-British or Asian-Welsh", up from 41.8% in 2011. About one third (34.8%) of residents identified themselves as "White" in 2021, compared to 42.5% on 2011. Almost half of the population living in Redbridge was born abroad; 7.6% from India and 5.3% from Pakistan. One in three of our residents describe themselves as Muslim (31.3%), followed by Christian (30.4%) and no religion (12.6%).

Within our community, the uptake of most prevention and intervention services has been historically low. We know that stigma can affect the way residents perceive their conditions and their decision to access support services.

We hope that addressing stigma around specific conditions will reduce barriers to seeking support and early intervention. This will improve health outcomes at the individual and population level. In the case of communicable diseases, such as HIV or Chlamydia, diagnosis and treatment can have further public health benefits including limiting transmission. On a broader level, tackling stigma in marginalised groups helps widen their participation in society and improve social cohesion.

We hope that this report will raise awareness around the impact of stigma on our residents and help guide our efforts to address it.

MENTAL HEALTH

MENTAL HEALTH

Mental health conditions are very common

Studies show that 1 in 6 adults living in England experienced symptoms of anxiety or depression in the past week and met the criteria for a common mental health disorder (CMD)[1].

Mental health issues are also very common in children and adolescents, with data showing that 18% of those aged 7 to 16 had at least one probable mental health condition in 2021. This figure has increased from 12% in 2017[1].

18% of those living in Redbridge have a mental health condition

This is slightly higher than the England average at 17%. Depression is very common in Redbridge, with more than 7% of the population having been diagnosed with it[2].

This means that more than 40,000 people in Redbridge live with a mental health condition. 356 lives were lost to suicide between 2001 and 2021[2].

For comparison, there are more people living with a mental health condition in Redbridge than people with diabetes and cancer combined[2].

Mental health is closely related to deprivation

The prevalence of common mental health conditions is twice as high amongst those in the lowest fifth of household income compared to the highest. This effect is even more pronounced for severe mental health disorders; psychotic illnesses are 9 times more frequent in those with the lowest household income compared to wealthier residents[3].

Housing influences mental health

Deprivation is often associated with poor housing. We know that good quality housing is a protective factor for mental health, whilst homelessness and poor-quality housing are risk factors for mental health problems[4]. We will address the impact of stigma on homelessness later in the report.

Unemployment is linked to anxiety and depression

Employment has a strong link to mental health; studies show that people who are unemployed are between 4 and 10 times more likely to report anxiety and depression or to complete suicide compared to those who do work[5].

Some people are more likely to experience mental health conditions

In England, some categories of people are more likely to live with mental health conditions. These include women and those who identify themselves as LGBTQIA+.

Women are more likely to live with mental health conditions

Women are more likely to report symptoms of both common and severe mental health conditions compared to men. One in 5 women reported having a common mental health condition, compared to 1 in 8 men. Similarly, 1 in 10 women reported severe mental health symptoms, compared to 1 in 17 men[6].

The proportion of women living with mental health conditions has increased steadily since 2000, whilst it has remained stable for men[6].

LGBTQIA+ people are more likely to experience mental health issues

Those who identify themselves as LGBTQIA+ are 2 to 3 times more likely to live with a mental health disorder compared to those who identify as heterosexual. Half of LGBT people reported living with depression over the past year, and 3 in 5 said they experienced anxiety[7].

A recent report shows that almost half of trans people thought about taking their own life in the last year, as did 1 in 3 LGB people who aren't trans[6]. This percentage is higher compared to the general population, where an estimate 1 in 20 adults thought of taking their own life in the last year[8].

Most people living with a mental health condition experience stigma

Despite mental health issues being very common, mental-health related stigma is a highly prevalent issue. Nine in 10 people diagnosed with a mental health issue report experiencing stigma and discrimination because of their condition[9].

Compared to people living with other long-term health conditions, those living with mental health issues are less likely to find and maintain a job, be in a stable relationship and be socially included in mainstream society[9].

Mental health stigma delays diagnosis and treatment

People experiencing stigma due to their mental health condition are less likely to seek help, therefore perpetuating a cycle of illness. Data show that only 1 in 3 people living with a common mental health condition receive treatment, in the form of medications, talking therapies, or both. After adjusting for other factors, white British females aged 35 to 54 are more likely to receive treatment for their mental health condition compared to other groups[6].

Media language affect mental health perception and stigma

The language used by the media to portrait those living with mental health conditions can contribute to stigmatisation. Although trends appear to be improving, with anti-stigmatising articles increasing in 2019 compared to both 2016 and 2009, specific mental health illnesses are still heavily stigmatised by the media. Articles referring to people living with schizophrenia, for instance, were six times more likely to be stigmatising compared to those focusing on other mental health issues[10].

1 in 5 women develop a mental health issue during pregnancy or in the first year after the birth of their baby

As many as 1 in 5 women develop a mental health issue during pregnancy or in the first year after the birth of their baby[15]. Depression is very common, with more than 1 in 10 mothers affected within a year of giving birth[16]. The risk of developing psychosis also increases by more than 20 times post-birth; affecting 1 in 500 mothers[17].

Up to 1500 women experience perinatal mental health issues in Redbridge each year

Data from 2017/2018 show that in Redbridge, an estimated 350 to 530 women experienced mild to moderate perinatal depression, and 107 severe perinatal depression. It is also estimated that 7 women developed post-partum psychosis within the same time frame, and up to 1070 women are estimated to have experienced perinatal adjustment disorder and distress[14].

Stigma is a barrier to accessing support and treatment in the perinatal period

Stigma often prevents women from asking for help and support; this might result in delayed treatment and worsening of the underlying mental health condition. A recent report shows that 1 in 3 women in the perinatal period felt there was stigma attached to their mental health problems, and 2 in 5 were worried that their mental health problems would be noted on their medical records[13].

Untreated maternal mental health conditions can affect the health of both mother and child

A report published in 2015 showed that 1 in 4 of all maternal deaths between 6 weeks to 1 year after childbirth were related to mental health problems, with 1 in 7 directly due to suicide. The report showed that in 2 out of 5 cases, improvements in care might have made a difference to the outcome[18].

In the UK, there is wide regional variation in care provision. In almost half of the UK, pregnant women and new mums have no access to community maternal mental health services.

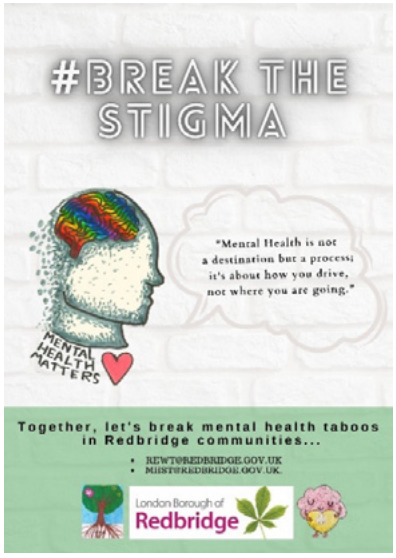
Lack of diagnosis and treatment of maternal mental health issues might also affect the infant and result in several issues such as low birth weight, premature delivery, attachment difficulties, anxiety and irritability[19].

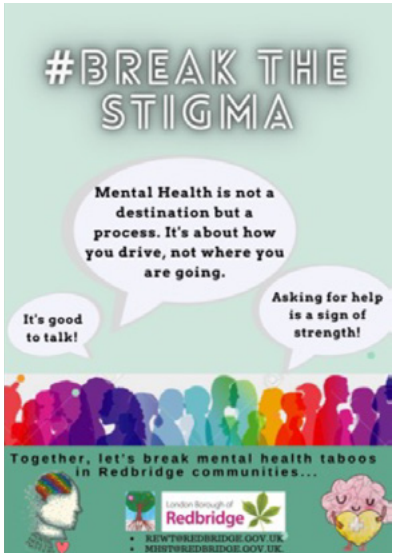
Mental health stigma within different communities

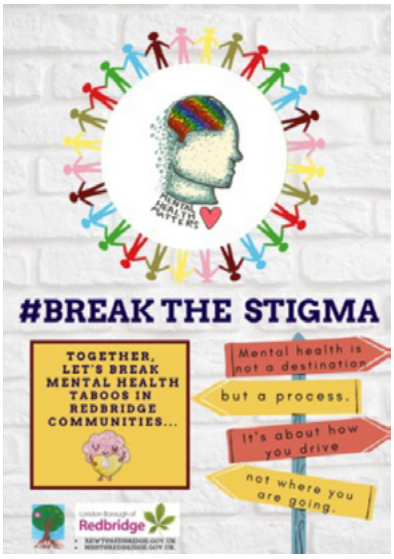
We know that attitudes towards mental health conditions vary widely across different cultures and communities. According to the latest census, the population of Redbridge is predominantly Asian (47.3%), followed by White (34.8%)[11].

A recent study focused on the London borough of Harrow explored mental health stigma within south Asians communities. It showed that many people from the community perceived mental health conditions as something to be kept private and not openly discussed, not even with members of the immediate family[12].

Participants reported that the family's reputation and status needed to be protected at all costs. Mental health conditions were often hidden to prevent community gossip, which was felt as highly threatening to both the person living with the condition and their close family[12].







Good practice in Redbridge

Good progress has been made in reducing mental health stigma over the past 15 years, however stigma still exists within many communities.

"Time to change" was a national campaign aimed at reducing mental health stigma which ran from 2009 to 2021. The campaign aimed to change the way people think and act about mental health problems and focused on building knowledge and awareness of local communities on the issue.

A communications campaign produced and disseminated information about challenging stigma and discrimination when you see, hear, or experience it. Advice was shared widely, including tailored interventions in workplaces and schools, around topics such as tips for talking to someone about their mental health. Resources emphasised the difference an intervention could make.

Since it was launched in 2009, mental health knowledge has increased by 10% within the population.

Public health recently published the councils Suicide Prevention Strategy 2023-2028, which includes an ambition to address mental health stigma in Redbridge. In January 2023 we partnered with the Local Government Association as part of their suicide prevention sector led improvement Programme to run a mental health stigma workshop to commence this work and will continue to engage with partners and communities to improve our understanding of mental health stigma and deliver this programme. We are adopting a life course approach from pregnancy to older age with a particular focus on those who are more likely to experience stigma, e.g., perinatal mental health, those experiencing domestic abuse, substance misuse etc.

In 2021, Redbridge Educational Wellbeing Team (REWT) launched a 'Break the Stigma' campaign to reduce stigma around mental health. The campaign aimed to increase public understanding of emotional wellbeing and decrease stigma and discrimination around mental health, with a particular focus on children and young people in schools.

Local young people were invited via a competition to design a logo and decide on the name for the campaign. A campaign launch event was held at a local high school with 15 different professional stallholders and a panel of speakers aimed at young people present, with over 120 students from across the local authority in attendance.

Following from this, REWT based their work on the direction of suggestions from student councils, collecting student voice by administering a questionnaire for pupils to answer containing eight questions around what mental health means to them, and in what ways stigma exists around it. Schools have been encouraged to put forward representatives to attend local Great Mental Health Days, where representatives can speak openly about their mental wellbeing in a safe environment. REWT has also run understanding-building workshops in local Scout groups, where a mental health professional presented over the four main areas of mental health and the audience were asked to write down what they thought the content meant.

Through workshops, signposting and attendance at forums, the team aims to continue to build awareness of campaign strands with school staff and professionals, as well as developing an additional programme of action to raise awareness with parents.

Additionally, the team aims to raise awareness of campaign strands in the wider community. The Mental Health Support Team (MHST) has worked in conjunction with psychological wellbeing practitioners from Redbridge Talking Therapies to present a webinar during South Asian Heritage Month 2022 to raise awareness of stigma. Plans have been made to run stalls in Ilford Town Centre to talk to people from the local community, and community drop-ins have been proposed in collaboration with the Redbridge Faith Forum.

What we can do

- Public health campaigns to increase awareness and normalise mental health/illness.
- Initiatives to promote contact between those affected by from mental health issues and their wider communities.
- Language is important: we are trying to talk about people living with mental illness, as opposed to "suffering" from mental illness.

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OBESITY

2 in 3 adults living in England are either overweight or obese

Obesity is very common in the UK, with recent data showing that 68% of men and 59% of women living in England are either overweight or obese. The proportion of adult living with obesity in England has increased from 14.9% in 1993 to 28% in 2021[1]. The same is true for Redbridge, where 61% of the population is either overweight or obese[2].

1 in 3 children living in Redbridge is obese

Almost 1 in 4 of reception age children in England are either overweight or obese; this figure increases to more than 1 in 3 for children in year 6. Obesity is highly prevalent in children living in our borough, with almost 1 in 3 of those attending Year 6 living with obesity and severe obesity[3].

Obesity is associated with reduced life expectancy

Research shows that, on average, those who are obese (BMI 30-35kg/m^2) have their life shortened by 2 to 4 years, and those who are severely obese (BMI 40-45kg/m^2) might have their life shortened by as much as 10 years due to their condition[4].

Obesity increases the risk of developing many health conditions

Those living with obesity are seven times more likely to develop type 2 diabetes[5], and 2.5 times more likely to develop high blood pressure, compared to those who have a healthy weight[6]. Obesity can also increase the risk of some types of cancers; colon cancer for example is 3 times more frequent in those living with obesity compared to healthy weight individuals[6].

Obesity has a negative influence on mental health

Obesity affects not only physical but also mental health. Those living with obesity are more likely to live with depression compared to the general population; the risk of developing depression seems to be directly correlated to BMI above 30 kg/m^2([7]).

The overall cost of obesity is estimated at more than £27 billion per year

In 2014-2015, the NHS spent an estimate of £6.1 billion on obesity-related ill health; this figure is expected to reach £9.7 billion by 2050.

The overall costs to society were estimated at £27 billion in 2015 and are expected to reach £49.9 billion per year in 2050[6].

Obesity is a multi-factorial issue

Studies show that several factors, such as environmental, genetic, and behavioural contribute to the development of obesity.

Obesity is closely linked to deprivation

The context in which people are born, grow and live plays a big role in the development of obesity. The prevalence of obesity is 9% higher in the most deprived areas of England compared to the least deprived[6].

The same trend is seen in children, where those aged 4 to 5 are more than twice as likely to be obese if they live in the most deprived areas in England (13.6%), compared to the least deprived (6.2%). In year 6 (age 10-11), those living in the most deprived areas in England are almost 3 times as likely to be obese (31.3%) compared to those living in the least deprived areas (13.5%)[6].

The food environment determines what we eat

On average, the concentration of fast-food outlets is proportional to deprivation. This means that those living in less affluent areas are more likely to be surrounded by fast food outlets and unhealthy food advertisement compared to those living in wealthier areas[6].

Poverty makes it difficult to maintain a healthy diet, with processed, nutrient poor foods often being much cheaper than healthier, nutrient-dense foods.

Those living with obesity are often blamed for their condition

People living with obesity often face pervasive stigma and discrimination due to their condition. They are often blamed for their condition, and several studies have shown how some people believe those living with obesity to be "lazy" and "lacking in motivation, self-discipline or willpower"[8-10].

We often fail to recognise how the obesogenic environment we live in contributes to the development of obesity

Studies show that society often perceives obesity as something ultimately caused by factors within personal control, neglecting the role played by the environment we live in[11]. This contributes further to stigmatisation, as it is known that conditions which are felt to be completely under control of the individual attract less compassion compared to those which are felt to be outside one's control.

Obesity related stigma contributes to delaying access to effective intervention

People living with obesity often experience stigma in several settings including education, workplace, and healthcare, where they experience barrier to accessing services and treatments[12].

Stigmatisation of obesity perpetrates a cycle of health disparities, and ultimately interferes with effective obesity intervention efforts[12].

Those living with obesity are often stigmatised within healthcare settings. Obesity is a complex, multi-factorial issue; still, it is often perceived by professionals as a condition solely caused by controllable factors, such as diet and physical exercise 8-9. Research shows that health providers tend to spend less time in consultations with obese patients, compared to thinner ones[13-14].

It takes an average of 9 years for obese patients to discuss their concerns with a healthcare professional

Studies show that less than half of those living with obesity discussed their weight with a healthcare professional in the last 5 years. Evidence shows that it takes an average of 9 years for people with obesity to talk about their weight concerns with a healthcare professional. This delay can partially be explained by the fact that 4 out of 5 people with obesity see their weight as completely their responsibility[15].

Healthcare professionals often report not talking about obesity with their patients because of a lack of time, need to address health matters which are perceived to be more urgent, and feeling that patients might not be motivated at reducing their weight.

We often over-estimate how much weight can be lost and maintained long-term through diet and exercise alone.

Whilst diet and exercise might be effective in the short term, maintaining the results long term is challenging. Studies show that 80% of the weight lost through dieting tends to be re-gained within 5 years[17].

Positive health effects do not always correlate with significant weight loss

Available food and exercise programmes are known to lead on average of only around 10% weight loss. This is usually sufficient to reduce the risk of comorbidities such as hypertension, type 2 diabetes and high cholesterol[16]. Still, this degree of weight loss often means that those affected might remain obese and continue to be subjected to stigma.

Stigma might contribute to the development of eating disorders

Studies show that those experiencing stigma might engage in more frequent binge eating and might be more likely to develop an eating disorder. We also know that those affected by stigma are more likely to develop mental health issues such as depression and low self-esteem[17-20].

Obese women are less likely to attend cancer screening due to stigma

Obesity stigma also affect physical health in multiple ways. Women living with severe obesity, for example, reported reduced access to healthcare services and gynaecological screening programmes due to stigma. The perception of stigma appeared to be worse the higher the BMI[17].

Obesity stigma means that patients are rarely referred to secondary care

Finally, obesity stigma prevents those living with obesity from accessing appropriate care. This includes referral to secondary care services including bariatric surgery where appropriate. Data show that, on average, those undergoing bariatric surgery lose 15-30% of body weight, which is accompanied by a dramatic improvement in the incidence of diabetes, high blood pressure and heart attacks [22-24].

Less than 1% of those eligible for bariatric surgery in the UK receive it

In 2017-2018, around 3.6m people were eligible for bariatric surgery in England, however only 6,627 received surgery. This rate of 0.2% is much lower compared to the European average of 1.4% of eligible people[25]. The number of bariatric surgeries was almost unchanged in 2021 (6,740)[26].

The UK performs less bariatric surgeries compared to other European countries

Data show that, despite having a higher proportion of residents living with obesity, the UK performs less bariatric surgeries compared to other European countries such as France, Belgium, or Sweden.

In Redbridge, hospital admissions for bariatric surgery are similar to the national average of 12 per 100,000 residents[27].

Good practice in Redbridge

The NELFT Healthy Eating team has introduced group sessions for children and their parents or carers to raise awareness around the importance of healthy eating and maintaining a healthy weight. They discuss strategies that families might be able to adopt to improve their general health within a welcoming, non-judging environment. Our leisure provider offers a range of activities that families can participate in which are fun and low cost, which is especially important at a time where the cost-of-living crisis is affecting more of our residents.

It is important that issues around positive body image are addressed, particularly for children. Negative body image can impact on children's mental health and lead to anxiety and depression. The public health team in Redbridge has developed a classroom resource where teachers can discuss the topic of positive body image within a non-judgmental environment.

What we can do

- Focus on public health campaigns addressing the environmental causes of obesity, including social injustice, deprivation, and the obesogenic environment.
- Support children and their families by signposting them to activities which are conducive to maintaining a healthy weight.
- Targeted campaigns around how stigma and discrimination might impact those living with obesity.
- Incorporate anti-stigma messages into obesity prevention campaigns, especially when targeting youth.
- Public health promotion campaigns should include overweight and obese images to reduce the inequality in uptake to prevention and early intervention e.g., cancer screening.

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POVERTY

POVERTY

In Redbridge, more than 1 in 4 adults and 1 in 3 children live in poverty

1 in 5 of the UK population live in poverty, and over half of these live in working households[1]. The numbers are even higher for Redbridge, where more than 1 in 4 adults and 1 in 3 children live in households with an income of less than 60% the UK median, after housing costs have been subtracted[2].

Poverty as a public health issue

In England, those living in the least deprived areas live on average 8 to 10 years longer compared to those who live in the most deprived areas. Poverty is closely related not only to life expectancy, but also to healthy life expectancy. This is defined as the number of years lived in full health, and it is strongly associated to poverty and deprivation. The healthy life expectancy gap between the most and least deprived areas of England is 17 years[3].

Poverty impact people's health

There are many ways through which poverty can affect health. It can affect individual's sense of control, leading to increased stress levels, and reduce access to experiences and material resources. Unemployment and low-wage employment are associated with adverse effects on health, as well as risky health behaviours such as smoking and increased alcohol consumption. Lack of monetary resources can lead to fuel poverty, where people might not have enough money to heath their homes, leading to poor physical and mental health[4].

Poverty makes it difficult to maintain a healthy diet

Poverty can also make it difficult to adopt and maintain healthy behaviours; it is three times more expensive to meet our daily energy needs through healthy food than unhealthy food. People on lower incomes tend to eat more low nutrient, processed food and sugar compared to those on higher incomes[4,5].

Poverty has a negative effect on mental health

Deprivation directly impacts physical and mental health, with those experiencing poverty facing higher levels of mental health issues compared to those living in wealthier communities[6]. Living in overcrowded accommodation is also known to negatively affect mental health[4]; similarly, poverty and debt can also affect people's abilities to plan for their future, such as investing in studies or training courses.

Those living in poverty often experience stigma

People who live in poverty often experience stigmatisation. Poverty stigma refers to a process whereby individuals are devalued because they live in poverty or because they access services designed to support people living on low incomes. Similarly, to other types of stigma, poverty stigma can be divided into structural, pubic and internalised[7].

Structural poverty stigma refers to institutional policies that disadvantage or punish those living on low incomes.

An example of this are sanctions on social security. Structural stigma can also contribute to "gatekeeping of support". This refers to policies which impose excessive barriers to access support, for example by requiring extensive information and proof of eligibility[7].

Stigma acts as a barrier to accessing support

Another example is the process needed to claim disability benefits, where individuals often must face an invasive and intimidating application process to "prove" their condition. Not only this acts as a barrier to people accessing support, but it also reflects a general sense of distrust towards people who cannot work due to their disability[7].

Public stigma refers to people's attitude towards those living in poverty and the systems in place to support them

Examples of this are media representing poverty as being the result of poor individual choices as opposed to structural failings. Narratives around poverty being the result of poor individual choices, rather than societal structures, influence policy and exacerbates stigma. Negative views of people relying on social security can ultimately incentivise a reduction in investment in these resources. Public figures, such as politicians, celebrities, or influencers, can have an important impact on how poverty is perceived[7].

Those working in public facing roles might have stigmatising views of poverty

People working in public facing roles in the public sector might themselves have stigmatizing views of poverty, which might affect how they interact with people in need. This is particularly relevant for those services more often accessed by those living in poverty such as job centres and social services.

Those living in poverty often experience internalised stigma

People experiencing poverty may internalise stigma and apply it to themselves directly causing shame, isolation, and secrecy about the reality of their financial situation. Ultimately, internalised stigma acts as a barrier to accessing the support those living in poverty might be entitled to[7].

Stigma often leads to poverty being kept secret

This might result in feelings of shame which prevent people from being open about their circumstances, often leading to poverty being kept secret. An example of this is residents travelling very far to access food banks away from home, in order not to be seen by their community[7].

Stigma contributes to lack of knowledge around poverty and support networks

Overall, this means that people are less likely to be open about the support they are receiving or have received in the past. This contributes to the lack of knowledge about what support is available for those who experience poverty, such as available benefits and debt advice[7].

Stigma can act as a barrier towards a fuller understanding of poverty

Given the shame often experienced by those who live in poverty, it is difficult to expect that they might be completely open with researchers, both in the government and third sector. Co-design and a greater involvement of those experiencing poverty first hand are crucial to address this[7].

Intersectionality is an important feature of poverty related stigma

Certain groups, such as children, single moms, disabled people, BAME, and those who experienced the criminal justice system, are more likely to experience poverty related stigma on top of other stigmas associated to their identity[7].

The impact of poverty related stigma is often most felt by children and young people

Emotional consequences include feelings of shame, embarrassment, humiliation, and low self-esteem. Stigma impacts on pupils' behaviour and affects educational attainment. Children, for example, might not be able to complete homework due to lack of heating, internet, and electricity. They might not be open about their situation to avoid feelings of shame. Pupils might also try to hide poverty by reporting no interest in extra-curricular activities such as school trips[7].

Some children living in poverty have end up skipping social activities and, often, meals

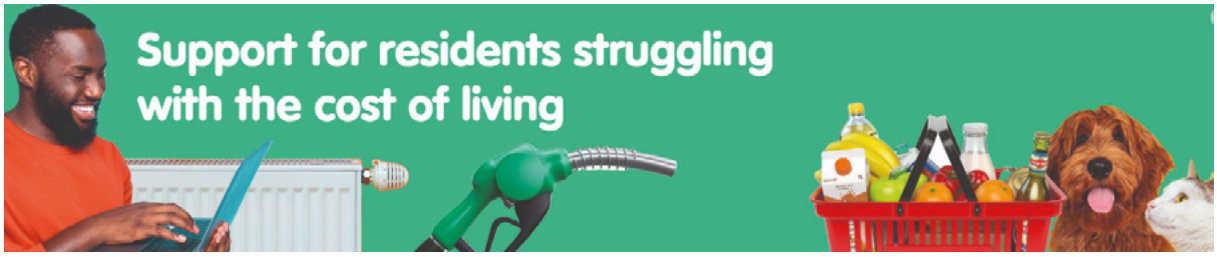
Some children who might be entitled to school meals do not use them so that they can spend time with their peers during lunch breaks, even though this often means going without food all day. Not being able to participate in activities ultimately leads to social isolation. For many young people, this means spending a lot of lunch time and other leisure time on their own[7].

Good practice: drop-in sessions around debt and poverty

The borough has been hosting support initiatives aimed at residents who are experiencing poverty and debt. The Anti-Poverty Team are responsible for coordinating and delivering vital cost-of-living outreach sessions across the borough to ensure residents can access much needed support at a location convenient to them. These are arranged monthly and comprise of critical council services (Housing, Benefits, Work Redbridge, Rent Recovery, Council Tax) and local organisations (Citizens Advice Redbridge, HSBC).

The outreach sessions are designed to provide information and advice to local residents on a range of social welfare issues, including debt, employment, housing, and benefits. They are also designed to carefully evaluate a resident's household and financial circumstances to identify those households in crisis and place them on a pathway of resilience.

The Anti-Poverty Team also arranges larger 'marketplace' events, which consist of a wider range of council services and local organisations, to provide information and advice on a range of cost-of-living aspects. These events can also be themed to focus on particular cohorts and vulnerable groups. For instance, an upcoming event in July will focus on families with children and an event in August will focus on vulnerable and disabled households.



What we can do

- Invest in programmes aimed at increasing benefits take up by those who are entitled to receive them.
- Campaigns to raise awareness of the structural determinants of poverty, particularly amongst public facing staff such as teachers, health professionals and social workers.
- Ensure that policy making is informed by those who had direct experience of poverty.
- Continue to support initiative to support residents experiencing poverty and debt.
- Targeted campaigns to ensure residents know where to go for early debt advice if needed and to normalise seeking help.
- Encourage drop-in sessions to discuss financial and housing concerns.

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HOMELESSNESS

Homelessness is a public health issue with profound impact on people's lives

In England, the average life span of those who are homeless is 45 years for males and 43 years for females. This is about 35 years shorter compared to that of the general population[1].

The number of people sleeping rough has increased substantially over the past few years

According to CHAIN, the number of people sleeping rough in London almost quadrupled over the past 15 years, reaching around 8,329 in 2021/2022[2]. Recent estimates show that 247 people sleep rough Redbridge, up from 214 in 2018/20192. Of these, 71 rough sleepers in Redbridge come from populations with no recourse to public funds[3].

Health conditions are common amongst those who are homeless

Those who are homeless, and rough sleepers in particular, are more likely than the general population to live with chronic health conditions. These include cardiovascular diseases, respiratory conditions, mental health issues and infectious diseases.

A recent study showed that in England more than 1 in 3 of those who are homeless live with long-term health conditions, compared to about 1 in 9 amongst the general population[4].

Homelessness and stigma impact on access to health services

Despite being more likely to live with health problems, those who are homeless are subjected to widespread stigma and face the greatest barriers accessing health care services. This includes primary care services such as GPs and secondary care services such as hospital appointments.

Those who are homeless often struggle to register with a GP

In England, everybody has the right to register with a GP, regardless of whether they have a fixed address. In the past, homeless residents of Redbridge have struggled to register with a GP for this reason.

When people who are homeless do manage to register with a GP, they often face additional barriers when trying to see a clinician. Intermittent access to phones and long phone waiting queues have often been cited as common barriers faced by rough sleepers when trying to book a GP appointment.

People who are homeless face pervasive stigma

In Redbridge, there have been instances where rough sleepers have been asked to sit further apart from other patients whilst in the GP's waiting room.

Due to their challenging living circumstances, people who are homeless might not make health appointments on time. Lack of flexibility by all public sector services, including primary and secondary health care services, often mean that those who turn up late risk being refused further appointments.

Good practice in Redbridge: The Welcome Centre and Healthy Living Healthy Lives

The Welcome Centre in Ilford and Healthy Living Healthy Lives are very positive examples of how we can work together to help those who are homeless and reduce stigma.

The Welcome Centre provides support to those who are homeless by giving advice and guidance on a number of topics including substance misuse, housing, and benefits. They also provide invaluable practical support, including with food, showers, and clothing.

The Welcome Centre also hosts regular events where homeless residents can access several health services at the same time. These include the NHS Health Check, Tuberculosis screening, mental health, and sexual health services.

Redbridge holds drop-in health event for rough sleepers

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Healthy living Healthy Lives provides the homeless health service for Redbridge and offers weekly walk-in clinics in a number of locations such as the Welcome Centre and multiple hostels across the borough.

The nursing team working at Healthy Living Healthy Lives assist those who are homeless by facilitating GP registration, including for those with no recourse to public funds. They assist with booking GP appointments and help overcome barriers deriving from poor access to phones by those who are homeless.

They also provide valuable clinical expertise and facilitate continuity of care within the homeless population. The team is supported by a number of GP practices across the borough who have been excellent at facilitating registration and collaborate with the community team to provide care.

Overall, Healthy Living Healthy Lives helps bring services into the community and facilitates access for a population who might otherwise struggle to engage with traditional set-up services such as GPs and secondary care.

Thanks to the joint efforts of Healthy Living Healthy Lives and GP practices, virtually every homeless person living in Redbridge has now been registered with a GP.

What we can do

- Work with the placed-based partnership and continue to invest in projects that bring services out in the community to reach the homeless population.
- Ensure GP practices are aware that providing an address is not a requirement for registration.
- Continue to host regular health events at the Welcome Centre.
- Improve access to primary and secondary care.

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HUMAN IMMUNODEFICIENCY VIRUS (HIV)

As of 2019, there were around 105,200 people living with HIV in the UK

Most of these are aware of their diagnosis, however around 1 in 16 do not know they carry the virus[1].

Data show that more than two third of those living with HIV in the UK are males, and less than one third (31%) females. Most of those receiving care for HIV in the UK are white (52%), followed by Black African (29%) and Asian (4.3%)[1].

2 in 5 of those living with HIV in the UK live in London

The vast majority of those receiving treatment for HIV in the UK live in England (96%), with almost 2 in 5 living in London[1].

The prevalence of HIV in Redbridge is high

According to a recent report, the rate of diagnosed HIV in Redbridge is 2.8/1,000 of those aged 15 to 59[2]. This means that our local authority is classified as having a high prevalence of HIV.

As of 2021, around 500 residents of Redbridge were living with HIV; 17 of them were diagnosed late[3].

In the UK, HIV is most frequently acquired through sexual contact

Most (92%) of those receiving treatment for HIV in the UK acquired it through sexual transmission. Slightly more people acquire HIV through heterosexual sex compared to homosexual sex[1].

A small number of people who receive treatment for HIV in the UK acquired it through drug use (1.5%) or following transmission from an HIV-positive mother during birth or breastfeeding (1.7%)[1].

Early HIV diagnosis and initiation of treatment saves lives

Early HIV diagnosis is very important, as one of the main determinants of life expectancy is whether treatment is started early and taken regularly. Delaying treatment means the immune system might be affected by HIV, making people more susceptible to infections[4].

In Redbridge, HIV testing is available at multiple sites

These include GP practices and sexual health clinics; tests can also be ordered online through Sexual Health London. Testing can take place either through a quick finger prick test, or with a normal blood test.

U=U Undetectable = Untransmissible

Most people with HIV in the UK have undetectable virus levels in their blood: this means that they can't transmit the disease

The vast majority (98%) of people diagnosed with HIV in the UK are receiving treatment; this is taken daily and blocks the virus from replicating in the body. Almost all (97%) of those on treatment in the UK are virally suppressed, which means they have undetectable HIV levels in their blood and can't pass on the virus[1].

Effective treatment means that those with HIV have a similar life-expectancy as the rest of the population

Effective HIV therapy means that those who access treatment, especially when this is started early and taken regularly, are likely to have a similar life expectancy as those not affected by HIV.

A recent study showed that when treatment is started early, those living with HIV are likely to live only very few years less compared to the rest of the population[4].

Effective treatment results in around half (48%) of those living with HIV in the UK today being aged 50 and over, and 8% older than 65. Overall, most of those living with HIV in the UK are aged 35 to 64[1].

HIV stigma can be defined as a set of negative beliefs, feelings and attitudes towards people living with HIV

Stigma can broadly be divided into four categories: internalised, organisational, societal, and interpersonal[5].

Internalised HIV stigma often results in withdrawal from society

HIV stigma can result in feelings of low self-esteem and anxiety; in more severe cases this might result in suicidal ideations.

People who experience internalised stigma might be concerned about how other people might react if they knew of their HIV status. Fear of rejection, whether real or perceived, can lead to withdrawal from usual social circles, further perpetuating a cycle of anxiety and isolation[5].

Stigma means that some people living with HIV fear meeting people they know as part of their health checks

Some patients living with HIV report being concerned about meeting other people from their community as part of their health checks; this might result in hesitancy to attend appointment or efforts to plan those far from their main residence. This might ultimately result in patchy treatment uptake with potentially serious health consequences.

Interpersonal stigma might result in isolation from friends and family

Stigma often results in people feeling unable to discuss their concerns around HIV testing, or their HIV status, with their family or friends. This further contributes to social isolation and withdrawal and might result in mental health issues, including poor self-esteem and self-harm. In extreme cases, this can lead to violence from family members and death threats.

HIV stigma can be present within religious communities, with some faith leaders known to use stigmatising language to refer to those carrying HIV. This can contribute even more to people concealing their HIV status and fearing being discriminated and isolated from their community if it was disclosed.

Anecdotally, people with HIV have stopped taking medications under the advice of religious leaders, some suffering serious harm.

Organisational HIV stigma stems from an "acceptable tolerance of discriminatory behaviour"

Organisational stigma stems from how organisations, including health providers and employers, perceive those living with HIV[5].

Stigma coming from health providers might result in delays in diagnosis and treatment

Stigma coming from health providers might result in delays in diagnosis and treatment initiation by creating a barrier to discussing patients' concerns about HIV status and testing. This is particularly concerning when stigma comes from those working in primary care.

Our service provider in Redbridge, such as Positive-East, highlighted how this might result in some patients preferring to discuss HIV testing and treatment in sexual health clinics as opposed to GP practices.

Stigmatisation can sometimes be unintended

Stigmatisation can sometimes be unintended, where not up to date knowledge about HIV and its treatment might result in professionals feeling not comfortable discussing it, inadvertently perpetuating stigma.

Patients report experiencing stigma during hospital admissions

Healthcare stigma often extends to hospital stays. Patients living in Redbridge have reported episodes of discrimination, such as staff refusing to change their bedsheets or leaving their food outside the door.

Patients also expressed concerns around lack of confidentiality during ward rounds, where other patients in the bay could easily overhear their diagnosis being discussed by the medical team.

Societal stigma often relates to the withdrawal of rights and freedoms of those affected by HIV

Examples of societal stigma include criminalisation of those actions that might result in HIV transmission, such as homosexual sex, as is still the case in many countries around the world.

Freedoms that we take for granted, such a travelling, are not granted to those living with HIV. 47 countries currently have restrictions on people with HIV travelling to visit[5].

Societal stigma influences employment and accommodation

We know that people living with HIV in the UK are often concerned that they might need to disclose their HIV status as part of their employment checks. This might limit the type of positions people affected by HIV might apply to, even though the job itself carries no HIV-related risk.

Service providers working across Northeast London have reported of people with HIV being offered a place in shared accommodation and being asked by their housing officer to disclose their HIV status to those living in the house to be allowed to stay.

HIV stigma often reflects a wider issue: sexual behaviour stigma

Stigma around HIV often reflects an underlying stigma around how HIV is transmitted. Having multiple sexual partners, sex between men, and condomless sex are still heavily stigmatised by parts of the population. This can result in individuals being blamed because of their condition, further perpetrating a cycle of stigma and social exclusion[6].

Attending a sexual health clinic can sometimes be perceived as stigmatising. This perpetuates a cycle of stigma and lack of awareness around not only HIV, but also other sexually transmitted diseases and contraception.

Failure to fully implement the sexual health curriculum in Redbridge schools is an example of how difficult it still is to raise awareness around important topics such as sexual health within society.

Good practice: opt-out HIV testing and engagement

A recent national initiative resulted in everyone attending A&E in areas of high HIV prevalence to be tested for HIV, Hepatitis C and Hepatitis B, unless they wish to opt out. Within the first 12 months of the initiative, almost 2,000 people living with HIV, Hepatitis B or C in England have been diagnosed as a result of opt-out testing[7].

In north-east London, sexual health medicine specialists have been liaising with healthcare professionals in both primary and secondary care to improve asymptomatic testing for HIV. This includes thinking about HIV testing when patients present to GP practices and secondary care appointments.

Service providers such as Positive East have also been supporting patients with HIV who had negative experiences in both primary and secondary care, and advocating on their behalf to ensure concerns around stigmatising behaviours are raised and addressed. They are also working with service users to reduce HIV stigma and increase their ability to access sexual health services.

What we can do

- Information campaigns aimed at both the general public and targeted groups to increase awareness.
- Provide support in the form of counselling, peer support or therapy to help challenge internalised stigma.
- HIV transmission and treatment mandatory learning for all professionals working in health, including those who have regular contact with patients despite not being formally clinically trained (healthcare assistants, porters, wider hospital team).

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DOMESTIC ABUSE

Domestic abuse can take many forms

According to the UK law, domestic abuse is defined as an incident or pattern of abusive behaviour between two people who are personally connected, with the perpetrator often being a partner or an ex-partner.

"Abuse" might take many forms, such as physical and sexual abuse, violent or coercive behaviour, emotional, digital, or economic abuse[1].

Women are more likely to be victims of domestic abuse

Although everyone can become a victim of domestic abuse, this tends to disproportionately affect women. Women are more likely to experience certain types of domestic abuse such as stalking, physical and sexual violence. Domestic abuse often begins in times of higher vulnerability such as pregnancy, where an estimate 1 in 3 pregnant women experience domestic abuse[2].

1 in 20 adults experience domestic abuse each year

In the year ending in March 2022, an estimated 2.4 million adults in England and Wales experienced domestic abuse (1.7 million women and 699,000 men). This equates to around 5% of the adult population. Th majority of adults experience domestic abuse by a partner or ex-partner (3.5%), followed by a family member (2.1%). Of those who experienced abuse by a partner, 84% experience non-physical abuse, 13% sexual assault and 21% reported stalking[3].

In Redbridge, it is estimated that 10,000 people experience domestic abuse from an intimate partner every year[4].

Those aged 16 to 19 are at higher risk of experiencing domestic abuse

Statistics show that 1 in 5 adults had experience domestic abuse since the age of 16. Similarly, 1 in 5 children have lived with an adult perpetrating domestic abuse. Both men and women are more likely to experience domestic abuse as very young adults, aged 16 to 19, compared to later in life[2].

3 in 4 cases of domestic abuse are not reported to the police

Domestic abuse related crimes are on the rise, with an increase of 14% in March 2022 compared to March 2020. It is estimated that only 1 in 4 instances of domestic abuse a reported to the police, making this a largely hidden crime[2].

Those who experience domestic violence experience multiple layers of stigma.

Stigma might delay disclosure and access to support

Victims of domestic violence often first disclose their abuse when accessing health services. Due to lack of understanding of the complexities surrounding domestic violence, many victims are stigmatised for what might be perceived a willingly remaining in an abusive relationship. Being able to discuss their situation without feeling stigmatised is important to ensure that victims can seek support and access services as soon as possible[5].

Fears of being labelled a "bad parent" might prevent disclosure of the abuse

Victims with children might fear stigmatisation and being labelled as a "bad parent" for remaining with an abusive partner. Stigma and fear of consequences on their family act as barriers to seeking help and accessing support.

Both males and females can be victims of abuse

Male victims of domestic violence also often experience stigma, due to historic perception that domestic violence equates violence against women. Men can feel stigmatised when disclosing their situation to services and fear they might not be believed because of their gender.

Fear of not being believed might prevent disclosure

Victims experiencing more subtle forms of domestic abuse often fear that they might not be believed if they reported their perpetrator. This is also often the case when the abuser is a well-respected member of society.

Victims can be stigmatised for seeking help

Some victims of domestic violence fear disclosure because of the effect this could have on the wider family. In some communities, women in particular are stigmatised for seeking support against domestic violence. Disclosure can result in them being blamed for their situation and isolated from their family and community.

Victims of imaged-based sexual abuse are heavily stigmatised

Domestic abuse involving image-base sexual abuse, such as revenge porn, is a source of stigma. Victims often fear being blamed for what happened. A recent survey showed that only 4% of victims successfully prosecuted their offender, and 3 in 4 victims did not report the crime to the police. Anonymity was cited as the main barrier to disclosure, cited by 97% of respondents as important. Under the current UK law, these crimes are classified as communication rather than sexual offences, meaning anyone can name victims. 9 in 10 victims reported that they would have reported the crime to the policy if they were guaranteed to remain anonymous[6].

Good practice in Redbridge

"This has to stop" is a campaign aimed at ending violence against women by the London Borough of Redbridge. This initiative is aimed at tackling sexist behaviour within our borough, and the second stage of the campaign will focus on domestic abuse.

Children's services have adopted the **"safe and together"** model within Children's services; meaning that social workers partner with the non-offending parent to support those in need.

The council also commissions the **"Free Your Mind"** service, aimed at supporting children and young people to break the cycle of abuse.

"Reach Out", the council's first in-house domestic abuse service

Redbridge is also launching "Reach Out", which will be the council's first in-house domestic abuse service which includes public health funded training to equip professionals with the skills to support survivors. The service provides both emotional support to victims and help with practical issues such as finance, housing, and benefits.

Domestic violence survivor programmes

The council sponsors a number of domestic violence survivors' programmes, such as the "Freedom" and "Sahara" programme, the latter working mainly with Asian women and aimed at breaking down stigma and barriers within the community.

Support for perpetrators

The council has launched "Spotlight", an accredited perpetrator programme aimed at supporting those who have been abusive and are committed to change their behaviour.

What we can do

- Work with faith organisations to spot abuse and respond appropriately.
- Share positive stories from survivors who sought help, received good levels of support, and help and feel safer as a result.
- Perpetrators often have themselves experienced abuse. We should challenge perpetrators' stigma and encourage them to come forward and seek support.
- Ensure that the Sex and relationships curriculum addresses stigma, particularly around of accessing support.
- Campaigns addressing fear of being outed in communities, particularly around relationships out of wedlock or same sex relationships.

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DEMENTIA

DEMENTIA

What is dementia?

Dementia is a broad term which refers to several diseases which cause issues with memory, language and other thinking abilities that are severe enough to interfere with daily life[1]. In the UK, Alzheimer's disease and vascular dementia are the most frequent diseases causing dementia.

There are about 900,000 people living with dementia in the UK, a figure which is expected to raise to 1.6 million by 2040. In Redbridge, more than 3,000 residents live with dementia; this figure is expected to raise to more than 3,800 by 2030. Overall, dementia costs the UK £34.7billion per year[2].

Dementia is not a normal part of ageing

Despite being more prevalent amongst older people, dementia is not part of normal aging. It is estimated that around 7% of older adults in the UK live with from dementia[2]. Most people with dementia are older than 65, however 1 in 20 patients are diagnosed with "early onset" dementia[3].

Some cases of dementia are preventable

Some cases of dementia are preventable; reducing risk factors such as smoking, high blood pressure, and diabetes, might prevent up to a third of all cases of dementia[3].

1 in 3 people with dementia have never had a formal diagnosis

It is estimated that 1 in 3 people with dementia has never had a formal diagnosis[4]. These numbers might have been impacted by the COVID-19 pandemic, although it is difficult to estimate to which extent. Patients are often less likely to be seen in person by healthcare providers, which might result in delays receiving a diagnosis and care plans, compared to before the pandemic[5].

Referral pathways to reach a definitive diagnosis can be complex, meaning it is not unusual for people to have experienced symptoms for a long time before being formally diagnosed. In Redbridge, after being referred by their GP, people often wait around 6 to 9 weeks before being seen by the memory services.

In the context of dementia, stigma can broadly be divided into three categories: self-stigma, public stigma, courtesy stigma.

Self-stigma

Self-stigma refers to internalised prejudices which affect how people with dementia perceive their own condition. In Europe, round 1 in 4 of respondents would keep their dementia a secret when meeting people. Layers of stigma might influence whether those living with dementia seek help and engage with services, often resulting in delayed diagnosis and treatment. Similarly, self-stigma can affect how those affected by dementia interact with other people, often resulting in social isolation and withdrawal[6].

Public stigma

Public stigma refers to the discrimination that those living with dementia face because of stigmatising views from other members of the public. Overall, public stigma might result in loss of social status and independence, including exclusion from decision making.

Public stigma can result in patients not being fully involved in discussions around the diagnosis and care, and in delayed referral to dementia-appropriate services[6].

Courtesy stigma

Courtesy stigma refers to situations where prejudices result in discrimination of those close to individuals with dementia. This often results in social exclusion of the family members of those living with dementia. Carers stigmatisation often adds to the burden of those caring for people with dementia[6]; a recent UK based study showed that the majority of carers are aware of being treated differently, and stigmatised, by others[7].

Dementia related stigma is pervasive

The "World Alzheimer report 2019" focuses on global attitudes to dementia. Almost 70,000 people worldwide took part in a survey looking at how patients, carers, healthcare professionals and members of the public perceive those living with dementia[6].

Stigma surrounding dementia might result in delayed diagnosis

This extensive report highlights how stigma represents a major barrier to people with dementia seeking help, information, and support. Stigma might lead to delays in diagnosis due to people not seeking medical help when they first become aware that something is wrong, due to prejudices surrounding dementia[6].

Journalist Pippa Kelly, in this report, articulates that
"Stigma stems from fear. Fear breeds silence, which in turn perpetuates ignorance and misunderstanding".

Younger residents living with dementia might find the path to diagnosis particularly challenging and experience more stigma due to dementia often being associated with old age. Dementia services also tend not to be designed for younger patients, which might further exacerbate inequalities in access and availability of support.

Poor understanding of dementia is widespread

Worryingly, the survey highlighted that 2 in 3 members of the public and 3 in 5 healthcare providers worldwide think that dementia is part of the normal aging process, rather than a disease[6].

Those living with dementia struggle to be heard

The report showed that more than 85% of respondents living with dementia felt their opinion had not been taken seriously. Similarly, almost 40% of the public living in high income countries felt that doctors and nurses ignore people with dementia[6].

"My neurologist ignored my presence when my diagnosis was discussed with my husband".

Stigma surrounding dementia affects friendships and intimate relationships

One in 3 of those living with dementia in high income countries felt they were treated unfairly in dating and intimate relationships. Those responding to the survey highlighted how, due to having dementia, they were no longer invited to social gatherings[6].

"I call it the friendship divorce. I have lost a fair amount of people in my life that at one time considered friends".

1 in 3 carers has hidden the diagnosis of a person with dementia

One in 3 carers reported having hidden the diagnosis of a person with dementia, and 3 out of 5 said their social life suffered due to their caring responsibilities[6]. Still, many carers reported positive experiences with caregiving, suggesting that the relationship between stigma experiences and caregiving is a complex one[7].

An estimated 700,000 people living in the UK are primary carers for people with dementia[8]

A recent report shows that around 1 in 5 of those caring for someone with dementia are in some form of paid work. Around 1 in 5 of working age carers report having to reduce their hours or struggling to balance work and caring. In England, this is estimated to result in an estimated £654.9 million billion cost of lost output due to caring[9].

Good practice: programmes available to residents of Redbridge who have been diagnosed with dementia

Dementia-related stigma has slowly been improving over the past few years due to several campaigns which have increased the public's knowledge around dementia.

The memory services in Redbridge are supported by an Admiral nurse, a nurse who specialises in dementia and who can support families who deal with complex situations involving a loved one with a diagnosis of dementia. The services are hoping to receive funding to support a second Admiral nurse, and a psychologist in the near future.

There are a number of initiative available to support residents of Redbridge who have been diagnosed with dementia.

Age UK sponsors the "Living well with dementia" groups, a set of activities aimed at supporting those living with dementia. It includes sessions on how to manage the diagnosis of dementia and the challenges of disclosing this to others.

Another programme available to North-East London residents is "Strategies for relatives (STAR)", a programme aimed at reducing anxiety and depression in those caring for a person with dementia.

North-East London NHS Foundation Trust also provides a 14-week long "Cognitive Stimulation Therapy", where numerous techniques are employed to stimulate memory, multi-sensory stimulation, and reality orientation.

Patients with mild cognitive impairment, who have issues with memory but do not meet the threshold for a dementia diagnosis, are followed up yearly by the memory services in order to diagnose dementia promptly if it was to develop.

What we can do

- Public health campaigns focused on dementia and dementia related stigma, particularly targeting younger people with dementia.
- Increase awareness around unpaid caring (carer's week).
- Encourage collaboration between dementia services and community leaders to raise awareness around dementia and reduce stigma.
- Create 'dementia friendly' communities and become a 'dementia friendly' borough.
- Public advocacy by those living with dementia and training for professionals to ensure that they treat a person with dementia with dignity.
- Focus on prevention campaigns to raise awareness of vascular dementia prevention amongst residents, particularly middle-aged residents with cardio-vascular risk factors such as diabetes.
- Language is important: we are trying to talk about people living with dementia, as opposed to "suffering" from dementia.
- Ensure that services can offer ongoing support to residents diagnosed with dementia, as opposed to focusing on obtaining a diagnosis.
- Ensure that easy to reach physical spaces are available to host support programmes for those living with dementia.
- Campaigns to raise awareness of dementia and reduce stigma within communities where English is not fluently spoken, and who might not have access to technology, especially amongst older residents.

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CONCLUSIONS

What can we do to address stigma?

As we have seen throughout the report, stigma can be deep rooted within society and manifest in many different forms. Multiple interventions may be needed to address it. While it is difficult to measure the direct impact of stigma on health and wellbeing outcomes, the evidence demonstrates that in its interplay with other economic and social determinants of health, it can have a significant impact on health and wellbeing, particularly for those who experience multiple disadvantages and are exposed to multiple layers of stigma. An example might be somebody who is a new parent, with a mental health problem, living in poverty making it challenging for them to discuss or access support.

Stigma can sometimes stem from structural discrimination, meaning that legislation is necessary to address the underlying inequalities.

Education plays an important role in reducing stigma, focusing on both professionals and the general population. Raising awareness of what stigma is, how it develops, and its role as a factor alongside other structural determinants of health, can improve public understanding of challenges such as poverty or obesity.

Throughout the report, we have explored a number of different areas to better understand how stigma impacts on our residents' health and wellbeing. We have provided examples of good practice to reduce stigma where these are available and made suggestions of what else could be done in the future.

It is essential that stigma is explored as part of any work that we do with efforts made to understand how it impacts on our residents and how they seek support. Through doing so, we can change our language and adapt our services and create an environment where it feels safe to seek support.

Overall, talking openly about how residents might be impacted by stigma is a starting point which we hope will contribute to raising awareness around this important topic

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London Borough of
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MENTAL HEALTH DEMENTIA **DOMESTIC ABUSE**
OBESITY HOMELESSNESS POVERTY HIV