Main Outcome Measures
Hypertension was defined as systolic blood pressure $\geq 140$ mm Hg, diastolic blood pressure $\geq 90$ mm Hg, and/or taking prescribed medication to lower blood pressure.

Results
A higher proportion of participants in London than elsewhere in England with survey-defined hypertension were on treatment (2005–2007 average: 61% men, 66% women in London; 45% men, 55% women in England, p for London vs rest of England <0.001 for each sex). Regression analysis showed this regional effect for odds of treatment persisted after adjustment for demographic, socio-economic, and health behaviours (OR 1.48, 95% CI 1.04 to 2.10, p=0.029) and was strengthened (OR 1.57 (1.25 to 2.11), p=0.005) by including self-reported health, long-standing illness, diabetes, and cardiovascular disease in the model. Apart from the regional differences, treatment for hypertension increased with age and was more likely among women (OR 1.59 (1.29 to 1.97), p=0.001); former smokers (OR 1.44 (1.05 to 1.99), p=0.026); and people who were married; were overweight (OR 1.40 (1.03 to 1.89), p=0.033) or obese (OR 1.80 (1.32 to 2.42), p<0.001); reported limiting (OR 2.49 (1.93 to 3.20), p<0.001) or non-limiting (OR 3.25 (2.48 to 4.24), p<0.001) long-term illness; or reported diabetes (OR 2.36 (1.60 to 3.47), p<0.001) or cardiovascular disease (OR 1.54 (1.18 to 2.02), p=0.002). Treatment was 39% and 61% less likely in widowed (p=0.004) and co-habiting participants (p<0.001), respectively, and 40% less likely in binge-drinkers (p=0.014).

Conclusion
The proportion of people in London being treated for hypertension is above the national average even after adjustment for sociodemographic and health-related factors. This may be due to greater population mobility in London with more people having new Patient Health checks. Education and financial incentives for improvements in detection, treatment and control of hypertension in primary care in England have been beneficial but remain inadequate.

Background
Social Fragmentation is the idea that isolation and disorganisation within an area influences individual health. Some, but not all, studies have shown it to be related to suicide and parasuicide risk, higher GHO12 scores and higher admission rates for psychoses. The aim of this study is to determine if fragmentation per se affects mental health or if the association is due to other factors relating to fragmented areas.

Methods
A measure of social fragmentation was constructed from four census variables (as per Condgon, 1996) for each of the 890 super-output areas in Northern Ireland (avg pop. 1900). These were divided into quintiles and added to the 2005 Health and Social Wellbeing Survey (HSWB) as a contextual variable. Respondent characteristics known to be associated with mental health were included such as age and sex, marital status, living alone, perceived social support, socio-economic status (based on car availability and housing tenure) and health status (based on limiting long-standing illness (LLTI)). A GHO-12 score of 4 or more was taken as indicative of significant psychological ill health. Logistic regression analysis was restricted to 3506 individuals aged 25–74 years.

Results
As expected, people in the most fragmented quintile were more likely to be unmarried and living in single person households, much more likely to be deprived, and were more likely to have a significant psychological disorder (OR 1.70, 95% CI 1.30 to 2.24), after adjusting for age and sex. Although level of perceived social support was strongly associated with GHO12 score, adjustment for this did not significantly explain the likelihood of poor mental health across fragmentation quintiles (OR 1.44, 95% CI 1.08 to 1.91). However, adjustment for SES and LLTI completely eliminated the association between social fragmentation and psychological ill health.

Conclusion
Social Fragmentation is associated with poor mental health, but only because these areas tend to be more deprived. After adjustments are made for SES, social fragmentation has no association with the likelihood of psychological disorder. It’s who you are not where you live that determines mental health. However, before we completely sound the death knoll for social fragmentation we should take into consideration the recognised imperfections of the construct and modify it. Until then, policies to improve mental health should focus on reducing individual poverty and material disadvantage rather than changing the character of areas.