Tackling social inequalities to reduce mental health problems:

How everyone can flourish equally

A Mental Health Foundation report

Mental Health Foundation

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This report should be read alongside the long reference *'Mental Health Inequalities'* report by the Mental Health Foundation to be published in January 2020.

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Foreword

Social inequalities are all around us: poverty and financial strain, racism, sexism, bullying based on sexual orientation, homelessness, and social exclusion due to disability or age, to name just a handful.

Yet discussion on the causes of mental health problems often focusses on individual factors. Rarely does public discourse acknowledge that the circumstances in which we are born, raised and live profoundly affect our chances of having good mental health.

Tackling social inequalities seeks to shine a light on the social inequalities that put too many people at a disadvantage in achieving mental health and wellbeing. We do not all have an equal opportunity to flourish. Rather, too many children start from a position of disadvantage in the journey towards good mental health, too many adults are hindered by circumstances beyond their control. The evidence gathered in this paper will help us to

understand what types of social inequalities negatively affect mental health and how.

For the Foundation, an inequalities approach is fundamental to how we will achieve our prevention strategy. One could call it 'having a heart for inequalities', or using an 'inequalities lens'. Through this paper, the Foundation affirms that, firstly, we will consider inequalities and their influence on mental health in all of our prevention work. By taking account of inequalities in our prevention programmes, we seek to model a process for adoption by all Government Departments, public agencies and service providers, who should all 'have a heart for inequalities'. Secondly, the Foundation will seek to undertake activities that specifically promote social justice and address social and economic inequalities. In doing so we hope to demonstrate effective, scalable solutions that minimise the effects of disadvantage and foster resilience in people with experience of inequality.

Tackling social inequalities sets out a framework for social justice work to prevent mental health problems. Now, it is up to all of us to heed its messages and carry a 'heart for inequalities' into all we do to prevent people from experiencing mental distress.

Dr Jacqui Dyer MBE
President of the Mental Health Foundation

Introduction

We all have mental health and we all can experience mental health problems, whatever our background or walk of life. But the risks of mental ill-health are not equally distributed.

The likelihood of our developing a mental health problem is influenced by our biological makeup, and by the circumstances in which we are born, grow, live and age. Those who face the greatest disadvantages in life also face the greatest risks to their mental health. This unequal distribution of risk to our mental health is what we call mental health inequalities.

This report describes the extent of inequalities that contribute to poor mental health in the UK today. It explains how certain circumstances interact with our individual risk and discusses communities that are facing vulnerabilities. It makes a clearly evidenced case for why addressing inequalities can help to reduce the prevalence of mental health problems and makes a strong call for cross-sectoral action on mental health. The report concludes with proposed actions to address mental health inequalities.


Flourishing unequally
Child adversity / trauma
Unemployed / economically strained
Economically secure / well-housed / majority culture / well-educated
Minority status
Disabiity / health condition
Poor environment

For centuries, mental ill-health has been overlooked, misunderstood, stigmatised and, for a long time, inappropriately treated. Much of this is now changing, although misunderstanding and stigma are not yet things of the past. As a society, we have some way to go before the extent of mental health problems and their damage to our individual and collective wellbeing is fully recognised and comprehensively responded to. Reducing mental health problems and their effects warrants the most urgent and committed public health effort of our generation. As this paper will show, addressing social, economic, cultural and environmental inequalities will take us a long way towards achieving this goal.

Note on the limits of our knowledge

Every attempt has been made for this report – as well as the longer reference report supporting it – to be based on some of the best available evidence on the issue of mental health inequalities. There is indeed a wealth of evidence in relation to these social, economic, cultural and environmental circumstances and their impact on our mental health.

However, it should be acknowledged that, both historically and to this day, there has been an underrepresentation of women and minority communities in research.[1–4] The reasons for this are structural and complex, but they include, among others, cultural and gender biases, institutional racism, lack of diversity in the funding bodies, and underinvestment at a government

level. For example, prominent disability activist Jenny Morris has argued that research by non-disabled people has tended to focus too much on impairment as a cause of depression, rather than researching the mental health effects of disability-related prejudice and discrimination.[5] This is leading to a smaller evidence base on the experience of mental ill-health of these disadvantaged groups and we should be careful not to associate this smaller body of research and the relative lack of data with the actual very real disproportionate risk certain population groups are exposed to.

Looking at these drivers of inequality in this report individually provides valuable insight into the ways that society can affect our mental health. However, people are multifaceted, and focusing on one aspect of group identity or experience at the expense of another can sometimes mean we miss a more detailed and diverse understanding of how things like life experiences, disability, sexual orientation, gender and gender identity, and racial or ethnic identity interact to affect people's mental health. In general, to fully develop our understanding, more research is needed that takes this intersectional approach.

1. The nature and extent of mental health inequalities

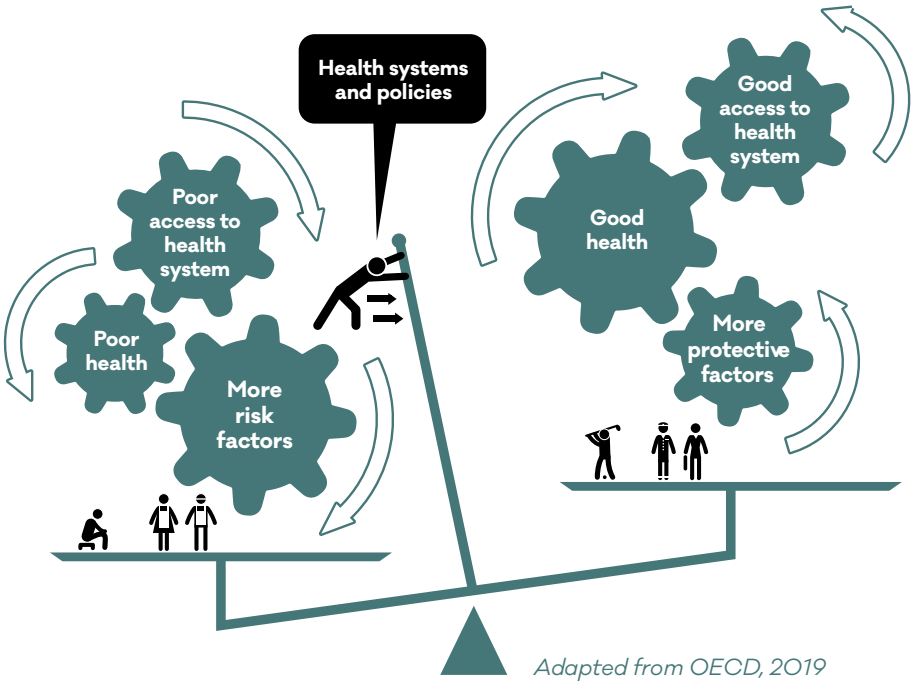
1.1 The social gradient in mental health

In general, people living in financial hardship are at increased risk of mental health problems and lower mental wellbeing.[6] This link between poverty and mental health has been recognised for many years and is well evidenced.[7] The relationship operates in two directions: being poor can bring about mental health problems (most commonly anxiety and depression), but mental health problems can also lead people into poverty due to discrimination in employment and reduced ability to work.

More recent discussion has focused on income inequality (the unequal distribution of income across society) as a cause of poor mental health. People in the lowest socioeconomic groups have worse health than those in the middle groups, who in turn have worse health than those in the highest.[8] This 'social gradient' means that mental health problems are more common further down the social ladder.[9] This is evident even in early childhood, with children as young as three and five

years of age showing a social gradient for socioemotional and behavioural difficulties.[10] Importantly, it has been argued that the greater the income inequality in a society, the worse the social outcomes for that society as a whole.[9] The social gradient is not a purely economic term, as it is compounded by cultural, relational and environmental influences.

Health, risk factors and access to the health system: The odds are stacked in favour of the better-off



Adapted from OECD, 2019

Beyond financial circumstances and economic position, a variety of other social circumstances are known to be

associated with poor mental health. These circumstances can relate to being part of a disadvantaged group (for example BAME (Black, Asian and Minority Ethnic) communities or LGBT+), being female, having a long-term health condition, or having certain experiences. Experiences that can lead to mental health problems include prejudice, discrimination, sexual or physical abuse, emotional abuse and neglect, exposure to a natural disaster, homelessness, and a range of other adverse experiences in childhood or later in life. In whatever way it happens, these factors can increase the risk of having a mental health problem, and often they will interact with one another.

1.2 How do socioeconomic inequalities lead to mental health problems?

It is now widely accepted that inequalities in health, including mental health, arise because of inequalities in society – in the conditions in which people are born, grow, live, work and age.[8,10] For example, there is evidence that socioeconomic disadvantage is a cause of depression.[10] It is thought that this may happen because of people comparing themselves to others in unequal societies, or because of inadequate bonds of trust and less frequent interaction between unequal groups.[11]

Another way of looking at the problem is to think about the cumulative effects of disadvantage. The negative effects of social disadvantage and its associated stress accumulate throughout the lifespan. These factors will affect each individual

differently, depending on how they are buffered by things like social support, financial resources and emotional resilience,[10] but overall it is harder to develop this resilience and have access to the right social support when we are in a position of disadvantage.

To understand this interaction between social factors and our health, we need to take an integrated approach to the causes of mental ill-health. Although gaps in research remain, evidence from neuroscience and genetics is clearly converging with evidence from epidemiology and developmental psychology to highlight the role that social systems play in shaping our developing biological systems. Exposure to stress, trauma and deprivation can lead to physical changes in the parts of our brains that help regulate our emotions, thereby making us more vulnerable to developing mental health problems .[12–16]

This starts from a young age. A growing body of evidence supports a link between exposure to Adverse Childhood Experiences (ACEs) and poor physical and mental health outcomes.[17] Associations between individual ACEs and a range of mental disorders have been established for common and more severe disorders, as well as for mental wellbeing,[17] and ACEs have been found to account for 29.8% of mental disorders.[18] They are thought to create chronic stress, which then leads to problems with child development; these problems, in turn, lead to health-harming behaviours and poor mental health. Like social disadvantage, the impact of ACEs is

cumulative: the greater number of ACEs one experiences, the more likely one is to have a mental health problem.

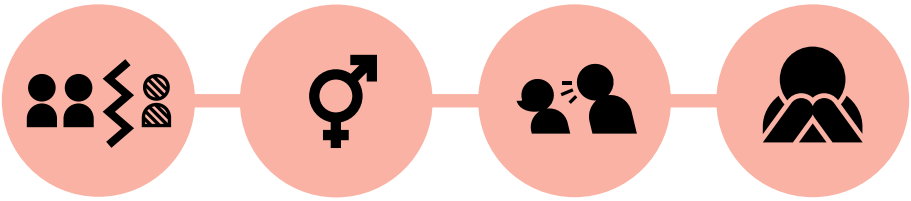
There are overlaps between ACEs and the wider issue of trauma, which has also been linked to mental health problems. Trauma makes it hard for people to feel safe, as they expect danger in similar situations. It triggers a stress response: hypervigilance and fight-flight-freeze. The results of trauma can be sleep disturbances, impulsive behaviour, mood swings, impaired judgement, poor memory, dissociation, intrusive thoughts, lowered immune system functioning, greater risk of cardiovascular disease, greater risk of mental health disorders and greater risk of substance misuse issues.[19]

1.3 Grouping inequalities

In this report, we unwrap those factors that place individuals at heightened risk of developing mental health problems so that we can identify where preventative action should be focused. We describe these factors as mental health inequalities and examine them across four categories of influence, namely:

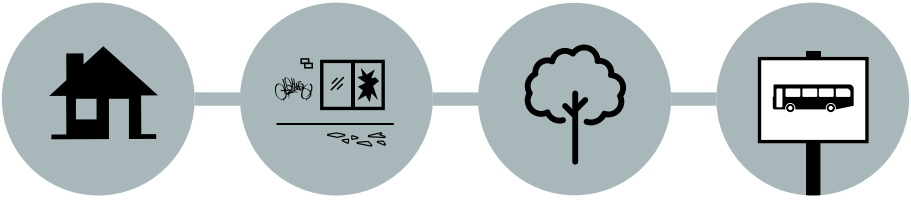
1. Economic influences

2. Other relational influences



3. Health, disability and ageing influences

4. Environmental influences



There are various ways of grouping the factors that influence mental health inequalities. As economic status is experienced most widely, we have separated this category from other relational or social determinants, both in order to enable us to explore economic factors in more depth, and so that we do not lose sight of some of the other important relational factors that can affect mental health directly or worsen the impact of living in poverty or financial insecurity. These other relational influences include being a member of certain social or cultural groups, and experiencing adversity in childhood or adulthood. We have also included health-related and environmental factors affecting mental health.

Some groups, such as those that share characteristics protected by the Equality Act 2010*, are easier to identify than others, particularly if they have a visible characteristic associated with social inequality (e.g. physical disability). However, there are also 'hidden groups' – for example, those who have a family history of mental health problems and suicide, who are homeless, who have a hidden disability, who are in recovery from mental health problems, who are experiencing abuse or being victimised, or who experience multiple disadvantages.

* The characteristics that are protected by the Equality Act 2010 are age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion, belief and sex.

2. Mapping the problem: inequalities that influence mental health

2.1 Economic influences

Those living in poverty or with financial insecurity need to be a priority group for preventative action. Not only can the stress and social problems attached to poverty and debt lead to mental health problems, but they can also worsen existing mental health problems and inhibit recovery. Poverty and debt are often closely tied to education, which is critical to people accessing good employment opportunities and achieving wider life goals. Education inequity can start at a very early age, with some young children being poorly prepared for the communication, social and emotional challenges of school and pre-school education. This can lead to a cumulative disadvantage in learning that has a lasting impact into adulthood.

2.1.1 Living in poverty/debt/income inequality

The Health Survey for England has consistently found that people in the lowest socioeconomic class have the highest risk of a mental health problem .[20] Debt itself is an issue: people in debt are more likely to have a common mental health problem,[21] and the more debt people have, the greater the likelihood.[22] There is some evidence that problem debt (particularly housing debt) has a negative impact on mental wellbeing similar to that shown for marital breakdown and job loss.[23] However, a causal link is not yet proven,[24] and the relationship can probably work both ways: personal debt may lead to some mental health problems, while mental health problems may also lead to being in debt.

'People in the lowest socioeconomic class have the highest risk of a mental health problem'

The risk to mental health of economic hardship starts early in life. In general, socioeconomically disadvantaged children and adolescents are two to three times more likely to develop mental health problems .[25] This appears to be supported by evidence from England, where a 2017 national survey found that children and young people living in households with the lowest levels of equivalised household income were about twice as likely as those living in households with the highest income to have a mental health problem.[26] However, it may

'Socioeconomically disadvantaged children and adolescents are two to three times more likely to develop mental health problems'

be the environmental factors related to income, and not the income itself, that have the biggest influence (such as parental education, neighbourhood violence and family benefit status).

At country level, higher national levels of income inequality are linked to a higher prevalence of mental health problems. As countries become richer, but the distribution of this wealth remains unequal, the rates of mental ill-health increase.[27]

Importantly, developing better emotional and cognitive skills only partially offsets the effects of material disadvantage. People from poorer economic circumstances are still more likely to have worse mental health, even if they have been supported to develop good emotional and cognitive skills. Similarly, high educational ability in early life is generally not able to protect against the effects of childhood economic disadvantage.[27]

2.1.2 Employment and unemployment

Employment is one of the most strongly evidenced influences on mental health.[28] It can be an important factor in individual fulfilment, bringing autonomy, pride and confidence. For adults in the workforce,

employment is usually the main source of income, a determinant of social status and an important source of vital social networks.[29] In later life, previous working life often determines our ability to support ourselves financially and socially in retirement.

Conversely, lack of access to either employment, or employment of good quality, can decrease quality of life, social status, self-esteem and achievement of life goals.[30] Unemployment has been found to cause mixed symptoms of distress (including depression and anxiety), and it has been estimated that 34% of unemployed people have mental distress, compared to 16% of those in employment.[31] Job loss has a traumatic and immediate negative impact on mental health and there is further damage when unemployment continues into the long term.[32]

Once someone has a mental health problem, they can face substantial barriers to re-entering the job market. Employer attitudes towards employing people with a mental health problem worsened between 2009 and 2018; a 2018 survey found that 56% of employers were reluctant to employ someone with a mental health problem due to fear of them being stigmatised by their co-workers.[33] Half of employers who completed the survey viewed employing individuals with mental health problems as a 'significant risk' to their business. These beliefs are not just discriminatory, but also incorrect. People living with mental health problems contributed an estimated £226 billion value-added to UK gross domestic product (GDP) in 2015 (12.1% of economic output), which is as much as nine times the estimated cost of

economic output arising from mental health problems at work.[34]

While having employment is important to mental health, the quality of employment also matters. Poor-quality work is associated with lower mental wellbeing. This may be due to insufficient household income, having irregular/unsocial working hours, a lack of representation, a lack of participation, and – particularly for women – being in part-time or involuntary employment.[35] Less job security and control also negatively affect mental health. By contrast, good work is characterised by: a living wage, control over your work, opportunities for in-work development, flexibility in the workplace, protection from adverse working conditions, provision of ill-health prevention and stress management strategies, and appropriate support for illness or disability that facilitates a successful return to work.[8] The Organisation for Economic Co-operation and Development (OECD) has expressed concern that the increase in job insecurity, as well as the pressure in contemporary workplaces, could drive higher levels of mental health problems. The share of workers exposed to work-related stress, or job strain, has increased in the past decade across the European nations studied by the OECD.[36]

2.1.3 Education level

Having lower educational achievement has been associated with mental health problems in adulthood. Women with low levels of literacy are at five times more risk of depression than those

with average or good literacy skills.[37] Similarly, dropping out of education has been associated with substance misuse, mood disorders and suicidal ideation.[38]

'Dropping out of education has been associated with substance misuse, mood disorders and suicidal ideation'

In the educational context, the World Health Organization (WHO) has identified several risk factors for mental health,[39] including:

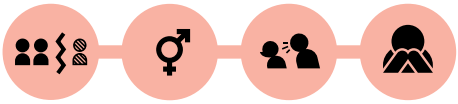
- Failure to provide an appropriate environment to support attendance and learning.
- Inadequate or inappropriate provision of education to assist those that require additional support.
- Academic failure.

A key point of vulnerability is the issue of transitions: traditional higher education students will have experienced at least five transitions in their initial learning career, and some students may find these transitions difficult to cope with.

There is strong evidence that students who have experienced school-age perpetration, victimisation, and/or witnessing of bullying behaviour will have an increased risk of experiencing

a mental health problem.[40–43] In fact, the evidence supports a causal association between exposure to bullying and victimisation in children and adolescents and adverse health outcomes including anxiety, depression, poor mental health, poor general health, non-suicidal self-injury, suicidal ideation and suicide attempts.[43]

2.2 Other relational influences



Being socially connected is closely linked to good mental health outcomes; access to positive relationships from an early age is critical to our development, as well as our health and happiness across life. Conversely, many of the main risks to mental health also involve social relationships – for example, exposure to discrimination and social exclusion based on race, gender, sexual orientation, and other protected characteristics; and experiences of adverse events in childhood and adulthood, including trauma, sexual abuse or maltreatment, violence, domestic abuse, parental separation, bereavement and isolation, among others.

2.2.1 Cultural/social group status

Being identified with a particular cultural or social group can bring with it a higher risk of mental health problems when it leads to adverse experiences. It is well known that immigrant

status, being female, or being a member of a BAME community, a religious minority, or the LGBT+ community can all increase the risk of having a mental health problem, as is shown in this section. Sometimes this risk is linked to experiences of prejudice and discrimination, but it can also arise from greater vulnerability to experiences such as bullying, hate crime, domestic violence or abuse, or other types of trauma.

Immigrants, refugees and asylum seekers

There is consistent evidence of a higher incidence of psychosis among immigrants, particularly among ethnic minority populations.[44] The risk is particularly increased in immigrant groups who migrate from a country where the population is predominantly black to a country where the population is predominantly white.[44] Refugees and asylum seekers are more likely to experience mental health problems than the general population, including higher rates of depression, post-traumatic stress disorder (PTSD) and other anxiety disorders.[45,46] The increased vulnerability to mental health problems that refugees and asylum seekers face is linked to pre-migration experiences (such as war trauma) and post-migration conditions (such as separation from family, difficulties with asylum procedures and poor housing).[47,48]

BAME communities

Being a victim of racism has been associated with mental health problems .[49] The emotional and psychological effects of racism

'Being a victim of racism has been associated with mental health problems'

have been described as consistent with traumatic stress[50] and the negative effects are cumulative.[51] Racism and a lack of cultural awareness may also contribute to the discrimination experienced by people from BAME communities in mental health services,[52] with evidence showing a persistent greater use of compulsory detention and coercion involving the police and criminal justice system among BAME communities (particularly people from Black African and Caribbean communities).[53,54] Black men have the highest rates of drug use and drug dependency in the UK,[55] and suicide rates are higher among young men of Black African and Black Caribbean origin, and among middle-aged Black African, Black Caribbean and South Asian women, than among their White British counterparts.[56]

Sexual orientation and gender identity

Experiences of bullying and violence place LGBT+ people at substantial risk of poor mental health outcomes , especially

'Experiences of bullying and violence place LGBT+ people at substantial risk of poor mental health outcomes'

through their link to suicide attempts, substance use and difficulties attending school.[57] One review found that sexual minority individuals were almost four times more likely to experience sexual abuse, and also more likely (though to a lesser extent) to experience parental physical abuse, to experience assault at school, and to miss school because of fear.[58] For transgender people, the available studies generally suggest high rates of negative mental health outcomes.[59]

'In England in 2014, young women were three times more likely than men to experience common mental health problems'

Gender also influences an individual's mental health risk. In England in 2014, young women were three times more likely than men to experience common mental health problems , with over 25% reporting symptoms of common mental health problems in the week prior to the survey. Rates of self-harm amongst young women tripled between 1993 and 2014, and young women are three times more likely to experience PTSD or eating disorders.[55] As a result, young women have emerged as a high-risk group in England.[55] There are also gender differences in the ways that mental distress manifests itself. Just over three out of four suicides (76%) are from males,[60] and men are also nearly three times more likely than women

to become alcohol-dependent (8.7% of men are alcohol-dependent compared to 3.3% of women).[61]

Stigma and mental health

Experiencing prejudice and discrimination can also compound and hinder recovery from a mental health problem. Stigma is an all-too-common experience for those with mental health problems. Stigma can include problems of knowledge (ignorance), attitude (prejudice) and behaviour (discrimination).[62] Research has found that as many as nine out of ten people with mental health problems have experienced stigma or discrimination at one time of their life (either at work, in education, from professionals or at home).[63] Experiencing stigma and discrimination can have a highly detrimental impact on those with mental health problems, creating further and significant barriers to accessing a good quality of life and achieving wellbeing. Mental health service users have said that stigma and discrimination negatively affected them in relation to: employment; building new and retaining existing friendships; being able to join groups and take part in activities within the community; feeling confident to go out and about; being able to openly disclose mental health issues; and being able to speak up to professionals.[64] In a recent survey, it was found that 45% of respondents who had a mental health problem in the past five years had chosen not to disclose to an employer during that time. The biggest reported barriers were fear of being discriminated against or harassed by colleagues (44%), feeling

ashamed to do so (40%) and the feeling that it is none of the employer's business (45%).[34]

2.2.2 Adverse childhood experiences (ACEs)

Adversity in childhood is directly responsible for 29.8% of adult mental health problems, with evidence showing that the more severe and prolonged the exposure to adversity, the greater the risk of developing a mental health problem.[18] ACEs have been defined as "stressful experiences occurring during childhood that directly hurt a child (e.g. maltreatment) or affect them through the environment in which they live (e.g. growing up in a house with domestic violence)".[65] Typical ACEs include experiencing physical, sexual or verbal abuse, violence, parental separation, and being in a household with mental illness, alcohol or substance misuse, or where a household member has been imprisoned.

'Adversity in childhood is directly responsible for 29.8% of adult mental health problems'

A study on ACEs involving more than 17,000 adults in the USA indicated that the majority of adults have experienced more than one ACE during their childhood. There is a strong relationship generally evident between the number of

ACEs and risk of mental health problems among men and women.[66] The evidence shows that, the more one has been exposed to childhood adversity, the greater the likelihood of having negative outcomes such as depression and substance misuse.[67–69] A review of research found that people with at least four ACEs are four times more likely to have mental health problems. The authors of this study emphasise that the impact of ACEs is cumulative, with greater risk of poor health outcomes arising from a greater number of ACEs.[70] Early life trauma affects factors such as emotional regulation and fear responses, and increases the odds of taking up health-harming behaviours.[71] Such findings suggest that experiencing multiple forms of abuse or household dysfunction during childhood may have particularly deleterious consequences for adult mental health.[67] In particular, sexual abuse in childhood increases the risk of most mental health problems, including PTSD, suicide, depression, anxiety, low self-esteem, obsessive-compulsive disorder, phobias, substance abuse, eating disorders and personality disorders.[72]

ACEs and health-harming behaviours are also associated with deprivation: in England, people in the most deprived socioeconomic quintile were almost three times more likely to have experienced four or more ACEs compared to those in the most affluent quintile.[71]

Looked-after children have poorer mental health than other children.[73] This difference is evident from an early age, with

one study finding that 18.9% of looked-after children under the age of 5 have emotional or behavioural problems. For looked-after children of all ages in the UK, estimates are that 45% have a diagnosable mental health problem, with up to 70–80% showing signs of distress.[74,75]

Research has shown that poor or insecure family attachment is associated with depression, anxiety, PTSD, suicidal thoughts or behaviours, and eating disorders.[76] Parental mental health problems, in particular, have the potential to negatively affect children, if not managed well.[77] Research shows that the mental health problems of a parent are an important predictor of their children's mental health and wellbeing at other stages of childhood, though contextual factors (i.e. other types of socioeconomic disadvantage) may be stronger influences than the parent's mental health problem.[77]

Parental substance misuse can also reduce their ability to provide practical and emotional care to their children, which can have serious consequences for the child, including mental health problems, conduct and behavioural problems, early sexual relationships, relationship difficulties in later life, academic underachievement, and increased risk of experiencing drug or alcohol misuse themselves.[78] It can also lead young people to become carers for their parents. In the UK, more than 250,000 dependent children are living with a parent who has used a Class A illicit drug in the past year, and 3.4 million are living with at least one binge-drinking parent.[78]

2.2.3 Adverse experiences in adulthood

Experiencing two or more adverse life events in adulthood – such as serious illness, job loss or bereavement – is also associated with mental health problems .[79] Adverse experiences at this stage of life can be more difficult to cope with if someone has also experienced adversity in childhood.[80]

Experience of trauma is common: it has been estimated that more than 70% of the general population has been exposed, either directly or indirectly, to a traumatic event, where a traumatic event is defined as threatened death, serious injury or sexual violence.[19] Trauma disproportionately affects marginalised populations and is inseparably bound up with systems of power and oppression.

There is an important gender dimension to trauma: women are more likely than men to develop PTSD after a traumatic experience.[81] Self-harm, eating disorders and emotionally unstable personality disorder – which are more common among

'Experiencing two or more adverse life events in adulthood – such as serious illness, job loss or bereavement – is also associated with mental health problems'

women than men – have all been associated with experiences of violence and abuse.[19]

Being a victim of hate crime or other types of social trauma are also risk factors for mental health problems. The Crime Survey for England and Wales showed that victims of hate crime were more likely to be affected emotionally and psychologically than those experiencing other types of crime.[82]

More widely, there are well-established statistics demonstrating more frequent trauma-related mental health issues in societies that have faced conflict. Studies looking at the consequences of mass organised violence and genocide demonstrate the impact of war on the trauma of societies or nations; the intergenerational transmission of trauma; and the gaps in mental health support.[83,84]

Loneliness

Loneliness in adulthood can lower people's mental wellbeing. Social isolation is an important risk factor for both deteriorating mental health and suicide.[85] Living alone is a predictor of suicidal thoughts, with people under 60 who lived alone being found to be more likely to have suicidal thoughts than those of the same age who were living with others.[86] A survey by

'Social isolation is an important risk factor for both deteriorating mental health and suicide'

the Mental Health Foundation found that 48% of participants believe that people are getting lonelier in general. Only 22% of participants never felt lonely and around one in ten participants felt lonely often (11%). Worryingly, well over a third of participants (42%) had felt depressed because they felt alone.[85] Another study found that for older people, 30% of those aged 65 and over say they feel lonely, with 9% reporting this as severe loneliness,[87] representing the highest levels of loneliness among the population. Other researchers have reported that older adults who are widowed or divorced are more likely to present with increased symptoms of depression and poorer physical functioning, as well as to face a greater mortality risk than their married counterparts.[88]

2.3 Health, disability and ageing

The connection between physical and mental health is reciprocal: those who have a physical health problem are at increased risk of developing mental health problems, while mental health problems increase the risk of physical health problems. Reducing the mental health risk for people with health conditions and disabilities can be complex, often requiring improvements across a mix of health behaviours, alongside improvements in social and environmental circumstances.

People with long-term health conditions are two to three times more likely to experience mental health problems , with anxiety

problems or mood disorders being particularly common.[89] Despite this, non-psychiatric health professionals' detection of depression in patients with physical illness is low,[90] as is wider discussion and treatment of emotional problems in the context of physical illness.[91] Co-morbid mental health problems have a number of serious implications for people with long-term conditions, including poorer clinical outcomes and lower quality of life.[92] Perhaps most worryingly, people with co-morbid mental health problems are more likely to die, and die sooner, from physical health conditions such as cardiovascular disease, diabetes, chronic obstructive pulmonary disease or asthma.[89]

Those experiencing severe and enduring mental health problems die, on average, 15–20 years earlier than the general population,[93] while those with depression die 7–10 years earlier.[94] These striking inequalities show the huge loss to society of a failure to integrate mental and physical healthcare and to provide effective and timely responses to symptoms of mental ill-health.

The evidence from numerous studies is that there is a strong association between substance misuse (including alcohol misuse) and both mood and anxiety disorders.[95] Alcohol dependence is roughly three times more likely amongst those experiencing depression,[96] and excessive drinking increases the chance of developing depression.[97] Using some illicit drugs may also increase the risk of developing a mental health problem. For example, regular cannabis use in adolescence increases

the risk of developing psychosis,[98] and illicit drug use has been associated with increased risk of depression.[99]

While not inevitable, having a physical disability can increase the risk of experiencing mental health problems and low wellbeing. There is consistent evidence of an association between physical disability and depression,[100] though experiences of stigma and discrimination may significantly contribute to this relationship.[5] Nevertheless, recent research points to how inner resilience (in terms of the individual being able to adapt to change or stress) can protect people with physical disabilities from having mental health problems.[100]

Individuals with sensory impairments have also been found to be at a much higher risk of having mental health problems across their lifetime. Estimates suggest a 40% prevalence rate of mental health problems in deaf children, compared to a 25% prevalence rate in children without hearing loss.[101] For older adults who are visually impaired, the prevalence of major depressive disorder (5.4%) and anxiety disorders (7.5%) is significantly higher compared to their fully sighted peers.[102] Again, it is reasonable to conclude that many of the mental health problems among people with sensory impairment arise from the social isolation they experience due to inaccessible environments.

Similarly, people with learning disabilities have an increased risk of developing a mental health problem (between 25–40% of those with learning disabilities are found to experience mental

health problems)[103] due to social, economic, psychological and emotional factors, as well as some biomedical factors. The prevalence of diagnosed mental health conditions is estimated to be 36% among children with learning disabilities compared to 8% among children without. Increased prevalence is particularly marked for Autism Spectrum Disorder, Attention Deficit Disorder and conduct disorders.[104]

2.4 Ecological influences

There is now strong evidence that the environments in which people live, grow and work affect their mental health . Ecological risk factors for mental health problems include lack of adequate housing and transport options, neighbourhood deprivation, an adverse built environment, living in an urban environment, and an adverse natural environment. Conversely, a good environment can bring positive benefits to mental health. For example, evidence points to the positive effects of green spaces on mental health and stress,[105] while transitioning from homelessness to housing, or experiencing housing improvements, has been shown to improve mental health.

The Mental Health Foundation has previously highlighted the importance of a safe, secure and suitable home for mental wellbeing.[79] Being homeless or at risk of homelessness is strongly associated with mental health problems.[79] A 2014 study found that 80% of homeless people in England reported that they had mental health problems, with 45% having been diagnosed with a

'The environments in which people live, grow and work affect their mental health'

mental health problem.[106] But the quality of the home environment is also important. Poor-quality housing, and housing that is unsafe and insecure, is a risk factor for mental health problems and may exacerbate existing mental health problems.[107,108]

Social fragmentation and conflict in communities, as well as high levels of neighbourhood problems, influence health outcomes independently of socioeconomic status.[27,109] For example, young people in the UK who experience fewer positive and greater negative social relations have been found to have lower wellbeing.[110] Emerging evidence also suggests that social cohesion may reduce the negative effects of neighbourhood deprivation on mental health.[111]

A person's neighbourhood environment can also reinforce isolation and exclusion. For example, for people with learning disabilities, segregated schools and activities, living a separate existence to the general community, and lack of community connections make them vulnerable to hate crime and discrimination, leading, in turn, to an increased risk of mental health problems.

Living in an urban environment is a known risk factor for depression and anxiety.[112,113] Urbanisation and urban living are linked to mental health stressors such as concentration of socioeconomic

deprivation, low social support, social segregation, and physical environment stressors such as air, water and noise pollution, as well as exposure to physical threats (accidents and violence).[113] Furthermore, a lack of public space can prevent community cohesion from developing, which is needed to increase social connectedness and reduce loneliness.[114]

There is some evidence, also from the UK, that the built environment can have an impact on self-reported mental wellbeing. In a study of 2,696 adults in four areas of Greenwich, London, the most important factors negatively affecting wellbeing were neighbour noise, a sense of overcrowding in the home, lack of 'escape' resources such as green spaces and community facilities, and fear of crime, all of which led to lower reported mental wellbeing.[115]

As reported in the Mental Health Foundation's report Poverty and Mental Health, the impact of the built environment is evident across the life course, with school-age children's attitudes and behaviours affected by the quality of the built environment and local neighbourhoods, and the poor physical condition of neighbourhoods adversely affecting schools. The lack of outdoor play space has been found to be a causative factor in increased mental health problems among children and young people.[7]

In the context of the global climate crisis, it is important to note that the natural environment can be both a positive and a negative influence on mental health, depending on the type of environment.

Individual distress in the wake of a natural disaster is a typical response and is usually temporary; however, for some, it may lead to a mental health problem.[116] The North Atlantic Treaty Organization (NATO) has developed a model that shows it can take up to three years for a community to adjust to its new environment following a natural disaster.[117]

On the positive side, spending time in natural environments reduces levels of stress and/or improves attention fatigue and mood more than the built environment.[118] A recent systematic review has found strong evidence for a positive association between the quantity of green space and perceived mental health.[119] Evidence also supports an association between availability of blue space and good mental health.[118] Thus it may be that, by making green and blue space more available for people in deprived areas, their levels of anxiety and distress would decrease, though this requires further research.

3. Tackling socioeconomic inequalities to reduce mental health problems

Given the strong evidence for a range of social, economic, cultural and environmental drivers of poor mental health, reducing the prevalence of mental health problems requires action that directly addresses these factors.

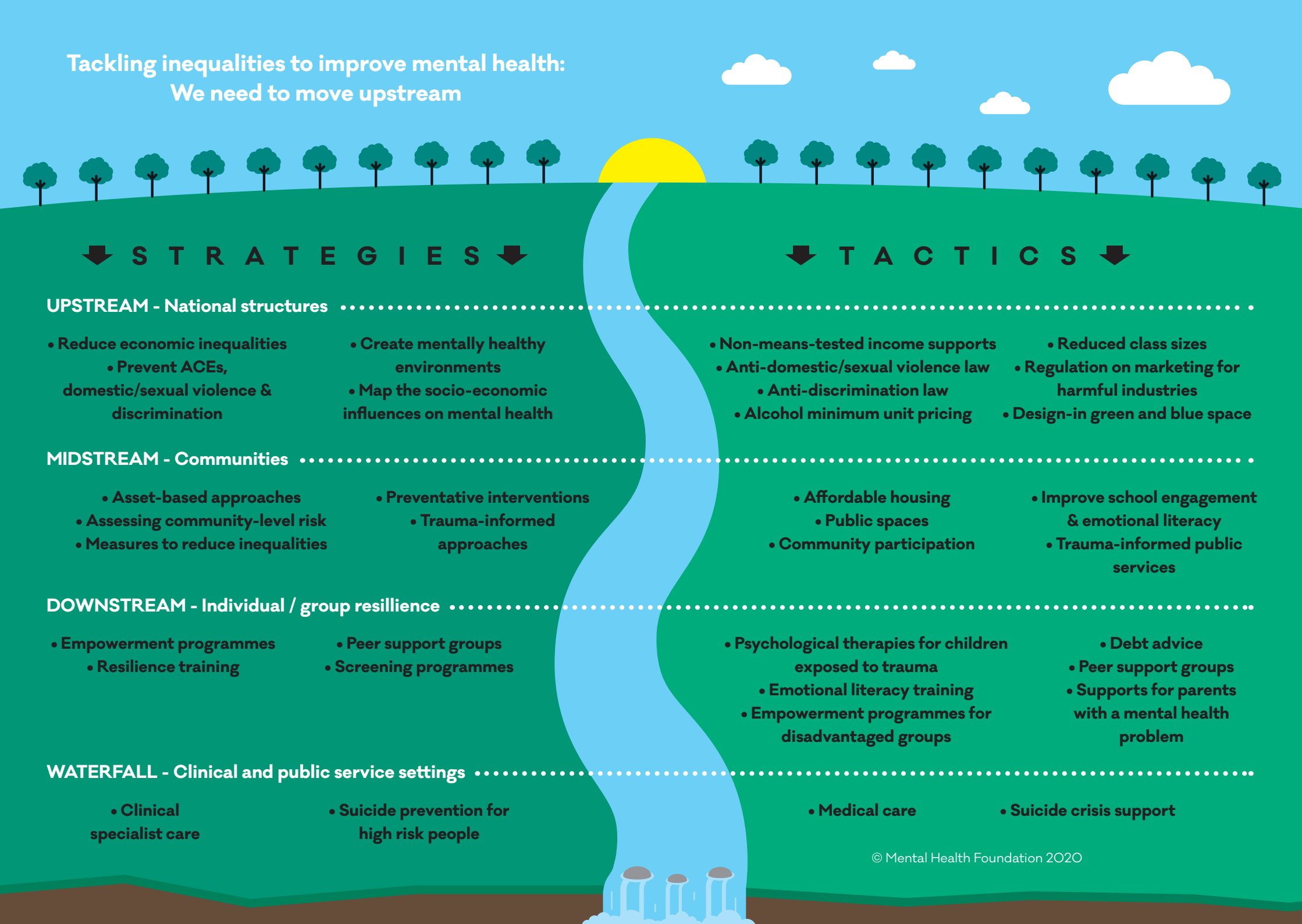
In general, action should be undertaken at three levels: structural measures, strengthening community assets, and increasing individual and group resilience. Structural measures consist of actions to change the social and economic influences that can lead to mental health problems. Such measures might include seeking to reduce income inequality, poverty, unemployment, domestic violence, discrimination and homelessness, for example. Measures to strengthen community assets include activities to increase social connectedness, improve community environments, foster participation in community decision-making, and

increase awareness of both risk factors and community resources to support mental health and wellbeing. Measures at the individual level can involve education about how to look after one's own mental health, peer support, and showing people how they can contribute to the mental health of their communities and families. In order to maximise impact and address the interrelationship between these factors, concurrent action should be taken across each of these three levels.

3.1 Why all sectors of society must be involved in preventing mental health problems

International and UK experts agree that action to reduce the prevalence and impact of mental health problems must occur in sectors beyond mental health. For example, the UN Special Rapporteur on Health has said that mental health must be reflected in policies concerning general health, education, poverty reduction, violence prevention, etc.[120] The need for cross-sectoral action on mental health has been recognised at European level and was part of the EU Joint Action on Mental Health and Well-being.[121] The WHO has said that action to address social inequalities and "improve the conditions of daily life" throughout the life course can help to improve the mental health of the population and reduce the risk of mental health problems,[10] and this view has been supported by Michael Marmot.[122]

Tackling inequalities to improve mental health: We need to move upstream



STRATEGIES

TACTICS

UPSTREAM - National structures

- Reduce economic inequalities
- Prevent ACEs, domestic/sexual violence & discrimination
- Create mentally healthy environments
- Map the socio-economic influences on mental health
- Non-means-tested income supports
- Anti-domestic/sexual violence law
- Anti-discrimination law
- Alcohol minimum unit pricing
- Reduced class sizes
- Regulation on marketing for harmful industries
- Design-in green and blue space

MIDSTREAM - Communities

- Asset-based approaches
- Assessing community-level risk
- Measures to reduce inequalities
- Preventative interventions
- Trauma-informed approaches
- Affordable housing
- Public spaces
- Community participation
- Improve school engagement & emotional literacy
- Trauma-informed public services

DOWNSTREAM - Individual / group resillience

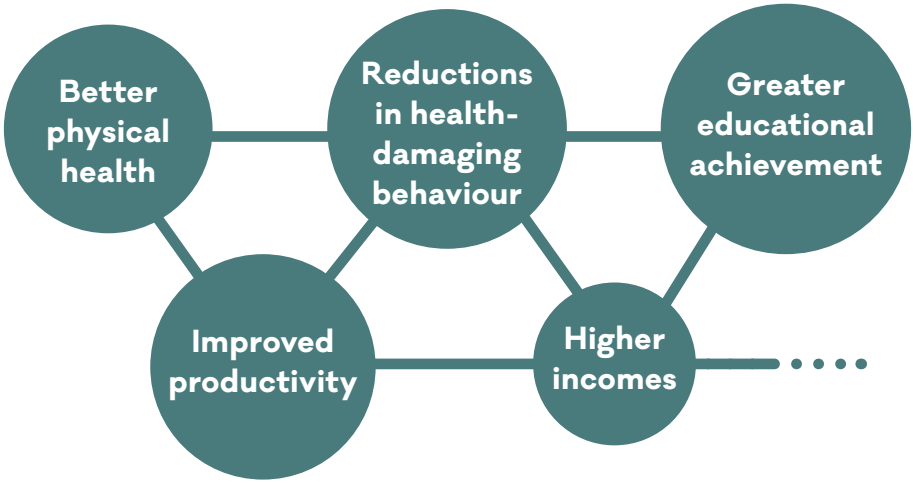
- Empowerment programmes
- Resilience training
- Peer support groups
- Screening programmes
- Psychological therapies for children exposed to trauma
- Emotional literacy training
- Empowerment programmes for disadvantaged groups
- Debt advice
- Peer support groups
- Supports for parents with a mental health problem

WATERFALL - Clinical and public service settings

- Clinical specialist care
- Suicide prevention for high risk people
- Medical care
- Suicide crisis support

Another reason for addressing socioeconomic inequalities across all sectors concerns where benefits can accrue. The costs of mental ill-health extend well beyond the health sector, and reducing mental health problems can help achieve strategic policy goals in other government departments and agencies. It is likely to result in lower costs in the criminal justice system and in workplaces, as fewer people with mental health problems will go to prison and productivity will increase. It is likely to improve educational outcomes, thus making the education system more effective and improving employability. Reducing sickness and long-term disability from mental health problems would also accrue savings in social welfare benefits.

Overall, the Department of Health and Social Care has reported that achieving good mental health and wellbeing in the population would result in the following benefits:



It is clear, then, that prevention cannot happen within the health sector alone – action must be taken in the spaces where people are born, raised and live (in the home, community, schools and workplaces).[122] Measures to address social determinants at the structural level require action by government departments other than health (e.g. housing, education, justice, transport and welfare).[122]

Also, action needs to take place in contexts where people at high risk can be reached. Many people at higher risk of developing a mental health problem will not come into contact with health services, so preventative actions need to be undertaken in places where people are situated, such as in emergency accommodation and housing for homeless families, women's refuges, and transitional accommodation or services for asylum seekers and refugees.

3.2 Addressing the socioeconomic drivers of poor mental health

3.2.1 Act with proportionate universalism

There is often a tendency to focus mostly either on universal campaigns and messages or on targeted interventions for specific at-risk groups. However, since anyone can be at risk of developing a mental health problem and everyone benefits from good mental health and wellbeing, we support 'universally proportionate' approaches to interventions and measures, as recommended in the Marmot Review.[8] Such approaches balance universal and targeted approaches, allocating resources according to levels of need and risk for particular social groups in order to obtain the greatest gains for the resources available. In simple terms, this is an approach to addressing inequalities that means ensuring support for everyone, because we all have mental health, but focusing targeted support to address the greater risks that some groups face.

3.2.2 Adopt a whole-community approach

A whole-community approach takes account of all the factors that influence mental health at an individual, family, community and structural level, and allows for mental health to be considered across a wide range of local policies, services, systems and datasets that affect the mental health and wellbeing of communities. This approach takes account of the role that people play in influencing their own mental

health, while also considering their significant relationships – such as with their families, neighbours and colleagues – as well as their environment.

Four strategies underpin the whole-community approach:

1. Task relocation – expanding mental health ownership into other aspects of the public sector and beyond (for example, schools and workplaces), and taking action in these spaces to foster good mental health.

2. Making every contact count – embedding mental health at the centre of all health and social care as a mediating factor driving outcomes.

3. Mental health in all policies[121]– incorporating mental health into wider policies and ensuring that their impact on mental health is routinely assessed.

4. Understanding data – using data that produces an understanding of those factors/outcomes that are in the cause and effect chain in relation to mental health (for example, crime levels, domestic violence, bullying and absenteeism).

When the whole-community approach is implemented in a specific geographical and social context, it is referred to as a 'place-based' approach. This approach has been endorsed by the WHO (2010).[124] A valuable first step in this approach

is to map the social and economic determinants of mental health in an area as a basis for prioritising action and planning and resourcing interventions, as has been done by the Mental Health Foundation in the boroughs of London.[125] This was followed by extensive community consultations that innovatively defined how citizens view the application of this place-based approach.[126]

3.2.3 Mobilise community assets

The Five Year Forward View for Mental Health acknowledges that, if it is to meet growing demand for health improvement, people who use services, and the community and voluntary sector, must be partners in health.[127] It will not be enough to expect public policy alone to achieve the level of change required. To make a real difference and reduce the number of people in distress in the future, we need to build strong, resilient, sustainable communities. In short, we need to empower people to use their strengths and resources to build thriving communities.[128]

Asset-based approaches to community development are gathering momentum as a result. This approach builds on the positive capacity of individuals and communities, rather than focusing on their needs and problems.[129] In this context, assets are strengths that are identified as valuable to a community and can be used to positively transform that community. Assets can be physical resources (land, money, buildings), but, more

often in public health, assets tend to be psychosocial, such as self-esteem, confidence, a sense of coherence, knowledge, skills, social networks and collective efficacy.[130] There is some evidence that asset-based approaches at the community level can improve mental health outcomes such as self-esteem and social isolation.[129]

3.2.4 Work together in equal partnership

The concept of co-production has been applied increasingly in practice across the UK. Co-production means people who use services and providers of services working together in equal partnership. Co-production can be used to innovate, plan, develop, implement and evaluate new approaches to health improvement. One example is the Expert Citizens movement in Stoke-on-Trent[131]– a citizen-led group of people who experience multiple needs (combinations of mental ill-health, homelessness, addiction and offending behaviour) that advises on the development of services for people with multiple needs. Another example is Black Thrive in London.[132]

Action to involve communities must recognise that power is not only differently distributed between service providers and community members, but also amongst community members. This power distribution is not always explicit and can be hidden or subtle.[133] If all members of the community are to be able to participate equally in decision-making processes, then consideration needs to be given to acknowledging different

expectations, roles, access to information and responsibilities, as well as how these dynamics will impact on the process.[134] If successful, community members will view themselves as architects of change rather than its recipients.[126]

3.2.5 Prioritise poverty and income inequality

Given the extensive evidence on poverty and income inequality as risk factors, prevention measures need to be particularly focused on addressing these two related issues. Action to reduce poverty and disadvantage, among other actions, may help to reduce the prevalence of depression.[135] As discussed previously, debt and financial difficulties can lead to mental health problems, with evidence showing that the more debt people have, the more likely they are to have mental health problems overall.[22] Conversely, debt relief can reduce distress and improve mental health.[22] The Mental Health Foundation's report Poverty and Mental Health provides comprehensive recommendations on how to reduce the negative impact of poverty on mental health.[7]

3.2.6 Provide adequate housing and access to green/blue space

Addressing housing need may also improve individuals' mental health. Clearly, ensuring that people can access and retain safe, good-quality accommodation should be considered a positive mental health measure, given that improving housing conditions can improve mental health.[135] This should include ensuring adequate supported housing

for people with mental health problems who need this specialist resource.

Beyond housing, ensuring that people have access to green and blue spaces may also help protect against mental health problems.[118] The Mental Health Foundation has previously advised that ensuring people are living in a safe and secure setting – free from conflict and limiting the effects of disasters, such as flooding, bombings and economic disasters – can have a direct impact on mental wellbeing.[79]

3.2.7 Protect people from discrimination, abuse and other adversity

As discrimination on the basis of identity (e.g. ethnicity, disability, gender, or sexual orientation) has been shown to be a risk factor for mental health problems, action to protect individuals from prejudice and discrimination is likely to promote better mental health for individuals in these identity groups. There are good reasons for thinking that anti-racism measures would have a positive effect on the mental health of those from BAME communities.[136] At the very least, action should be taken to enforce the legal protections currently in place, while political leaders should ensure that their statements about ethnic minority groups are accurate.[137] Action should also be taken to prevent bullying, both directly and online, that is motivated by negative stereotypes around gender, sexual orientation, body image, disability or ethnicity.

Similarly, a greater focus on the prevention of gender-based violence, domestic violence and sexual abuse may prevent mental health problems from arising by preventing traumatic experiences that can result in mental or emotional distress.[138] For disadvantaged groups, another effective means of preventing mental health problems is to support their empowerment and participation in society.

Preventing adverse childhood experiences (ACEs) would be a particularly fruitful route to improving mental health in adulthood and later life. As discussed in Section 2.2.2, ACEs are known to be a factor in mental health problems. Since most ACEs are a direct or indirect result of socioeconomic circumstances, action both within and beyond the health sector is required to prevent ACEs. There is a range of evidence-based interventions that can help to prevent ACEs, including: parent training programmes; home-visiting programmes; school-based programmes to reduce violence, aggression, bullying and sexual abuse; adult and parental support; provision of psychological therapies for children exposed to trauma; safeguarding of children; prevention of alcohol abuse; and addressing domestic violence.[138]

3.2.8 Reduce substance and alcohol misuse

While mental health problems can sometimes lead to people engaging in alcohol or substance misuse, there is good reason to think that preventing alcohol and substance misuse could

reduce the prevalence of mental health problems. Alcohol misuse can be prevented through policy action (restrictions on price, availability, marketing, licensing) and more individual-focused actions (screening and brief interventions, including school-based interventions).[138]

3.2.9 Improve the educational attainment of teenagers

Given the links between educational attainment and mental health, another recommended preventative approach is to reduce dropping out of schooling.[139] While early school leaving has reduced in the UK since 2011, it was still at 10.6% in 2017.[140] Reviews of the research have identified a wide range of intervention strategies for preventing students dropping out of school, most of which are designed to target common risk factors associated with failure to complete school and to design more relevant schools for students.[141] One common approach is to reduce class sizes or otherwise create lower teacher–student ratios. There is limited evidence that any particular programme is better than others. The most important factor for success is choosing a programme that can be implemented well within the school.[141]

3.3 Interventions on an individual level

This report has identified a number of sub-populations where, by reason of their unequal position in society, the individuals within them are at high risk of developing a mental health problem. There is strong evidence for many interventions that operate at the individual level in terms of reducing the effects of socioeconomic inequalities and producing better mental health outcomes. The Royal Society for Public Health has published a comprehensive analysis of interventions designed to prevent mental health problems and promote mental wellbeing.[138] In general, a review has found that there is good evidence to support empowerment strategies to improve mental wellbeing among disadvantaged groups such as women, people in later life, and people at risk of HIV/AIDS.[142]

Given the positive association between debt and mental health problems, some interventions have been proposed for people in debt.[138] The Forum for Mental Health in Primary Care suggested a variety of initiatives that primary care staff could undertake to help their patients cope with debt,[143] including mental health screening for people in debt, and assisting patients to find debt advice.

Effective programmes have been developed to reduce the impact of identity group discrimination. For people who have experienced ongoing racism, the evidence suggests that emphasising the positive and trying to change the situation is

most effective, while, for people who have experienced acute racism, emotional distancing is more effective.[144] It has also been reported that seeking social support and having a strong sense of racial identity are helpful, while 'racial socialisation' has been recommended, which involves learning how to identify racism, having role models who demonstrate appropriate responses, and understanding the experience of racism.[144,145]

As loneliness has been identified as a risk factor, fostering the social inclusion of people at risk of loneliness – for example, older people and people with disabilities – would be one way of supporting their mental wellbeing and reducing the risk of mental health problems.

Given the high prevalence of mental health problems among people with long-term health conditions, improving the detection and treatment of problems such as anxiety and depression among this group would be likely to reduce the prevalence of mental health problems as well as improve overall health status and outcomes. For example, with more investment in mental health support there is evidence for reduced stress and improved clinical outcomes for people with cardiac disease, while mindfulness programmes have been shown to have a positive impact on people with diabetes and people with chronic health conditions.[138]

Finally, just as being the child of a person with a mental health problem can increase the child's risk of developing one

themselves, so family interventions and ensuring that mental health services are family orientated are likely to improve the mental health outcomes of these children. One approach is to follow the Social Care Institute for Excellence's guidance in 'Think child, think parent, think family', which makes practical suggestions on how to adopt a family orientated approach in mental healthcare.[146]

Conclusion

There is no escaping the uncomfortable fact that mental health has been misunderstood and mistreated for centuries.

Despite recent progress in addressing stigma, developing treatments and resourcing services, we argue that the public health aspect of mental health has remained largely neglected.

Public health is what we build together as a society when we shape our communities so everyone can achieve optimal health.[143] Public mental health is the art and science of improving mental health and wellbeing and preventing mental health problems through the organised efforts and informed choices of society, public and private organisations, communities and individuals. To achieve this high aim – which is understood so well when it comes to physical health – we

'Public health is what we build together as a society when we shape our communities so everyone can achieve optimal health'

need to start from understanding the causes and experience of mental ill-health in our communities and society. In this report, the Mental Health Foundation has sought to provide an overview of how social and economic inequalities contribute to mental health problems in the UK today.

The evidence is clear. Inequalities can influence and sometimes directly cause mental health problems. Experiencing poverty and living in a society with greater income inequality increase one's chances of having a mental health problem. Having an ACE is a risk factor in its own right, regardless of economic status, though living in poverty raises the likelihood of ACEs and compounds their negative impact. Other aspects of social status (such as being female, or being a member of the BAME, disability, deaf, and/or LGBT+ communities) also increase the likelihood of having a mental health problem, largely due to the negative impact of prejudice, discrimination, bullying and social exclusion. Furthermore, environmental circumstances such as being homeless, living in poor-quality housing, or having little access to green and blue space are all risks to mental health.

'Inequalities can influence and sometimes directly cause mental health problems'

The good news is that it is possible to act, collectively and individually, to reduce inequalities and their mental health effects, thereby improving the mental health of the population .

Socioeconomic inequalities are amenable to policy intervention, so action on these inequalities can lead to people having better mental health. Overall, action is needed across government and communities, taking a 'mental health in all policies' and whole-community approach. To succeed, policymakers and leaders across government should apply a mental health 'lens' to their policy areas; all should consider how they can reduce socioeconomic inequalities, and, by doing so, recognise that they are helping to realise the UK's mental health ambitions.

'It is possible to act, collectively and individually, to reduce inequalities and their mental health effects, thereby improving the mental health of the population'

At a societal level, one of the most powerful actions to be taken is to reduce poverty and income inequality. Building a society in which people are less worried about their financial circumstances and more economically equal has the potential to reduce stress and anxiety, thereby also reducing the pressure on overstretched mental health services and increasing life satisfaction and work productivity. The same is true for preventing abuse, bullying and discriminatory behaviour. Improving the communities and environments in which people live, ensuring the affordability of good-quality housing,

and widespread access to green and blue space can help to promote positive mental health.

Ultimately, of course, we all also have a role to play in advocating for such change, and in our own actions. By being active participants in our communities, articulating the desire to have resilient neighbourhoods, and maintaining connection with our friends and families, we can all contribute to reducing the impact of social and economic inequalities. In this way, policies and actions that support mental health can align with individuals' aspirations and actions to bring about the resilient communities in which everyone can flourish equally.

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